health futures

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This monograph follows on from recent work the Smith Institute has undertaken on health and early intervention. Over the past few years, the government has commissioned a series of reports that have helped bring a new focus to the urgent action which is required to help modernise the health service, and to make it more responsive to the needs of the citizen. But the primary focus of these reports has been to improve the existing service within the context of current pressures and expectations. Arguably, these are short-term, incremental measures, when a more radical and far-sighted approach is required. What are the challenges beyond the next 10 years? What more radical and challenging issues should government and other partners be addressing, to facilitate continuous improvement?

Asthma UK is the charity dedicated to the health and well-being of the 5.4 million people with asthma in the UK.

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Foreword
Rt Hon Alan Johnson MP, Secretary of State for Health

Little more than a decade ago, the presiding theme of any debate about the future of the NHS would not necessarily have been about how to improve it, but about whether it was worth saving at all.

Over the past 12 years, unprecedented levels of investment and greatly increased staff numbers have radically transformed the NHS. Its reputation as a service that could only provide the bare minimum and where long waits were endemic has finally receded and, as its 60th birthday celebrations demonstrated very clearly, it is an institution that is not only valued, but also cherished by the public.

There is a consensus that more or less spans the political spectrum that a national health service, funded out of general taxation and free at the point of need, is not only the fairest, but also the most effective and efficient way to provide health services. The NHS Constitution, published in early 2009, will help to protect both the values and principles of the NHS for future generations.

As the contributors to this publication point out, the challenges faced by the NHS are continually evolving. Our understanding of the causes of illness is greater than it has ever been. Heart disease, stroke and cancer have long overtaken infectious disease, as the major causes of mortality in this country, and, while genetics play an important role in health, in many cases such illnesses are preventable. Smoking, poor diet and lack of exercise play a major role in our health and account for many premature deaths in the UK.

While there have been tremendous improvements in people’s health and well-being over recent decades – including significant increases in life expectancy among the poorest – there is still a divide between the health of the wealthy and the health of those living in the most deprived communities.

New technology presents both challenges and opportunities – the public can, and generally do, access multiple sources of information about their health. They also – and rightly – have higher expectations of public services. The public expect to be able to access services quickly and conveniently, and for them to be organised around their needs, not what is professionally convenient.

The population is also older. There are now more pensioners than there are children, and there will soon be more over-65-year-olds than under-25-year-olds. This is, first and
foremost, a tribute to the NHS – the first generation to grow up with access to free healthcare are the longest-lived in this country’s history. But an ageing population raises important questions for all public services, not least for the NHS and on the future funding of social care.

All this means that demarcations between health and social care (and, indeed, all public services) are increasingly irrelevant, and the distinction between what is considered "public health" and what the NHS does feels even more artificial.

This thoughtful collection of essays provides an overview of the profound impact some of these questions are having on the NHS, and the practical measures that health and social care professionals are taking to deliver better services. It is a stimulating and welcome contribution to the continuing debate on what more must be done to improve the health and well-being of people in this country.
**Introduction**

Neil Churchill, Chief Executive of Asthma UK

**Where are we now?**

**The good news**

Historic sums have been invested in healthcare in recent years. OECD and World Bank figures show that total health spending accounted for 8.4% of GDP in the UK in 2006, compared with an average of 8.9% across OECD countries - nearly meeting Tony Blair's famous televised policy commitment to match average EU health funding levels by 2005. There is no doubt that this substantial investment has had an effect on provision. Latest figures show that in 2006 the UK had 2.5 doctors per 1,000 population, up from 1.9 per 1,000 population in 1998, but still below the OECD average of 3.1. Similarly, there has been a notable increase in the number of nurses in recent years. In 2006 there were 11.9 nurses per 1,000 population in the UK, compared with 8.0 in 1998. The OECD average was 9.7 nurses per 1,000 population in 2006. The investment has been essential in creating a platform for improved performance.

**The bad news**

The improved performance has not yet arrived to the degree that was expected. Greater numbers of doctors and nurses will not improve our health if we cannot encourage them to work in areas of high need. Senior government officials admit that we are losing the fight against rising trends in obesity and diabetes, both of which undermine the NHS’s long-term sustainability. Key reformers stress that we cannot continue with business as normal. Professor Paul Corrigan, one-time adviser to former health secretary Alan Milburn and more recently top strategist at NHS London, argues: “If we continue doing what we are doing, the NHS will go bust. We need to radically change the value proposition, the relationship between outputs and outcomes.”

Hoped for progress appears elusive. A recent authoritative survey of the English NHS cancer strategy, to take one example, which looked at survival rates of patients diagnosed with cancer in England and Wales between 2001 and 2006, suggested that the attribution

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1 This figure and those that follow come from OECD OECD Health Data 2008: How Does the United Kingdom Compare? (2008)
2 http://news.bbc.co.uk/1/hi/health/605962.stm
3 The UK is, however, well behind some other European countries such as France, Germany, Italy and Sweden, which all record 3.4 or more per 1,000 population.
4 Bob Ricketts, director of system management and new enterprise at the Department of Health, speaking at the Association of Chief Executives of Voluntary Organisations conference in March 2009
5 Keynote speech to Association of Chief Executives of Voluntary Organisations conference, March 2009
of improvements in survival in England to the cancer plan was “debatable.” “Alarmingly,” commented professor Karol Sikora, “there is still wide regional variation in survival, with deprivation still being linked to poor outcome – a factor the plan was meant to address.”

The challenge
The starting terms of debate, therefore, seem clear. Although there is political consensus that the NHS should be funded from general taxation and free at the point of access, there is also recognition that we must improve the productivity of that public spending and achieve radically improved health outcomes in order to maintain the sustainability of our system.

As Niall Dickson shows in chapter 1, improving productivity is not an easy road to travel and the alternatives are the less palatable options of more rationing or greater cost sharing. Productivity, rationing and cost sharing will all remain undercurrents shaping policy debate and “top-ups” remain the thin edge of a dangerous wedge in policy. Further challenges lie ahead in the credit crunch that is about to unfold in public services. Reduced spending was expected but not to this extent. The NHS will need to make large gains in capability financed by substantial savings from gains in efficiency and effectiveness. The readiness of the NHS to face the pressures arising from recession is considered by Michael Macdonnell in chapter 3.

Do we have the policy tools to meet these challenges? We do, but many of them are still in their infancy. World Class Commissioning is an important framework but primary care trusts have little competence as yet in developing local markets for healthcare, let alone managing them fairly. Lord Darzi’s Next Stage Review made quality the organising principle of the NHS, and yet much of it is unfunded and its improvements will take time. There is political consensus that healthcare should be less politicised, with minimal reorganisation and more focus on outcomes, not process targets. Also, more attention needs to be given to what works in improving public health and reducing health inequalities. As Scott Greer shows in chapter 12, however, there is more policy consensus about means within England than there is across devolved nations. We wait to see which route is most effective.

Key issues shaping our health futures
If we cannot continue the way we are heading, what needs to change? Two big leaps are clear. First, the NHS needs to make the leap from acute care into greater preventive provision through healthcare delivered in the community and in our own homes. We need
to intervene earlier to keep people healthy and stop us becoming ill, rather than pick up the higher costs of acute care further down the life course.

Second, we need to be much more involved in our own healthcare and to change our behaviours in key areas such as diet, smoking, drinking and exercise. Someone with asthma, for example, spends a small amount of time in NHS care and we need to know how to manage our asthma by ourselves if we are to avoid dangerous exacerbations that can lead to intensive care. Yet in the most recent figures, there were 80,000 emergency hospital admissions for asthma – a sign that we are not managing this common chronic condition well. This is true of most long-term conditions and shows that we require a step change in health literacy as well as more effective primary care.

The NHS, as with all health systems, seeks to balance the three policy goals of quality, access and cost. In the past, the NHS has arguably been most successful in managing cost, but as its emphasis has increasingly come to focus on improving quality and extending access, and its success in achieving the right balance will continue to be contested at local and national levels.

Looking to the future, the NHS faces relentless cost pressures from an ageing population, new technologies and rising expectations, which will make the three policy goals harder to achieve without fundamental improvements in productivity. Andrew Harrop assesses some of these known challenges, and our state of readiness, in chapter 4. These forces are now being underscored by the impact of a deep recession.7

The contributors to this monograph address many of these themes, and in this introduction I want to touch on four that will be powerful determinants of our health future.

1. Health equity
First is the question of health inequality. Although some might think this dimension of inequality has an unfortunate tendency to appear at the tail end of Labour governments, health equity does now seem firmly located as part of progressive politics of all political hues.8 Health is seen to underpin our ability to function fully as economic and social agents as well as active citizens, making it instrumental in achieving social justice. There is a need to strengthen equity in healthcare, not only through improved health outcomes

7 I won’t even mention the anticipated cost of a flu pandemic or the UK’s contributions to meeting the health challenges presented by global warming.
8 All main parties at Westminster have laid claim to being progressive, with the debate about means and not ends. For example, David Cameron: “Conservative means are the best way to achieve progressive aims will be the underlying philosophy of any government I lead” – speech on 22 January 2009
for the poorest (poor people should not be at much greater risk of emergency hospitali-
sation for their asthma, for example) but also to guarantee equity in the process of
delivering that care (research demonstrates that higher levels of dissatisfaction and lower
levels of healthcare use among some minority ethnic groups stem from discrimination).

For some people, for example those with severe asthma, a predisposition to poor health
makes them poor. For others, poor people with treatable ill health find it harder to access
health services and experience worse health outcomes because they are poor. As such,
active forms of intervention are necessary to erode barriers and extend access to people
who experience some of the worst health outcomes. With public resources tight, smart
government is needed rather than big government and savings can be made from better
prevention.

There is no doubt that tackling health inequality will cost money not only in the NHS but
also in education, employment and social protection policy. The role of the state is
explored in chapter 2, where Jenny Versnel asks what kind of active state will be required
to deliver smart and targeted health interventions, and whether it will be sufficient to
nudge and incentivise people to take more individual responsibility for their health. Martin
Dockrell examines the example of tobacco control in chapter 11 as an occasion when
government took a highly interventionist stance on a major public health issue and asks
what lessons can be learned for the future.

2. Maintaining health and well-being
Second, there is the extent to which health is considered in its broader context, and not
just through the perspective of healthcare. One of the more potentially radical departures
of current policy is the development of patient-reported outcome measures, which will,
in time, influence the way healthcare professionals (and perhaps in future other public
servants) are incentivised and rewarded for their effort. Of course, patients want to be
treated safely, swiftly and effectively. But the outcome of good healthcare will also be
seen by patients as the ability to function fully in our day-to-day lives. Rather than simply
reducing emergency asthma admissions to hospital, for example, effective care will reduce
days lost to asthma in the workplace and at school. To achieve that, we need self-
management and integrated care planning that covers more than the NHS. This is
recognised in the operation of US health insurers, which seek to minimise risk to the
individual being insured and reduce cost to the insurer. It should be recognised too in
school policy towards children with long-term health needs (as it is for those with
educational needs).

A similar approach in the UK could see the benefits, for example, of allowing a child with severe asthma extra support to complete their education and gain valuable qualifications, or an adult with a chronic health condition to retain stable employment. Both promote life chances and save government expense in the long run but require subtle interventions at the right time that do not easily fit departmental boundaries or budgets.

The contrasting narrow approach to healthcare is one where staff remain trapped in institutional blinkers, seeing the asthma they are treating, for example, but not the individual with asthma. In chapter 5, Tim Kelsey shows how we can overcome barriers to using meaningful information about individuals, localities and performance to improve healthcare. In chapter 6, Mikis Euripides investigates the importance of location in extending access to healthcare to the places we lead our lives, through the supermarket, the school and community institutions, and asks if this is a way to reach the missing millions who need, but do not access, more healthcare.

3. Public engagement

Third, there is the extent of public engagement in health. In 2002 Derek Wanless indicated that success or failure of policy towards the NHS would be influenced by the extent to which people become involved in maintaining their own health. Poor levels of health in the population will put huge pressure on the NHS and could swamp its efforts to meet targets and improve care. His "slow uptake" scenario envisaged people doing little to improve their lifestyles, in contrast with his "fully engaged" scenario, in which levels of public engagement are high and health status improves dramatically. In absolute expenditure terms, the gap between these best and worst scenarios is large – around £30 billion by 2022/23, or half of current NHS expenditure.10 Much of the recent debate has focused on individual responsibility for our own health, and this plays a significant role.11

In addition to asking whether people are doing enough for themselves, we also need to consider whether healthcare services do enough to understand people's behaviour. Not all of us are expert patients. As Asthma UK's 2008 survey suggested, one in five people with asthma say they are frustrated and confused by health information, although they are keen to do more to stay healthy.12 In chapter 9, Joan Walsh and Don Redding argue that the health service itself needs to become more health literate, redesigning services and interventions to be more tailored and fully inclusive. Also, Harry Cayton argues in chapter 10 that public accountability works. The improvement in access to information

11 For one well-publicised example: “David Cameron Tells the Fat and the Poor: Take Responsibility” in Times Online (8 July 2008)
12 Unpublished Asthma UK research (2008)
about “what works, what is available and what is good” will create a virtuous circle of transparency and accountability that will ultimately improve care.

4. A managed health market
Professor Paul Corrigan has outlined the need to improve the “value proposition” in health or the link between inputs, outputs and outcomes. The approach being taken in England is to develop managed health and care markets, with a diversity of providers and fair competition overseen by world-class commissioners. This lies at the heart of the Smith Institute’s interest in the interface between social justice and effective markets.

Markets in healthcare are not fair or efficient when left to their own devices. Many well-understood economic problems arise, including adverse selection, which can lead to exclusions; rising costs, leading to inefficiencies; unequal information, for example between clinicians and patients; and market failure, for example in public health. There is also the basic fact that demand for healthcare increases as people become richer, but many of those facing the worst health outcomes are older, poorer, frailer, living in disadvantaged neighbourhoods or members of marginalised communities. There is also considerable scope to debate economic incentives. How can these be developed to improve outcomes, not just deliver processes? Therefore, one of the key progressive challenges of the next decade will be to create markets in health that meet patient needs in ways that are fair, effective and affordable.

Improvements in the supply of healthcare are now emerging through an evolutionary process of reform. The goal of change, however, is disruptive in that it seeks to put in place innovations that are more effective than – and will ultimately replace – business as usual. New demands are also being made of commissioners, with primary care trusts seeking to become world class and overseeing practice-based commissioning, where the bulk of NHS resources are spent, while offloading direct provision to other parts of NHS, voluntary groups and social enterprises.

Yet the process of achieving innovation has not been smooth, and the improvements have not yet been consistently documented. We include two perspectives on these innovative but disruptive changes. Dr Richard More is an example of a clinical entrepreneur establishing a better model of provision in a changing health market, as he explains in chapter 7. In chapter 8, Maria Duggan, Ruth Hussey and Dominic Harrison describe the transformational policy framework that has been developed to address health inequalities in NHS North West.

Whether the NHS is on track to truly become world class is explored in the concluding chapter. Anna Dixon compares our trajectory with that of our European partners and
other developed world healthcare systems and considers how the NHS will look at the end of our current journey.

**Alternative health futures**

Rather than a single, consensual future, we must contemplate a number of possible health futures. The one we must work hard to avoid is a future in which the NHS and broader economy are undermined by rising costs of poor health literacy, greater morbidity, growing ill health and deepening inequality.

The 2008 recession has already forced a rethink of many long-standing tenets of public policy. It is clear that it will never again be “business as usual” for government, whoever is in power. This is already understood within the NHS. Although there will not be wholesale reorganisation, there will be radical and ever-increasing change. But are there lessons to learn from the experience of economic bubble and bust? It is important to recognise that there is no reason to unwind the mixed economy of healthcare delivered through social markets that are managed so as to be fair and effective.

There should be no doubt that the right balance of incentives, rewards and penalties is needed to optimise quality and manage cost in healthcare provision. GPs on their own will not decide to set up practice in poor inner cities; there needs to be an incentive – probably through a higher per-capita fee – to turn around provision in under-doctored areas. Similarly, primary care trusts need to be incentivised by the potential of cost savings to avoid unnecessary hospital admissions, especially readmissions, which can be avoided through effective case management.

The failings of Stafford Hospital show that the wrong incentives and poor risk management can distort outcomes in public services just as much as they can in banking. Current tensions exist, such as an NHS-funded by taxation but allowing top-up payments; the need for greater health literacy but the fact that a high proportion of healthcare is consumed by wealthier, better-educated, more assertive patients; the need for national priorities and standards but the desire for more care closer to home; innovations in IT but the need to respect patient privacy. We need to recapture our sense of moral purpose in the provision of healthcare, reinforcing the values described in the NHS Constitution, if we are to deal with such challenges.

It means that we will need smart, active government capable of making targeted interventions to ensure that healthcare is distributed fairly and that health outcomes are improving among those who most need it. A nudge will not be enough to achieve the improved health outcomes we need, and laissez faire will only exacerbate the divide.
between the health-rich and health-poor. Commissioners and providers of services need to be active in delivering better health outcomes where they are needed. That will require responsive local services and greater personalisation of care as well as national public health campaigns. It will also mean that gaps in provision need to be filled and that far more effective integration will be achieved across public services.

In addition, we need a greater emphasis on solidarity as well as individualism in public services. Of course, health services must be responsive to individual need, and choice has a part to play in achieving that. But few patients see themselves wholly as consumers: most people I meet are conscious of our duties as citizens towards the "public good" represented by the NHS and the claims of others on its resources. Good citizenship should be encouraged in healthcare and we need to engage patients in things they have in common, and not set them apart by arbitrary distinctions between different conditions (for example, the incoherent system of exemptions for prescription charges). I am always struck by the need for emotional support that I see in Asthma UK services and wonder why such support is not offered more consistently within the health service itself.

There need to be guarantees as well as choices. Yes, there is a place for individual health budgets, which will help some people with chronic co-morbidities or mental health problems receive better care. However, the majority of people want their local services to be good and safe, and want to be sure that whoever they see in general practice or acute care has the training and skills they need for the role. There are "moments of truth" in healthcare provision and we need to make the most of the opportunity for engagement that comes upon diagnosis, for example. At present, too often this opportunity goes to waste as patients leave with medication but without information. It should not be the case that substantial numbers of lead nurses with responsibility for respiratory care do not have the training they need to do the job or that nurses sometimes have to pay for relevant training out of their own pocket. These are basic guarantees the state should meet.

We need expert leadership balanced with the championing of patient interests. Clinical leadership is vital to improving services and delivering outcomes, but although there are examples of excellent practice, there are also pockets of disinterest, discrimination and poor practice and these need to be confronted. Increased public involvement and accountability will help make sure patient voices are heard and acted upon. But there will always be a role for politicians in making sure that the NHS responds to patient need, whether that is for dignity on the wards, good standards of nutrition, fair access to modern technologies or an end to poor performance or unacceptable local variation in quality. The NHS spends too much public money and plays too big a role in our lives for its decisions to be made by committees of experts.
Although we need more localism, we need to keep the N in the NHS. Patients have a right to expect that managers are commissioning the best care pathways and doctors are meeting national clinical guidelines. This could best be achieved with clear, national outcome measures, incentives to reach those in need – especially in poor areas – and national clinical standards as benchmarks for practice. This leaves considerable room for local manoeuvre on local priorities and on means to achieve ends that are compatible with community expectations, needs and cultures.

Thinking of our health futures, then, two scenarios present themselves. In the first, those receiving the best outcomes will have the best health literacy and will tend to have higher levels of education and affluence and live in the least disadvantaged communities. Distribution of resources will be heavily influenced by adversarial and self-interested interactions of commissioners, interest groups, public bodies, clinicians and local communities, and patients will increasingly see themselves as consumers of resources rather than citizens. Choices about rationing and reorganisation will be distorted and misunderstood, leading to little change. The result will be a segmented patient community much like we see in the labour market, with the gap widening between health-rich and health-poor, a growing sense of insecurity among those marginalised by services and a burgeoning expense that will become unsustainable.

In the second, effective interventions appropriate for those with least health literacy will improve their engagement and have systemic benefits for the whole patient community. Commissioning and case management will enable public services to reinforce each other in sustaining population health, leading to improved outcomes across society. Active interventions will continue to be made to reach out to people experiencing the worst health, and full use will be made of those moments when patients are most disposed to learn improved self-management.

Discrimination will be tackled and pockets of poor practice brought up to the standard enjoyed elsewhere, and patients will be increasingly confident that their local services are of good quality, wherever they live. Patients will be encouraged to see themselves as citizens as well as consumers, with greater emphasis on emotional support and sustainable consumption and the opportunity to engage meaningfully in discussions about resources. The result is improved outcomes for all, with growing numbers becoming health-rich and sustainable demands on the public purse.

I hope that ideas in this monograph contribute towards a renewed progressive vision and effective means for delivering better social justice in the social markets of our health services.
Chapter 1

Future challenges

Niall Dickson, Chief Executive of the King’s Fund
Future challenges

We have arrived at a unique moment in the history of our national health service. After a prolonged and unprecedented period of funding growth, we know that in about two years' time the days of plenty will be over. Instead we face the prospect of zero growth and almost certainly real-terms reductions, while the pressure of rising demand will be unrelenting.

This is unique not because of the severity of the downturn, which may or may not be worse or more prolonged than previous bouts of austerity, but because we know that it is coming. Never before has the system had a period of relative plenty to prepare itself for lean times ahead.

Financial challenge

In England, the focus of this report, the 2007 comprehensive spending review increased NHS spending by 4% per year in real terms, taking its budget from £90 billion in 2007/08 to £110 billion by 2010/11.\(^1\) These may not be very large increases in historical terms, but they are good compared with other parts of the public sector, and the NHS will benefit to some extent from lower-than-expected inflation. More to the point, they follow huge injections of resource that, arguably, have left the service better funded than at any point since it was launched in July 1948.

The extent of this growth – probably not appreciated by the public, but looked at with envy from other parts of the public sector – is remarkable. In the five years from 2002/03 to 2007/08 the average annual real-terms growth in the NHS in England was 7.4%.\(^2\) Spending on the NHS went up by almost 50% in real terms, and in cash terms by more than £43 billion. The government has nearly achieved its goal of matching the levels of funding found in the EU – with the proportion of the UK's gross domestic product devoted to healthcare rising to around 9%. The trend elsewhere in Europe has been to spend a smaller proportion of wealth on health in the last few years.\(^3\)

At the same time, it is worth remembering that the decision to increase funding was predicated on assumptions in the 2002 Wanless review that the heavy initial investment would still need to be followed by above-inflation growth in later years. Even in his least

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1 HM Treasury 2007 Pre-Budget Report & Comprehensive Spending Review: Meeting the Aspirations of the British People (HM Treasury, 2007)
2 Wanless, D, Appleby, J, Harrison, A and Patel, D Our Future Health Secured? A Review of NHS Funding & Performance (King's Fund, 2007)
3 OECD OECD Health Data 2008 (2008)
expensive scenario, Sir Derek Wanless argued that the increase in health spending would need to be followed by growth of 2.4% in real terms to meet the growth in demand.\(^4\)

That now looks decidedly optimistic. In October last year the Institute for Fiscal Studies pointed out that the current pencilled-in figures for 2011/12 and 2012/13 implied overall spending growth of 1.9% in the next comprehensive spending review\(^5\) – since then the outlook has worsened considerably, and there is now general agreement that present attempts to kick start the economy will have to be paid for down the line with higher taxes or curbs on spending and almost certainly both. In private, ministers and officials acknowledge that from 2011 on, whoever is in power, the NHS will probably have to cope with no real growth and possibly something worse than that.

**Changing demands and expectations**

Most attempts to look into the future take existing trends and stretch them ahead in time; what they find more difficult is to predict the impact of major events that can change the whole paradigm. There is probably a limit to how far the health service in this country or any other can prepare for pandemic flu, acts of terrorism, global warming or nuclear war, and less still can be done for other disasters not yet identified. It is possible, though, that any one of these could have a catastrophic impact on the capacity of the system and influence the way healthcare is delivered.

At a more prosaic level, even in the next 10 years health services will have to cope not just with an ageing population, which they have done for more than a generation already, but a population where the fastest-growing group is among the very old – in the next 17 years the number of those aged over 85 is set to increase by two-thirds.\(^6\) We know this will have a major effect on demand, with extended life bringing not only more healthy life years but more unhealthy ones as well. It is also likely to mean unprecedented demand for social care to support the big increase in older people living with dementia.\(^7\)

Alongside this, the pattern of disease will change, with conditions such as cancer becoming both acute and chronic.

We have yet to understand fully the impact of lifestyle changes or the extent to which they are amenable to correction. Already we have an epidemic of what has been termed

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\(^6\) Wanless, D *Securing Good Care for Older People: Taking a Long-term View* (King’s Fund, 2006)

\(^7\) McCrone, P, Dhanasiri, S, Patel, A, Knapp, M and Lawton-Smith, S *Paying the Price: The Cost of Mental Health Care in England to 2026* (King’s Fund, 2008)
“diabetes”, with a huge growth in Type 2 diabetes among children. There are unexplained increases in rates of asthma, which may be lifestyle-related. The World Health Organization has estimated that 60% of healthcare involves treating patients whose conditions are caused by lifestyle factors – if as a society we are not able to tackle rising obesity, growing alcohol consumption and persistently high rates of smoking (22% of men and 20% of women are still regular smokers), it is possible that the next generation could grow up to be less healthy than their parents.

Technology has already had a profound impact on the way each of us interacts with the world, including with public services. This has probably exacerbated a trend that was already under way to expect higher levels of more personalised service. There is no reason to suggest this is about to change – the generation now approaching old age will be more demanding and less willing to accept what they are offered.

Some of this lies behind the present government’s drive to make the NHS more responsive and to offer greater choice – a realisation that patients will not be as patient as they once were and that if the service is to retain public support, it will need to adapt and respond much more to individual needs. If the economic downturn continues, then the vast majority of patients will have no alternative but to use the NHS – so the risk of so-called middle-class flight is probably less than it has been, but that does not mean these patients will be as accepting or deferential as their parents or grandparents.

The business of healthcare is overwhelmingly about the care and treatment of older people and, if anything, that will become more pronounced as the number of young people declines – the percentage of the population under 16 has fallen every year since 1995. There are now fewer children than pensioners. This could prompt a renewed debate about the intergenerational contract that has remained more or less intact since the dawn of the post-war welfare state. In the immediate future that debate is likely to be more about the responsibilities of the state, individual and family in funding social care, but it could well spill into health as well.

A more resilient system?
At the heart of the health debate going forward will be the extent to which the national health service has used the good times to build a robust system, capable of weathering the coming storm.

9 Patton, G and Viner, R “Pubertal Transitions in Health” in The Lancet vol 369, no 9,567 (2007), pp1,130-1,139
10 http://www.statistics.gov.uk/cci/nugget.asp?id=949
If the present system has been better resourced than in the past, it should in theory be more resilient. Although much of the extra funding has gone on higher pay,\(^\text{11}\) it has also been used to expand the workforce and meet demand. According to the Department of Health, between 1997 and 2007 the number of hospital doctors increased by slightly more than 27,800, the number of GPs by 6,500, the number of qualified nurses by 80,000 and the number of qualified scientific, therapeutic and technical staff by about 40,600.\(^\text{12}\) These are significant increases, which should be enabling the system to do more and to meet previously unmet need. This should have put it in a better position to cope with reduced growth going forward.

The NHS in England continues to face major service challenges that will require fundamental changes in the way services are delivered – for example, the shift towards more services in the community set out in the white paper *Our Care, Our Health, Our Say*\(^\text{13}\) remains largely unrealised and all the regional service plans drawn up as part of the Next Stage Review signalled radical reforms in the way clinical services are organised and delivered.\(^\text{14}\)

On the other hand, the NHS should benefit from a period of relative organisational stability, with at least the main structures of primary care trusts and strategic health authorities protected from the usual desire of politicians to redraw boundaries. Both the main political parties have promised to resist any temptation to repeat the experience of the last 20 years, which have seen a succession of major reorganisations without any evidence of benefit.\(^\text{15,16}\)

There is evidence that healthcare systems that involve clinicians in the shaping and managing the way care is delivered are more effective. The alienation of doctors and other professionals in recent years has been a significant weakness and therefore there must be some cause for optimism in the current drive to involve clinical staff. The Next Stage Review signalled a commitment to achieve greater involvement of health professionals in both policy formulation and management, and the review itself did achieve greater engagement, particularly with the medical profession, in devising new clinical pathways.\(^\text{17}\)

\(^{11}\) Wanless et al, op cit (2007)
\(^{12}\) NHS Information Centre, March 2008
\(^{13}\) Department of Health *Our Health, Our Care, Our Say: A New Direction for Community Services* (HMSO, 2006)
\(^{14}\) Darzi, *A High Quality Care For All: NHS Next Stage Review Final Report* (Department of Health, 2008)
\(^{16}\) Rt Hon Alan Johnson MP (Hansard, 10 October 2007, col 298)
\(^{17}\) Darzi, op cit
There is some way to go but, with the encouragement of Monitor, the independent regulator of NHS foundation trusts, some progress has also been made within foundation trusts using service line management as an approach, which should lead to greater clinical ownership of processes and budgets and more of a shared agenda among managers and clinicians to improve efficacy and efficiency of services.\textsuperscript{18}

It would be easy to overstate this, but if it is possible to get the professionals on-side and backing reforms, then even in a more challenging economic climate it should be easier both to push through reform and to secure public support for changed patterns of care.

This is a health system that, for all its faults, is performing better – the reduction in waiting times for elective care has been dramatic,\textsuperscript{19} the experience of attending accident and emergency departments transformed,\textsuperscript{20} and progress made in reducing premature deaths from cancer and heart disease.\textsuperscript{21,22} The latest health check from the Healthcare Commission reports that 60\% of NHS trusts are now rated as good or excellent on the quality of services they provide – just three years ago, 60\% were weak or fair.\textsuperscript{23}

Patients are generally happy with the services they receive – 75\% are satisfied with primary care, while among hospital inpatients the figure is 92\%.\textsuperscript{24,25} These broad measures may not tell us much about the detailed experience of being cared for by the NHS and are by no means a cause for complacency but, accepting their limitations, these are good scores.

And after a rocky period in 2005 the NHS is now in financial balance (for now) in spite of considerable pressures in some institutions and local health economies.

The weaknesses
Inevitably, though, there are significant weaknesses that will need to be addressed if the system is to withstand the lean times ahead. Six areas stand out.

First, there remain large and unexplained variations in funding, service utilisation and clinical performance. Even after taking into account age, social deprivation and other factors, why

\textsuperscript{18} Monitor Service Line Management: An Overview (HMSO, 2009)
\textsuperscript{19} http://www.performance.doh.gov.uk/
\textsuperscript{20} http://news.bbc.co.uk/1/hi/health/3951353.stm
\textsuperscript{22} Department of Health Cancer Reform Strategy (HMSO, 2007)
\textsuperscript{23} Healthcare Commission The State of Health Care (HMSO, 2008)
\textsuperscript{24} Martin, J The Key Findings Report for the 2008 National Survey of Local Health Services (Picker Institute Europe, 2008)
\textsuperscript{25} Garratt, E and Boyd, J The Key Findings Report for the 2007 Inpatient Survey (Picker Institute Europe, 2008)
is it that some primary care trusts spend two-and-a-half times as long on cancer than others? Why is it that lengths of stay for the same condition can be twice as long in some trusts as in others? Why do rates of emergency admission (one measure of how well long-term conditions are managed by community services) vary threefold across areas of similar demographic make-up? Each of those variations suggests sub-optimal care and inefficiencies.

Second, there is now growing evidence that too many services are not in the right place – the Next Stage Review process identified new, more efficient pathways based on international evidence of best practice, but it will take time, commitment and resources to change the way care is delivered. In the end, as Don Berwick observed, quality may indeed be cheap but in this case it will be a challenge securing it.

Third, there is now agreement that commissioning – the engine of this government’s reform programme – is some way from having the skills, resources or know-how to drive the changes needed. The recently completed assessment of the primary care trust commissioning function demonstrated how much still needs to be done – too many commissioners lack the skills and resources to lead the changes that are needed. Unless they improve their performance significantly over the next two years, they will struggle even more when the funding begins to be constrained.

Fourth, healthcare is very largely a technological business, yet, as Derek Wanless found in his 2002 review of UK healthcare, the NHS is “a late and slow adopter of technology”, a view endorsed by the NHS Next Stage Review, which referred to the “reluctance” of the NHS to adopt new technologies.

Current difficulties with the national IT programme Connecting for Health suggest that progress could continue to be hampered for the foreseeable future, the programme having “experienced issues with implementation, interoperability, costs and timescales”. Yet the potential rewards are considerable – apart from improving patient experience and reducing clinical errors, embracing the digital age makes financial sense – evidence from the US, for example, suggests that hospitals that are high adopters of IT do achieve savings over time.  

26 Appleby, J and Gregory, S NHS Spending – Local Variations in Priorities: An Update (King’s Fund, 2008)
27 Darzi, op cit
29 Crump, H “PCTs Exceed Expectations in Year One” in Health Service Journal 5 March 2009
30 Wanless, op cit (2002)
31 Darzi, op cit
32 Liddell, A Technology in the NHS: Transforming the Patient’s Experience of Care (King’s Fund, 2008)
33 PricewaterhouseCoopers Tech Center The Economics of IT & Hospital Performance: A Population Study Reveals Challenges & Opportunities (2007)
The possibilities are not just around advanced robots and linear accelerators – bringing technology to customer-facing exchanges offers the possibility of better administration and transactions, and better-informed consultations and clinical care, as well as advances in diagnosis, monitoring and relationships. The barriers are now better understood, but the cultural change required to overcome them will be considerable.34

Fifth, the NHS lacks coherent mechanisms to provide meaningful accountability at local level. While the government has taken a number of steps to devolve power and responsibility from Whitehall to foundation trusts and to local commissioners, there has been little effort to devise a coherent system of local accountability to match these new responsibilities. In particular, while primary care trusts are urged to involve patients and the public in decision making, there is no effective way of holding them to account. As the cross-party Local Government Association Health Commission pointed out last year, organisations cannot be accountable if people do not know what they are or what they do. The commission found that more than half the public did not know what a primary care trust was, nearly three out of four could not name their local trust and among those who claimed to know about primary care trust responsibilities, refuse collection was among the top four activities cited.35

Finally, in spite of the relatively positive reports from patients, the health service is a long way from being able to say that it provides consistently compassionate care. Hospital care in particular can seem impersonal, with staff failing “to see the person in the patient”.36 There is also now a growing body of evidence that too often patients and their carers do not feel involved in their care, and on this the NHS fares worse than other, similar healthcare systems.37 Improving clinical quality and outcomes must be a top priority, but so too is ensuring that the service provided is responsive, individual, and empathetic, not least because how patients are treated has been shown to influence how well they recover.38

The challenges ahead

This, then, is the system that must now prepare for a sustained period of low or no growth. That will certainly mean that demand for services will exceed supply and that unless measures are taken to address this then the funding gap will widen year on year. There are three possible responses: ration care; raise productivity; or abandon or modify tax funding

34 Liddell, op cit
36 Goodrich, J and Cornwell, J Seeing the Person in the Patient (King’s Fund, 2008)
38 Goodrich and Cornwell, op cit
to encourage individuals to use more of their own resources to pay for healthcare.

The three responses are not mutually exclusive, but we can expect a debate about the feasibility and desirability of each of them over the next few years. Raising productivity for many will look the least painful and most attractive, although whether it can deliver the gains required is not clear.

The 2002 Wanless report warned that if the NHS was to contain costs to sustainable levels it needed to raise productivity in general, embrace information technology in particular and engage patients in managing their own care. Thus far progress on each of these objectives at best has been patchy, and by some measures NHS productivity has actually fallen.

The most common reaction when budgets tighten is to resort to short-term remedies, such as freezing posts and delaying developments. We know too that relationships can deteriorate as financial issues start to dominate, for example between health and social services (over discharging patients) and between primary care and the acute sector (over referral patterns and payments). Counteracting these forces will be vital, as will resistance to those who will inevitably look to new organisational solutions.

The debate over the adequacy of health funding looks certain to reignite and with it arguments over the viability of our tax-funded model – as yet, given the political consensus described above, it looks safe, but after three or four years of austerity the critics will have a stronger case if the health system has not responded by making itself more efficient and effective.

All this forms a formidable agenda, and the focus will inevitably be on those in the front line who have to manage and deliver the service while controlling costs, increasing productivity and driving up quality. Making that happen, though, also requires the right incentives and levers to motivate staff at all levels to do things better and to do better things.

There is no shortage of these incentives. In the last 10 years policy makers have introduced one after another in an effort to reform the system. We now have an array of financial instruments, from the quality and outcomes framework in general practice to payment by results for secondary care. Choice and competition have begun to make an appearance, as has contestability (competition for a market rather than within a market). Professional

39 Wanless, op cit (2002)
40 Wanless, op cit (2007)
and organisational regulation, both of which have been subject to extensive reform, have key roles to play, as too increasingly will the publication and benchmarking of performance data. Nor should we forget the power of that traditional motivator of many health staff – professional pride and a belief in the ethos of the NHS.

The challenge, of course, is to ensure that all these complex and sometimes powerful levers are aligned rather than overlapping and competing with each other, and that any perverse effects – of which there will always be some – are minimised. The truth is that our understanding of how the levers will work and interact with one another is rudimentary and that it will not be easy to conduct this orchestra from the centre without trying to dictate how each instrument is played.

There is a commitment to devolve power from the centre and to move away from crude targets and performance management towards more sophisticated incentives with an emphasis on outcomes rather than process. It remains unclear how real or sustained this commitment will be.

**Conclusion**

If it is to survive and prosper over the medium term, the health service must meet each of these challenges and, by measuring more clearly what it does, demonstrate the outcomes it achieves. It will have to show “world-class” results – meaning that the NHS in England is at or near the top when its performance is measured against comparable health systems in other developed countries.

That will include not only how it manages the population as a whole but also how it serves the most vulnerable. The health service is already one of the most fair but it struggles to tackle the poorer health of poorer sections of society – that can never be a matter wholly or even mainly for health services, but the NHS can do more and can do it better.

Lest all this sounds excessively gloomy, it is worth noting the odd sliver of silver lining on those approaching clouds. Downturns may not be all bad – one study in the US found that death rates declined sharply in the 1974 and 1982 recessions, and increased in the economic recovery of the 1980s. What is more, tougher times and the hard choices they bring may encourage managers and clinicians to seek new solutions to old problems – or, as the White House chief of staff remarked recently, “let’s not waste a good crisis”. There is opportunity here as well as challenge.


Chapter 2

Active state or nudge state?

Jenny Versnel, Executive Director for Research and Policy at Asthma UK
Active state or nudge state?

A little over 60 years ago, the birth of the NHS heralded a new era of greater health security for all citizens through the treatment and prevention of disease. The principles underpinning the NHS have not changed, but technological advances and societal influences have placed it under considerable pressure and there is a need to identify the changes required for the system to continue to deliver world-class care in the future. The purpose of this chapter is to explore how government and society can act to improve the health of its citizens, and whether any techniques aimed at influencing healthy behaviour are effective, and to suggest the direction of public policy if the NHS is to meet the challenges of the future.

There has been a rapid rise in lifestyle diseases and it would not be unreasonable to argue that whether or not we lead a healthy life cannot be a purely personal decision; after all, the NHS pays the costs when we become ill. Freedom of choice is a fundamental right but the problem for government is that freedom of choice does not guarantee that people will, or are able to, make informed or healthy choices. What roles do individuals, society and the workforce play in creating unhealthy lifestyles and what roles should they, together with the NHS, play in helping to create a healthier nation?

Government is acutely aware of the need for behavioural change related to health. Saving Lives: Our Healthier Nation refers to the need to change lifestyles, recognising the fact that “if people are healthier, their demands on the health service will be less than they would have been.” Although government is taking some steps towards addressing unhealthy lives, more urgent attention is needed to counteract the negative effects that long-term conditions are likely to have on the workforce, namely reduced productivity, leading to reduced collective output. However, current health policy is creating tensions that are not easily resolved; while striving to improve the overall health of the nation, it also aspires to increasing individual choice and, at times, the two are not synergistic.

The field of genetics is a classic example of where scientific and technological advances enable us to predict the likelihood of a disease developing in an individual and thereby the potential to improve the health and wealth of the nation through early diagnosis and prompt treatment. When it comes to individual choice, however, many people do not want to know their chances of developing a condition that is likely to impact heavily on their life sometime in the future and they certainly do not want employers and insurance

1 Department of Health Saving Lives: Our Healthier Nation (2009)
2 Ibid
companies to know for fear of discrimination. While many accept the need for government
to have policies around societal issues, such as communicable disease, they wish, as is
evidenced by the reduced MMR vaccine uptake, to retain an element of choice, which can
lead to unhealthy lives.

The Foresight report of 2007 entitled Tackling Obesities: Future Choices estimated that
60% of the UK population will be obese by 2050.3 If we are to succeed in addressing
unhealthy lifestyles, we need to view health in the context of physical, mental and social
well-being and not simply the absence or prevention of disease.4 It should be borne in
mind that while many of the factors that determine health outcomes are arguably avoidable,
some health determinants, such as one's genetic make-up, environmental factors or those
related to free choice, are unavoidable or more difficult to influence. To be successful, both
upstream and downstream policy interventions are required.

How can we address behavioural change?
There is little doubt that without some sort of intervention we are unlikely to reverse the
current rise in lifestyle diseases. The challenge lies in the level of intervention that will be
accepted against the backdrop of current health policy, where independence and choice
are driving the future of healthcare.5 If you intervene too strongly, there is a danger of
disengaging the very people you need to drive economic prosperity.

Richard Thaler, professor of behavioural science at the University of Chicago, recently
published a book with Cass Sunstein entitled Nudge and it is receiving a great deal of
attention from politicians across the globe.6 Thaler and Sunstein believe it is possible to
change people's behaviour, not by eliminating unhealthy choices or removing freedom of
choice but by placing greater emphasis on healthy choices or reducing inertia that can
significantly impact on our decision making. It is an approach to influencing behaviour
based on the rationale that people are highly influenced by suggestion and what we see
other people doing. Would we argue our free choice is affected if one enters a supermarket
and the first thing you see is an eye-catching display of fruit and vegetables or when you
enter the doctor's surgery you see information about a local exercise class? Nudging people's
behaviour is acceptable to most of us; after, all is this not the purpose of advertising?
However, the key factor is who is doing the nudging: if it is government, some people
argue, this is paternalism a step too far.

4 World Health Organisation definition of health
5 Department of Health Our Health, Our Care, Our Say: A New Direction for Community Services (HMSO, 2006)
6 Thaler, R and Sunstein, C Nudge (Yale University Press, 2008)
Thaler’s ideas are popular in the US, where schemes such as automatic enrolment in savings schemes have been successfully implemented and accepted and similar ideas related to pensions will shortly be introduced by New Labour. Inertia can play a significant role in decision making, and research shows that if someone is automatically enrolled in a pension scheme they are not likely to exert their right to opt out of it. In terms of health examples, presumed consent for organ donation is a topic that has resulted in heated discussions in the UK because, unlike the example of pensions, strong personal feelings are aroused, in part based on cultural and religious beliefs.

Nudging people to lead healthier lives is extremely challenging because in order to succeed you need to address the underlying reasons and beliefs that lead to unhealthy behaviours becoming established in the first place. People are influenced by the foods they see all around them in their daily lives – in vending machines, canteens or shops. If schools and NHS hospitals, places you would expect to lead the way in educating children and adults, are promoting unhealthy diets through the provision of vending machines and fast-food outlets, the messages many are receiving from early in life is that these foods are acceptable and the norm. If nudge theory is correct and the way to alter behaviour is to place greater emphasis on healthy options, then we have a long way to go in changing the way we promote food in schools, hospitals and workplaces.

All political parties believe *Nudge* has a place in policy development, but the Conservatives are particularly enthusiastic and are consulting Thaler for solutions to address current societal issues, such as binge drinking, knife culture and even climate change.

Nudging is a relatively subtle intervention and is not perceived as a direct target on individuals or their freedom of choice; while effective in removing inertia or highlighting alternative options, it is doubtful that it is strong enough to alter unhealthy behaviours that have become entrenched in society.

Jamie Oliver’s healthy school meal programme was faced with challenges right from the outset and indicates just how far we have to go to change behaviours. Even if we educate children, the parents are ultimately the ones influencing food choices at home. The heart of the problem is that many are unable, or unwilling, to make choices based on long-term impact. Teenagers are more likely to worry about obesity in terms of how their peers will view them, rather than the probability of getting cancer in the future. If we are to learn from research carried out into pensions, many of us wait too long before we invest in our futures.

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7 Pensions Act 2008  
9 *The Guardian*, 12 July 2008
Can incentives work?
The Liberal Democrats believe a more direct approach is required, and a mix of tax incentives and penalties has been suggested to place the NHS on a better footing. For example, Norman Lamb recently announced that people who give up smoking, lose weight or join a gym would receive tax incentives and those missing GP or hospital appointments would pay a £10 fine.10

Incentives as a means to encourage healthy behaviour are common practice in many countries and are gaining acceptance in the UK. For example, North East Essex Primary Care Trust is offering pregnant women who smoke vouchers to the value of £100 over a year to purchase anything except tobacco and alcohol,11 Eastern and Coastal Kent Primary Care Trust is paying overweight people up to £425 if they lose weight12 and the Young Foundation has developed a social enterprise called Healthy Incentives13 that both encourages and rewards people who look after their health.

If the popularity of store reward cards is anything to go by, incentives are a winner, but one could question whether it is morally right to provide incentives to people leading unhealthy lives; after all, are we not discriminating against those who lead healthy lives and should we not be encouraging everyone to be healthy?

A much more comprehensive and fairer incentive-based system has been devised in South Africa called HealthyFood™ benefit, a partnership between a medical insurance company and a supermarket chain.14 HealthyFood™ is a range of foods that help prevent chronic conditions related to lifestyle diseases, such as diabetes and heart disease. Under this scheme, you automatically qualify for a 15% discount off these foods and a further 10% can be achieved by completing an on-line "personal health review".

A 2008 US survey estimated that 71% of major US employers operated some type of incentive in 2008 to encourage participation in company-sponsored health and wellness programmes.15 In January 2008, Labour published the Healthy Weight, Healthy Lives initiative, with an initial focus on children but calling on society, individuals, families, employers and charities to work together to improve our control over diet and exercise.

10 Speech by Norman Lamb to the Liberal Democrat conference in Bournemouth, 2008
11 The Daily Mail, 23 January 2009
12 Health Service Journal, 22 January 2009
13 Young Foundation (http://launchpad.youngfoundation.org/node/244)
14 HealthyFood™ (www.discovery.co.za)
and thus lead healthier lives. Employers now recognise that people who lead healthier lives are less likely to be absent from work, and some UK companies have introduced incentive-based wellness schemes, such as tax-free bicycles available through the government’s cycle-to-work initiative or reduced gym membership fees.

While it would be foolish to suggest that incentives do not work, it is difficult to justify that a service that is free to all citizens needs to pay people to live more healthy lives simply because they do not. It is likely to cost the NHS more in the longer term. It is likely that incentive-based schemes will only prove successful in the longer term if the incentive continues to be provided; as soon as it is removed, a person is likely to return to unhealthy behaviours if the underlying reasons for those behaviours have not been addressed.

Therefore it is not as easy as some solutions claim; simply making healthier foods cheaper or providing tax incentives is unlikely to result in long-term changes in eating habits if the principal reason for buying more convenience or unhealthy food is because a person cannot cook, because they have just worked a 12-hour shift, or are simply too tired to prepare a meal. For this reason, policies have to focus on solutions that involve individuals, society, the workforce and the NHS and educational programmes need to start in childhood.

It is difficult to envisage a penalty-based approach working in practice and it would not be popular with voters: how can we be sure someone’s obesity is purely related to bad eating habits and not linked to a medical or genetic condition that predisposes them to obesity? Citizens and government may differ in their views on whether an intervention is a penalty or an incentive; it depends on whose viewpoint you take— and, if you want to win votes, this counts.

For example, the recently introduced incapacity benefit reform is argued by some to be a penalty-based system, but from Labour’s point of view is aimed at getting people back into work, which will ultimately be more beneficial for them and lead to healthier lifestyles. An alternative is not to target the individual but penalise the cause; for example, fast-food outlets could pay higher corporate tax or legislation could introduce laws that all fast-food outlets provide equally cheap healthy meals. These interventions would, however, need to be long-term in order to change behaviours.

The other end of the spectrum is highly targeted interventions such as Sure Start, a large-scale government intervention initiated in England in 1999 with a £450 million budget for

16 Department of Health Healthy Weight, Healthy Lives (2008)
17 Department for Transport cycle-to-work scheme
the first three years. The rationale was that early investment in children would lead to reduced costs in later life because those in disadvantaged areas suffered the worst health, achieved less at school and often become involved in crime during their teenage years. After a disappointing evaluation in 2005, a more targeted approach led to promising results, with three-year-old children in Sure Start areas now performing better than their matched counterparts, thus narrowing the gap due to health inequalities.

One of the lessons from this programme is that, although the intervention was well meaning, the very people it was so keen to assist were often sceptical of the reasons behind the attention they were receiving and were afraid that these interventions would be judgmental of their current lifestyles, and they often distrusted the professionals. While it is possible to direct such intensive interventions at those who are disadvantaged or in situations where people have less choice, it is unlikely that the majority of citizens would appreciate or accept direct interventions aimed at removing elements of independence and choice.

The 2004 white paper Choosing Health: Making Healthier Choices Easier is based on the principle of everyone working together, and this has to be the key to success. Any one individual, organisation or government cannot change behaviour in isolation, but working together and providing an environment that is supportive and addresses some of the underlying reasons for unhealthy behaviours is more likely to be effective. Policies need to focus on childhood, where education around healthy lifestyles can influence future behaviours, but we cannot afford to wait until the children of today become the adults of tomorrow to see improvements in the overall health of the nation.

Conclusions

Scientific advances have increased choice; for some conditions, it is now possible to take a pill rather than address the cause and the reality is that it is human nature to take the easier option. This fact, together with a free healthcare system, makes it difficult for government to encourage people to take responsibility for their health.

Any solution needs to be multifaceted, recognising that unhealthy lives are a consequence of a complex mix of genetic, psychological, cultural and behavioural factors. Interventions need to be carefully targeted to their audience if they are to be likely to succeed; not everyone is motivated by the same things. Therefore, there are unlikely to be quick wins or easy solutions for government, and commitment will need to be long-term and backed

18 Sure Start (http://www.surestart.gov.uk/)
19 Belsky, J, Barnes, J and Melhuish, E The National Evaluation of Sure Start (Policy, 2007)
by substantial budgets – something hard to envisage in the current economic climate.

Government must demonstrate clear leadership and determination to tackle the underlying causes of unhealthy behaviours. It needs to give priority to educating young children to create a future generation where healthy behaviours are embedded in society. Cost effectiveness will be achieved by focusing on interventions and incentives that address several lifestyle diseases, for example incentives to exercise. It is important that any intervention or incentive be used to address underlying causes, embed healthy behaviours and encourage people to take responsibility for their health. For example, paying someone to diet will not address the underlying causes of obesity if it is related to lack of exercise and dietary choices but incentives around exercise encourages healthy behaviours, which are more likely to result in long-term health gains.

Government is faced with some tough choices: taking a libertarian approach will not address the problem and taking a paternalistic approach will displease many voters by challenging freedom of choice and undermining principles of current health policy. However, anything less than a paternalistic approach is unlikely to address issues sufficiently quickly to ensure the NHS has the resources to withstand the costs associated with increasing ill health in the short to medium term. A "smart government" solution is to work in partnership to create a range of interventions that voters consider a common-sense approach given the magnitude of the problem – directive interventions where challenges are greatest, and gentler nudges and incentives to promote and encourage long-term health behaviour change.
Chapter 3

Surviving the resource crunch

Michael Macdonnell, Director of the 10 Partnership

1 A firm dedicated to public-sector improvement (www.10partnership.com)
Surviving the resource crunch

The physicist Niels Bohr warned that making predictions is very difficult, especially if they are about the future. Nevertheless, here is one: the impending "resource crunch" will radically change the terms of the healthcare debate over the next 10 to 15 years. This is not only because the current recession is likely to have effects on public-sector spending that last long after banks and businesses are again trading profitably. It is also because healthcare provision is caught in a pincer movement between nearly insatiable demand and increasing costs of care.

Health policy makers and practitioners alike have not yet faced up to the stark realities of a world in which investment can no longer be the principal means for meeting public expectations. Increased rationing of effective but expensive treatments and more emphasis on preventing disease will go some way towards alleviating the gap. But I argue that they cannot be the principal response. Instead, we will have to become radical about the rather unsexy objective of getting a much better return for the money we spend. The theme of productivity will be as central to the debate over the next 15 years as access has been over the past 15.

Healthcare predicaments

Our predicament is threefold. First, demand for healthcare has rocketed. The Office for National Statistics reports that, even without any adjustment for improvements in quality, the amount of healthcare provided was 50% greater in 2006 than it was in 1995, growing every year at an average rate of 3.9%. Hospitals and primary care trusts report that the provision of additional services tends to stimulate latent demand. If anything, this demand growth is set to accelerate as the population ages. It is not just the volume of healthcare activity that is growing: public expectations about the standards of care, including environmental factors such as the quality of hospital food and facilities, will also continue to increase. The NHS of the future will have to deliver vastly more healthcare, but also vastly better healthcare.

Second, the cost of care has exploded. Little systematic analysis of the drivers of healthcare spending has been done since the Wanless reviews, but the findings of an excellent recent study by the American Congressional Budget Office are instructive. This study confounds the common assumption that cost growth is largely down to demographic factors. In fact, the ageing of the population plays a modest role in driving cost growth; it is "excess cost growth" that matters most.

3 The Wanless review agreed that "it is unlikely that the future age structure of the UK population alone will have as significant an impact on future expenditure on health and social care as technological change or workforce issues" – Wanless, D Securing our Future Health: Taking a Long-term View (Interim Report) (2001)
growth” – or the extent to which spending per average individual exceeds per-capita GDP – that is the main cause of overall healthcare spending growth. This study (like many other analyses) points to the widespread adoption of new medical technologies – defined widely to include new drugs, therapies and the like – as the key driver of this excess cost growth.

This may seem counterintuitive, since technological innovation often reduces costs in other industries. However, in modern healthcare widespread technological change often leads to greater costs per patient or care episode. This is likely to hold true across all rich economies, including the UK. Indeed, in 2001 Derek Wanless estimated that, over the past 20 years, technology contributed 2% to the annual growth in health spending. There seems little reason to expect that at least this level of cost inflation will continue well into the future.

Third, public resources will become highly constrained. Spending on the NHS in England grew by an average of 6.4% per year between April 1999 and March 2008, bringing total healthcare spending to over 9% of GDP. To put this in perspective, between 1949 and 1997 NHS spending grew at an average of 3.5% a year in real terms. This level of investment is now the stuff of NHS dreams. April’s Budget set out an increase in total public spending of just 0.7%. After increased interest payments and welfare costs are accounted for, this amounts to a real-terms reduction. The NHS may do better than most areas of public spending, but it will not escape cuts. This will be as true, if not more so, with the Conservatives occupying No 10. Together, increasing demand, the rising cost of care and severely stretched public finances add up to an inevitable and dramatic resource crunch for healthcare.

Dealing with the resource crunch
What does this mean for healthcare policy? One option is to increase taxes sufficiently to finance continuing investment at a level that outstrips economic growth. This has been central to the reforms of the last decade or so — and no less central to their political positioning. However, it seems unlikely that there will be a public appetite for the increased taxation this would involve, not only because the recession may be longer and deeper than anticipated. There is also something of a consensus that too much of the investment in recent years has been wasted or gobbled up by pay inflation.

Public resistance to ever-increasing levels of healthcare spending may be no bad thing. After all, the causal link between greater healthcare spending and better health outcomes is debatable: according to 2006 figures from the World Health Organization, the US spent $3,074 per capita (at average exchange rates), while the UK spent $2,939 and Canada spent a mere $2,754 per head. Yet in these three cases healthy life expectancy inversely

correlates with the level of spending, with Canada coming out on top. This suggests that the way money is spent makes a difference and that there are real opportunity costs associated with spending on healthcare rather than other public services or priorities.

Another option is to increase the stringency of rationing. Rationing, a key role of the National Institute for Health & Clinical Excellence (NICE), is currently our primary line of defense against cost growth driven by new medical technologies and treatments. NICE has become something of a standard-bearer; the Obama administration, for example, is said to be considering how to emulate its approach. Its judgments about which treatments should be paid for by the NHS are rigorous and generally well respected, even if they are controversial, and it should be credited with the huge advance of developing a transparent methodology for measuring comparative cost-effectiveness. Therefore, a coherent response to the impending resource crunch might be to increase the strictness of the cost ceiling NICE applies (presently about £30,000 per quality-adjusted life-year). Alternatively, rather than rationing what care is provided, we might do much more to target resources on the unhealthiest people or populations.

Although rationing will undoubtedly be part of the future of healthcare, it cannot be the only or even the main response to the resource crunch. This is because politics places limits on how stringent rationing decisions can be. The NHS is premised on an implicit social contract that promises tax-funded, high-quality healthcare for everyone, free at the point of need. The NHS is emphatically not a system for providing basic care for the poorest or sickest: survey after survey demonstrates how little support there is for reducing the NHS to a safety net service for those on the lowest incomes.

There is support for targeting spending on the poorest or most unhealthy parts of the country but the middle-class, young and relatively healthy demand high-quality care too. Failing to meet their expectations, for instance by denying them access to expensive but effective treatments, would be catastrophic for the NHS. Feeling compelled to turn to the private sector for adequate care, these citizens would no doubt soon begin to question why they pay so much for a healthcare system they no longer use except, perhaps, for emergencies. The very existence of a tax-funded healthcare system would be at stake.

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5 The healthy life expectancy figures (at birth) date from 2003, the latest figures available from the World Health Organization. However, Canada has consistently and significantly spent less than the US since the WHO started collecting data in 1995.

6 NICE is not the only mechanism for rationing in the NHS: clinical decision makers make “implicit” rationing decisions every day. Primary care trusts also make rationing decisions and, until recently, queuing was an important means of rationing.

7 This is a consistent result of the British Social Attitudes Survey, for instance.
For similar reasons, rigid, universal resistance to “top-ups” is not sustainable, as the government has probably realised. It is not feasible to ask patients to support the NHS at the expense of their reasonable demands for high-quality and cutting-edge healthcare. If citizens conclude that excellence of care is being sacrificed to principles of equity, the NHS will not be able to command the widespread support it requires. Many commentators argue that top-ups will lead to an unacceptably two-tier service, and there are certainly risks against which we must guard. But the solution cannot be to create a one-tier service that does not meet the legitimate expectations of those who pay for it. The best way to guard against the emergence of an unacceptably two-tier system is to ensure that the NHS delivers to a standard that competes with any provider, public or private.

A third option for dealing with the resource crunch is to put much greater emphasis on prevention. Proponents of this approach point out just how acute-centred the UK healthcare system is, with a relatively paltry proportion of spend dedicated to public health: in 2002, Wanless estimated that yearly expenditure on public health amounted to less than what the NHS spends in a day and a half. Despite this imbalance, preventing disease, or preventing acute episodes of disease, is clearly more cost-effective than treating it. This is especially true of long-term conditions, which, according to the Department of Health, account for 69% of all primary and acute care expenditure in England.

A more preventive NHS, with less demand for acute care, is certainly an important objective. But it is doubtful that this will be a way of easing the resource crunch in the medium term. Partly this is because of the time it takes for public health interventions to make an impact. Partly it is because we currently lack a strong knowledge base about how effectively to encourage people to change their behaviours and adopt healthier lifestyles, which is crucial to the prevention of chronic disease.

However, even with a stronger evidence base, it is still not clear that the transition to a prevention-focused healthcare system will improve its affordability over the next few decades. Effective public health interventions and behaviour change programmes require significant up-front investment – and, at the same time, the existing acute-centred system needs to be maintained. In effect, the transition requires us to double-run the two types of system while waiting for the impact of healthy behaviours to translate into lower demand for acute services.

8 To some extent, the current system is two-tier: those who can afford it supplement their access to the NHS with private health insurance. So the goal must be to stop the emergence of an unacceptable gap between the care paid for by the NHS and that offered through private health insurance schemes.
9 Systematic yearly data are not collected. See: Wanless, D, Appleby, J, Harrison, A and Patel, D Our Future Health Secured? A Review of NHS Funding & Performance (King’s Fund, 2007)
10 Some progress has been made since the Wanless reviews emphasised the need to improve the knowledge base but, as a follow-up study concluded, in key areas progress has been slow. See: Wanless et al, op cit (2007)
Improving healthcare productivity

This means that neither increased investment, stringent rationing nor a more prevention-focused system are complete solutions to the resource crunch – at least over the next 15-20 years – though they will undoubtedly play a part. What does this leave us with? I suggest the rather unpopular subject of productivity will come up the agenda. At its simplest, productivity is the ratio of outputs to inputs. Outputs are a function of both quantity (for example, increased activity) and the quality of the service provided (for example, better mortality rates). A highly productive healthcare system is therefore one that turns its inputs into lots of high-quality services.

Until recently, there was no regular attempt to measure productivity in the NHS (or the wider healthcare system). However, the Office for National Statistics now publishes studies in health productivity, the latest of which concluded that, with quality adjustments, productivity fell by an average of 2% a year between 2001 and 2005. Although some dispute these figures, it seems clear that the NHS did not produce outputs commensurate to the increase in inputs it has received over the last decade or so.

Getting serious about productivity is our best hope of redressing the resource crunch in the medium term. The sums involved are far from trivial. The Wanless review estimated the value of the productivity gains in both the “solid progress” and “fully engaged” scenarios – 2% to 2.5% in the first decade and 3% in the second – at £46.5 billion by 2022/23. More localised evidence suggests similarly large potential gains. For instance, if in 2004/05 all London hospitals had achieved the English average for length of stay, this would have resulted in a saving of 800,000 excess bed days, with a value of £216 million. But the attraction of becoming serious about improving productivity is also political; tax-paying shareholders need to see a return on their investment – or they will be increasingly unwilling to invest. Governments of the future need to have a better response to increasingly loud questions about what healthcare spending has bought.

What would a reform programme for improving healthcare productivity look like? It should have three important characteristics. First, its objective should be better productivity rather than cost cutting. Gershon-style, centrally mandated targets are all too often met with slash-and-burn reactions. Although reducing the unit cost of inputs is one of its aspects, productivity is fundamentally about improving the quantity and quality of outputs. Managers can respond to the challenge of constrained budgets not only by cutting

12 A King's Fund study was unable to corroborate these figures. See: Wanless et al, op cit (2007)
costs, but also by improving the delivery of the services they offer. There are significant opportunities to improve healthcare at the same or lower levels of expenditure.

Second, reforms need to be radical and systemic if we are to extract the gains required to respond to the resource crunch. This means designing sharp incentives at each level. Commissioners should be rewarded for making contracting decisions on the basis of demonstrably better productivity. For example, commissioners could tie payment to the cost of the most effective or productive treatments, creating incentives to stop providing services that fall below the bar. We should be bold about allowing providers to fail when they are unable to provide high-quality services at the same cost as other providers. As a corollary, we should be willing to allow providers to compete on price as long as they are also able to demonstrate the quality of their service. Perhaps, most importantly, we need to design incentives that impact on clinical teams. For instance, policy makers should consider forms of co-operative ownership that allow doctors and other clinical staff the autonomy to productively structure their services, to share in surpluses and suffer directly from deficits.

Third, reforms need to address the physical and human configuration of the NHS. Is a hospital-centred service the right one when the chronic diseases suffered by 15.4 million people account for 85% of deaths in the UK? International evidence suggests that better outcomes can be achieved in settings without the fixed costs associated with hospital beds and facilities. Indeed, there is much greater scope for models of self-care when it comes to diseases such as diabetes. These questions raise thorny issues about the effective scale of different service tiers as well as the skill or professional mix appropriate to each. Could nurses or other clinical staff do much of what doctors currently do, releasing them for more specialist work? Incentives need to support configuration change; for instance, greater integration of primary and secondary care may be needed to encourage providers to treat patients in the most cost-effective setting.

These would be trenchant reforms. Some may argue that they are not politically saleable or that that the last thing the NHS needs is more disruption. But the scale of the impending resource crunch makes addressing productivity central to the challenge of sustaining a tax-funded system of universal healthcare.

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15 Figures from Department of Health, April 2008 (www.dh.gov.uk). The number of people with chronic diseases is expected to rise by 23% over the next 25 years.
16 Charles Leadbeater and Hilary Cottam make this argument in “The User Generated State: Public Services 2.0” in Diamond, P *Public Matters: The Renewal of the Public Realm* (Politico’s, 2007)
Chapter 4

Meeting known challenges

Andrew Harrop, Head of Policy at Age Concern and Help the Aged
Meeting known challenges

The ageing of the population and the rising incidence of chronic illness this implies is a "known known", at least over a five-year time frame. But the health service and the wider public sector is not adjusting to reflect this changing clientele. There needs to be a radical reorientation of healthcare towards preventive and "whole person" care – care that aims to maximise good health and not to treat specific disease. The costs of ageing, while significant, are not as great as people often think.

Health promotion and early intervention

We all know that life expectancy at the age of 65 is rising rapidly. Since 1980, it has increased by three years for men and by more than two years for women. But over this time there has been no reduction in the years of disability older people can expect; indeed, the average duration of future disability for people aged 65 has risen by one-and-a-half years for men and half a year for women. These figures mark the extension of chronic health problems in later life. In addition, older people with lower incomes and those from some ethnic-minority groups experience significantly poorer health than others.

Figure 1: Average years of disability a 65-year-old can expect before death

2 "Health Expectancies in the United Kingdom 2004–6" in Health Statistics Quarterly no 40 (Winter 2008)
Older people's ill health is associated with lifestyle across the whole life course as well as with influences beyond their immediate individual control, including genetics and social conditions. Nevertheless, there is much that can be done in mid-life and beyond to promote physical and mental health and well-being for older people. A healthy lifestyle, along with screening, assessment and treatment for acute and chronic diseases all affect the experience of ageing.

Over the past decade, the emphasis placed on public health by the government has increased significantly – and the Conservatives have proposals for a separate Department of Public Health. But none of the political parties have fully embraced the message: “never too early, never too late”. National, regional and local health strategies to promote mental and physical health must now address the needs of people through the whole life course, while taking into account health inequalities, gender and culture.

Regular physical activity helps to maintain a healthy mind and body. For frailer people, it also reduces the risk of falling, which affects at least a third of over-75s each year. Most people in England do not achieve recommended guidelines for physical exercise and, while an increasing number of people aged 65-74 are taking sufficient exercise, levels of activity still decline with age. Earlier this year the government published Be Active, Be Healthy: A Plan for Getting the Nation Moving. It is encouraging that the strategy recognises the benefits of physical activity in later life and increases opportunities for older people, including free swimming and organised walks, but good intentions now need to be translated into local delivery.

A new focus on promoting good health should also place more emphasis on targeted preventive interventions. Long-term, population-wide public health initiatives are essential, but this is a challenge for the whole public sector, not only the NHS. Within the health service, we need more a preventive orientation to healthcare commissioning.

This approach has been tested by the Partnerships for Older People projects, which evaluated a range of preventive interventions, some targeting the whole older population and others geared towards people at immediate or heightened risk of hospital admission. Services included medicines management, falls prevention, “hospital at home” schemes, signposting services, leisure activities and low-level support around the home – services offering “that little bit of help” such as DIY, shopping or gardening. The interim evaluation has shown that these interventions exceed NICE’s threshold for cost-effective care, in

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4 Speech by Andrew Lansley MP to the British Medical Association, 27 January 2009
5 Masud, T and Morris, R “The Epidemiology of Falls” in Age & Ageing no 30, supplement 4 (2001)
6 Department of Health Be Active, Be Healthy: A Plan for Getting the Nation Moving (2009)
terms of quality-adjusted life-years. They also generate savings for secondary care, which come close to matching their total cost (for every £1 spent, 73p was saved in emergency hospital bed days).\(^7\)

Clearly, not all these services constitute traditional healthcare, but it is the NHS budget that benefits. There could not be a better illustration of why we need to break down the barriers between health and local government. Preventive commissioning for good health must now be built into joint planning and commissioning by primary care trusts and local authorities. We have proposed that local public bodies commission integrated packages of preventive services for older people, grouped together under a new national brand, along the lines of Sure Start.

**Primary and community care**

Older people make greater use of primary care services, especially GP services, than younger adults. As part of the NHS Next Stage Review, the government set out a vision for primary and community services to make them more responsive to people’s needs. Much of the focus has been on extending opening hours to evenings and weekends. But the new strategy should first prioritise overcoming barriers for people who currently have the greatest problems accessing services, including carers – who cannot easily access health centres – and people living in care homes, who often have to pay for basic primary care that should be free at the point of need.

More responsive primary and community care must also mean reconsidering what services are available in each locality. As part of a new focus on sustaining health and well-being, there needs to be greater emphasis on common conditions associated with the ageing process and with underlying chronic illnesses. This means considering as important illnesses that are not life-threatening, but which cumulatively impact on quality of life and may lead to or exacerbate disability if unaddressed. Examples include sight loss, hearing loss, incontinence, poor mobility, foot pain, poor oral health and depression. Too often, older people find that they cannot access local NHS services essential to maintaining good health and well-being, such as dentistry and chiropody; others, such as hearing services, have been rationed using long waiting times.

Over the longer term, the NHS needs to venture even further if it is to refocus towards promoting good health and well-being. Across both primary and acute care the whole philosophy and structure of the NHS will need to move away from treating identifiable

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diseases towards the holistic promotion of good health. Today’s "silos" model, where ill health is broken down into a series of separate diagnoses, with their own recommended care pathways, does not reflect the complexity of health in old age. By focusing on the illness, not the whole person, this approach to healthcare frequently results in under-treatment, over-treatment and mistreatment. This is manifested in failure to treat people with symptoms or impairments where there is not a diagnosis; inadequate medicine management, including prescription of multiple drugs with little thought for their combined effects; and referral for treatment where ability to benefit is questionable, or where the disease is treated at the expense of overall functioning and quality of life.

In primary care, professional practice and the structure of incentives must move away from its current condition-specific focus. For example, the quality and outcomes framework currently rewards GPs with respect to diagnosis and treatment of specific conditions rather than sustaining overall health and well-being. Increasing reliance on prescriptive clinical guidance has also tended to narrow the range of treatments professionals offer, in spite of the diversity of patients’ needs and preferences.

A shift to person-centred healthcare does not imply second-class healthcare for older and frailer people. The principle of non-discrimination on the grounds of age and disability must be rooted more deeply into the culture of the NHS. It is hugely welcome that these values are enshrined in the new NHS Constitution and that age discrimination in healthcare will be outlawed by the 2009 Equality Bill. But equality between age groups does not mean "sameness". On the one hand, there must be an end to discriminatory practices in primary care, such as under-diagnosis, inappropriate treatment and lazy decision making on grounds of age rather than ability to benefit. On the other hand, personalised medicine, done well, should often result in more divergence in treatment choices, not less.

Acute care
The challenge of moving from condition-centric to person-centric care is even greater in acute healthcare. The NHS must reverse the trend of ever-greater specialisation and emphasise general clinical care and the importance of core skills and knowledge for every health professional. Care pathways need to be sufficiently broad and flexible that they are appropriate for people with complex symptoms, caused by a number of underlying diagnoses. Furthermore, commissioners of acute healthcare must recognise that frail, older people often need co-ordinated support, involving a range of public services and a mix of acute and primary healthcare. Support for people who are discharged from acute care

9 Oliver, M "Let's Not Turn Elderly People into Patients" in BMJ 338: b873 (2009)
care and for people at very high risk of hospital admission is a key challenge for this multidisciplinary approach. Current policy is failing and, in recent years, there has been a worrying rise in the rates of emergency readmissions to hospital.\textsuperscript{10}

These issues are at the most vivid when it comes to care at the end of life. The majority of older people die in hospital but most would prefer to die at home, or in a care home if that is their place of residence. The Department of Health’s recently launched end-of-life care strategy\textsuperscript{11} and a report from the National Audit Office\textsuperscript{12} have both highlighted the gap between people’s wishes for a good death and the reality of many experiences. It is welcome that the focus of end-of-life care is moving beyond cancer, which is not the main cause of death for most older people. Services that meet the needs of people with multiple conditions at the end of their lives, and which respect the diversity of their wishes and beliefs, now need to be developed. This demands a focus on the person rather than the diagnosis, excellent co-ordination of care, and an assurance that people will have access to emotional and practical, as well as clinical, support.

Looking more widely, the practice and training of almost every professional discipline should be based on the assumption that the majority of patients will be aged over 65 – and many much older than that. Mortality statistics show that the NHS must adjust to more of its clientele being very old; at the start of this decade, the proportion of people dying who were over 85 was under a third, but it will reach one-half sometime in the 2030s.\textsuperscript{13} Acute services, which should be orientated towards the needs of people nearing the end of their lives, therefore need to rethink who their users are and how they serve them.

Professionals should be trained to work with people who have multiple physical health complaints, and mental illnesses ranging from depression to dementia. There must be a new focus in basic training and continuing professional development, which today focuses too much on deepening rather than widening knowledge and expertise. A more "geriatric" orientation to training across disciplines should also be accompanied by greater respect and recognition for those specialists who co-ordinate and deliver care for the frailest and oldest. Currently, relatively few medical and nursing students wish to specialise in the care of older people. It is essential that the workforce is developed in line with population health needs rather than professional aspirations.

\textsuperscript{10} National Centre for Health Outcomes Development \textit{Emergency Re-admissions to Hospital within 28 Days of Discharge from Hospital: Adults of Ages 75+} (2008)
\textsuperscript{11} Department of Health \textit{End-of-Life Care Strategy: Promoting High-quality Care for All Adults at the End of Life} (2008)
\textsuperscript{12} National Audit Office \textit{End-of-Life Care} (2008)
The emphasis on clinician-led reconfiguration spelt out in Lord Darzi’s review is unlikely to achieve these outcomes alone. Practitioners excel at incremental improvement but are less likely to question their whole philosophy of care. In addition, there are potential conflicts of interest between the professional and the patient. Within health professions, where status has come to be associated with narrowing specialisation, “rowing back” is likely to be resisted. It is not clear that reforms that may be in the patient’s interests – redesigning care pathways, shifting resources from secondary to primary care, and requiring a wider range of skills and knowledge – will be championed by the professions.

Nor can it be guaranteed that clinician-led reform will prioritise “soft outcomes”, which older people value highly – “how” not “what” care is delivered. Over the past decade, clinical outcomes and the volume of provision have improved across most parts of the health service, with older people benefiting from increasingly sophisticated interventions and shorter waiting times for treatment. However, we need a wider understanding of quality, which includes issues of compassion and dignity in care.

In recent years, some of the essentials of this care – such as privacy, communication and personal hygiene – have suffered. Some 64% of people aged over 65 believe that older people are not always treated with dignity by health and care professionals.14 Meanwhile, in 2007 less than half of NHS staff believed that patients were their trust’s top priority.15 The statistics on specific aspects of care – for example, nutrition – are equally worrying. One in five older patients in hospitals report that they do not receive sufficient help to eat their meals and six out of 10 are at risk of becoming malnourished, or their situation becoming worse, while they are in hospital.16 Such lapses in care can equate to an infringement of fundamental dignity and human rights. The NHS Constitution presents an opportunity to restore quality care to the heart of the NHS. The service now needs to make a reality of the new guarantees on dignity and human rights.

Finally, there needs to be much better co-ordination of care for physical and mental health. For too long, older people’s mental health has remained an area of neglect. Age discrimination in both policy and practice was entrenched by the national service framework for mental health, which has focused on so-called “adults of working age”.17 When the current framework for mental health expires in 2009, the new approach must be inclusive of people of all ages, and make the connections with other aspects of health.

14 Age Concern and Help the Aged One Voice: Shaping Our Ageing Society (2009)
16 Age Concern England Hungry to be Heard (2006)
17 Department of Health A National Service Framework for Mental Health (1999)
Depression is the single largest mental health problem in later life, affecting up to a quarter of all older people. In most cases, depression goes unrecognised and people do not receive the support or treatment they could benefit from. As a result, GPs must improve their diagnosis of depression and other common mental illnesses in older people. A full range of treatments should be available regardless of age, including psychological therapies. The launch of the first national dementia strategy is a welcome step in tackling the stigma faced by people with dementia and could help to improve the support that they and their families receive. Also, it should lead to a new focus on dementia and cognitive impairment in the funding of health research.

Older people's demand for healthcare

Can we afford an ambitious programme for reorienting older people's healthcare towards prevention and the whole person? It is true that over the next five years the numbers of people using the NHS will rise steadily. No one can say it is coming as a surprise. People aged over 65 consume close to half the NHS's resources, and their number will rise by 13% during this period. Meanwhile, use of services is highest among people aged over 85, who will increase in number by 14%. Fortunately, the taxpayer is not in for as much trouble as these numbers imply. It is well known that the single greatest driver of cost for health systems is the number of people who die – or rather who are in the last year of their life. The mortality rate is starting to rise after decades of decline, but the pace of increase is much slower than the growth of the older population, because of rising life expectancy.

There is ongoing debate regarding whether deaths at older ages will have positive or negative implications for NHS spending. Some argue that very old people will need less care before death, not because of discrimination, but because they are more frail; their bodies will not withstand the rigours of disease and many treatments will not be clinically effective.

The other perspective is that the substitution of acute disease with chronic decline is creating a longer period of illness, causing great misery for older people. The costs of helping people with chronic illness could exceed any gains arising from reduced efficacy of acute interventions. For example, Cambridge academic Guy Brown suggests that "while

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18 Age Concern UK Inquiry into Mental Health & Well-being in Later Life (2007)
19 43% in 2004/05 – Philp, I A Recipe for Care – Not a Single Ingredient: Clinical Case for Change (Department of Health, 2007)
20 Government Actuary Department's principal population projections, on 2006 base
22 Gomes and Higginson, op cit
23 Professor Raymond Tallis, quoted in Financial Times, 2 July 2008
we have been remarkably successful at delaying death ... we have failed to delay ageing";
since the incidence of degenerative diseases increasing rapidly with age "maladies that
were formerly rare to non-existent become commonplace. The influential Dementia UK
study implicitly endorsed this view by assuming that the age-specific incidence of dementia
would remain fixed over the coming years, rather than rise in line with longevity.

However, rising morbidity will not increase the costs per person of chronic illness
significantly over a five-year time frame; the pace of change is simply too slow. The key
demographic factor driving the costs of chronic care is not cost per person; as with acute
care, it is the rising numbers of people in their last years of life. Nor should we take the
extension of morbidity as a foregone conclusion, since we know that so much illness is
determined by lifestyle and social factors. Good diet, not smoking and regular exercise
really can postpone most of the chronic diseases of old age.

Over the past 30 years, more than half the gains in older people’s longevity have
been years free from disability. When you see that people in their 50s from the lowest
occupational backgrounds have the same health outcomes as people in their 70s from the
highest, it is hard not to believe that we can continue to push back the clinical effects of
ageing through lifestyle and social change. For example, if the onset of dementia could
be postponed by an average of one to two years we could stabilise the incidence of the
disease rather than see it rise two-fifths by the early 2020s, as projected.

In any case, the cost implications of more people needing acute care are far greater than
rising numbers of people with chronic conditions. While chronic illness in old age has huge
costs – in terms of personal well-being, the burden on family carers and demand on the
social care system – it represents a relatively modest proportion of the NHS budget. For
example, the Dementia UK study showed that the NHS spends £1.4 billion each year
on people diagnosed with late-onset dementia, compared with social care spending of
£9.5 billion.

All told, demographic factors will have a containable impact on demand for the NHS over
the next five years. By 2017/18, the Treasury estimates that, with no change in policy,

25 Alzheimer’s Society Dementia UK (2007)
26 Men, two-and-a-half years out of four; women, one year out of one-and-a-half – Office for National Statistics
figures on “life expectancy and healthy life expectancy free from limiting long-standing illness (LLI)” 1981–2001
28 Alzheimer’s Society, op cit
29 2005/06 prices – data from figure 6.1 in Dementia UK study
demographic factors will have increased NHS spending by half a percent of GDP (from a baseline of 2007/08). This is modest compared with the rapid increase in spending over the last decade and is somewhere between one- and two-fifths of the extra resources Derek Wanless projected being required between 2007 and 2017 in *Securing Our Future Health*. New technologies and rising expectations are set to be far greater drivers of cost; PricewaterhouseCoopers projects that, over the long term, non-demographic factors will account for two-thirds of increases in the share of GDP going to health.

Even so, with the current state of the economy, public spending may not be able to keep up. The Institute for Fiscal Studies had predicted real growth in health spending of just 1% a year, leading to a reduction in the share of GDP spent on health. Over the short term, there is a clear possibility that demographic changes could eat up all the available resources; for the first time in living memory we could see a freeze in NHS spending per patient. This will pose severe challenges, not least on pay and investment in new technology – but it may make tough choices about priorities easier. If we cannot afford to throw more money at acute care, the service may come to accept that prevention and person-centred care is the cheapest route to improving health and well-being outcomes.

30 Wanless, op cit
31 Presentation to IPPR seminar by John Hawksworth, head of macroeconomics at PricewaterhouseCoopers in 2006
Chapter 5

An intelligent health service

Tim Kelsey, Chair of Dr Foster Intelligence

1 which is 50% owned by the NHS Information Centre
An intelligent health service

A TV reporter recently asked me to explain how it was possible that the hospital in Stafford – recently highlighted for its high death rates – could have been so unsafe for so long. In 2001, I explained, Dr Foster published data that suggested the hospital had a statistically high death rate; for the next seven years the data drew the same conclusion but neither the doctors nor the hospital nor the health authority took action that made any discernible difference. In 2009, after it launched an investigation, the healthcare regulator published one of the most damning reports ever written on an NHS hospital.

Patients were harmed at Stafford hospital in those years; we don’t know how many. I looked at the reporter and I had a strange vision of data populating the health and social care system like some kind of primordial algal bloom – everywhere, multiplying, pooling in dark corners, stagnating, untouched by humans. There’s data in our health system, but precious little intelligence.

I set up Dr Foster a decade ago with two friends to provide patients and professionals with information on the quality of local health services. There have been some improvements since then but, I’m sorry to say, few would be obvious to the patients in Stafford. The NHS is still unable to intelligently and routinely answer questions like “Is emergency care in Stafford hospital safe?” or “I want to find out how best my mother can be treated for Alzheimer’s in Somerset” – indeed, it cannot consistently and completely answer most questions patients and carers have about the services they fund. It is unable to provide the depth of customer insight NHS commissioners need in order to make sensible strategic decisions for the communities they serve; it does little to help clinicians adequately evaluate their own performance.

What we need is fresh, free-running intelligence that puts actual power in the hands of the users of health and social care services and provides the professionals with the wherewithal to deliver responsive services. This requires an evolutionary leap forward – but this is a leap that is do-able, and do-able now.

An intelligent health service is one that minimises harm and maximises human benefit – it should be as safe and as personalised as possible. Intelligence, in this context, is more than the fusion of data and technology; it is what raises the system’s level of consciousness – and this depends on each part of the whole learning how to comparatively assess itself so that it can learn from good and bad events.

Comparison allows a doctor to understand the contextual merits of treatments, or the
quality of their clinical outcomes against those of a peer/competitor/collaborator in another hospital; it enables a commissioner to risk-profile the local population against others with similar demographics or plan for an individual’s needs; it helps a patient, client or carer to make informed and real choices about their own care. Comparison is the key to quality in a healthcare system.

The life-saving importance of comparison was spelled out in the Bristol Royal Infirmary inquiry report in 2001 into children’s heart services – lives might have been saved if the data (which existed) had actually been analysed comparatively. Eight years later we have had another reminder in Stafford. Once more it seems the doctors and nurses and managers declined to use the data (which existed) to help them identify bad practice and protect their patients from harm. Comparative intelligence matters because it helps a healthcare system manage itself better, but it also provides its users with some protection against harmful and self-interested behaviour by professional advocates. It is a reality that we cannot always trust our doctors and nurses. It is a reality that the system will never be perfectly safe.

Martin Fletcher, the chief executive of the National Patient Safety Agency, which has done such important work to highlight specific ways in which the NHS can reduce harm to patients, recently reminded me of that old adage that safety, in any system, “is just one damn thing after another” – constant comparative vigilance is the only safeguard. We actually do not know how safe or unsafe the NHS is because we do not have the full intelligence – but when Dr Foster first published mortality rates, analysed by Professor Sir Brian Jarman and colleagues at Imperial College in 2001, it suggested that there was more than 76% difference in risk of death between hospitals in England. Last year, the variation was somewhat over 50%. The case of patient-murdering GP Harold Shipman came after Bristol, but we still cannot calculate mortality rates in primary care because the data that would help us do that (it exists) is simply not collected nationally. If there is another Shipman in the NHS, it will be good fortune that reveals it, not an intelligent system.

The data is already there
The amazing truth is that the data we need to produce these crucial comparative analyses already exists; it just sits, like that strange algae, on the surface of the system, barely used.

The central challenge, pinpointed by the scandals of Stafford and Bristol, is: how do we create a healthcare system that uses its own raw data to develop critical self-awareness?

The good news is that the data (largely) exists and the NHS is streets ahead of the rest of the world in recognising the need for intelligent use of data in delivery of services. There
are some real grounds for optimism about the future. You can already do simple (but very
important) things in the NHS, like measure comparative death rates in hospitals across
the system – how much longer would the people in Stafford have endured their hospital
if we had not even been able to do that?

In the US, you cannot. The hospital providers have extraordinarily advanced data tech-
nologies for ensuring they know what is going on inside their hospitals and groups (and
how much they cost), but there is no means by which you can comprehensively compare
one hospital with its competitors for the quality of all its outcomes. In fact, I don’t think
the American healthcare system wants this level of self-awareness. At a seminar recently,
a senior US health system manager told the story of how her organisation had simply
dumped 200,000 poor people from its care in order to balance its books.

The US system (and its political class) is equivocal about quality of care, when this
compromises commercial objectives. England (and its political class), by contrast, is
absolutely unequivocal about the overriding priority of patient and client outcomes in the
NHS – and, as a result, the value to be put on good-quality patient intelligence. The new
National Quality Board, widely seen as a precursor to an independent NHS board, is a
symbol of that commitment.

There is no practical reason why, by 2015, there should not be a vibrant, accessible
comparative information market in the NHS, playing itself out through all manner of
digital and non-digital channels to a multitude of users. Hospitals will report their patient
experience scores for the week on the back page of the local newspaper, next to the
weather forecast and the pollen count; GPs will sit with their patients and consider the
performance profile of local consultant specialists; carers will be able to access up-to-date
information on how their infirm elderly relative is faring by secure on-line email. You and
I will be able to access our own patient record and take it on holiday with us. We might
consult independent specialists (rather like independent financial advisers) to help us
make the right care choices.

Local NHS organisations will consider themselves commissioners of information as well
as commissioners of services. The evolution of an intelligent NHS will lead quickly to a
personalised NHS in which information-based digital technologies will help us individually
shape the way in which we manage our own health and our relationship with the
NHS when we need it. In this way, data and technology will be resources in the hands
of service users rather than stratagems in a giant (and expensive) civil service game of “Risk”.

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What needs to be done
We have the raw data; I hope we now have the will. This is what we now have to do to raise the level of consciousness in our health system:

1. Free the data
The first requirement is: free the data! A precondition for an intelligent health and social care system – the most important – is that we construct a comparative dataset in health and social care that follows the patient journey, not organisational convenience.

Ten years ago we had national data on all hospital admissions, from which we could calculate and compare hospital mortalities and other things. That is still – quite astonishingly, despite all the reform rhetoric – all we actually have. When you read about the NHS in the newspapers, what you are generally reading about is hospitals. There is no national primary care data; no standardised private sector data; no national community or social care data. No linked or comparative data. The government should simply require every provider of NHS services to supply patient-level data – appropriately anonymised – as a condition of the contract. At this moment, we cannot describe the relative quality of interventions on any patient journey at all – except those that occur entirely in a hospital context. Which services are best for Alzheimer’s or maternity? Forget it.

The data exists in computer systems all over the NHS, and extracting it in ways that will allow for patient journeys to be reconstructed is not difficult. Creating a unified national dataset for all health and social services does not require new technologies; I would be the last person to advocate another national IT project. Central governments are not good at them. Creating an intelligent, joined-up database simply requires everyone who supplies an NHS service to supply their data in return.

The evolution of an intelligent health system has been hampered not only by the failure to harvest the data that is already collected, but also by the insularity of the industry that was created to manage it. The NHS employs hundreds (perhaps thousands) of public health professionals who are, technically, its intelligence officers – many are first-class (and I mean that) but it has in part become an academic argument for the public service to adopt a policy of “splendid isolation” and deny the potential for other sectors (especially the commercial one) to make a useful contribution to the purist ethic of a post-war social contract.

The former chief executive of the NHS Information Centre, an academic who used to work for the UN, actively campaigned against data being made available to university researchers who were not directly funded by the NHS. Very few of these academic
statisticians have ever worked in the real-life world of health and social care, and sometimes, it seems to me, they do not really have a grasp on the urgency with which frontline professionals need better intelligence. They won’t be thanked in the long run for restricting the flow of data around the system: data doesn’t like defenders; it has no loyalties; it wants to be used. Encouragingly, the new management of the Information Centre takes a much more user-centric approach, and I hope that the data now starts to flow more effectively.

The first precondition, then, is that the data that exists in the myriad computer systems of the NHS is made widely available.

2. Create a clinically credible data infrastructure
The second requirement, one way or another, is that there is a clinically credible data infrastructure. At present the data infrastructure is considered a national project; indeed a precious national monopoly – managed by the NHS Information Centre and Connecting for Health, which have amassed a treasure trove of data that is insufficiently disseminated to health service and other users. It seems to me that there is a legitimate (and, frankly, less expensive) role for the centre in setting standards and enabling comparison, but the lessons of the last decade are essentially that we should make the responsibility for data collection and verification as local as possible. Data quality is assured only when those collecting it are those that use it on a daily basis – not large, slow national bureaucracies.

I believe that clinicians should regard it as an intrinsic part of their job that they have responsibility for ensuring the accuracy of their own data; commissioners should be responsible for interrogating the validity of that data. There is a cultural shift required – but the experience of many in introducing service line management suggests that this is achieved when clinicians are allowed to take responsibility for the quality of their services and, by definition then, the quality of their data. Hospital doctors have understood that responsibility and its professional benefits (in the main), but primary care physicians lag a long way behind. They will, in my view, resist the additional obligations of data collection and validation in the short term. Governments of any persuasion will need to steady themselves for a fight, but know that in the long run the GPs – just like the hospital doctors – will come to value high-quality comparative performance data that tracks the patient journey.

3. Address security issues
The third requirement is that the new data environment does not present the public with undue data security risks. This is a highly sensitive area, but it is essentially a technical matter, not one that merits the level of moral panic that too often infects the debate.
Health, more than any other public service, has well-worn approaches to anonymising and linking large datasets – and if we can do it for hospital data, as we have for years now without any breach of confidentiality that I know of, there is no reason that we cannot do it for primary care data too.

This is entirely separate from justifiable scares about lost disks and data sticks. No one, in my view, has properly made the argument that government can be neither effective nor efficient without better data. The importance of ensuring proper security for confidential data must not obscure its fundamental importance in public service reform.

Indeed, government must support the health and social care system in adopting bolder strategies for much more cross-Whitehall data sharing. The NHS cannot plan for complex people like you and me, who live in the real world, without understanding our behaviours better – that means tackling head-on the need for cross-public service data sharing.

4. Ensure the tools for comparison are available
The fourth requirement is that an information strategy stimulates an efficient reliable marketplace in comparative tools and technologies. The development of clever, informative and useful analyses and benchmarks cannot be a monopoly – many brains are required to develop those analyses and many outlets are required to determine their usefulness. Once you have established an anonymised database, it needs to be made available to entrepreneurs to experiment and innovate. In supplying such analyses, whether to providers, commissioners or the public, the market will verify their usefulness and accuracy.

5. Provide public access to the data
The fifth is that these data, or rather well-presented analyses of those data, are always made available to the public and their advocates – and that they are given opportunities to share their own experiences and views. That is the key to verifying the truth or otherwise of the basic clinical data: we know well that a GP or hospital can provide technically proficient care but their patients may experience it as terrible because they felt disrespected, or were put in a mixed-sex ward, or did not feel fully involved or informed. The key point is that clinicians must be given the freedom to validate the data and develop metrics but that all that data must be published in accessible modern and inclusive ways so that there is transparency about performance. There is nothing intrinsically difficult about this.

6. Develop a modern consumer information strategy
This last requirement – put a slightly different way – is that the NHS develops a modern consumer information strategy. Of all the requirements for an information revolution, this is potentially the most challenging. It means local NHS organisations need to have new
responsibilities to promote data on local services to their local communities. It means that data infrastructures in the NHS need to be designed from the start for the best advantage of the ultimate end-user of the information: that is me, you, the individual user. Right now, people like me are not using data to make choices of service very often – but that's because there is hardly any relevant data, frankly, that any ordinary person can actually understand or use.

The NHS already leads the world here – NHS Choices\(^2\) is by far the best on-line information service of its kind and has pioneered the development of “Trip Adviser”-style interactive pages on which patients can rate and comment on the quality and experience of their treatment – but it is still in the foothills of exploiting the vast potential of digital media to deliver personalised information and services to citizens.

There are pockets of digital innovation all over the NHS – here and there, systems being developed that will allow patients to book appointments on-line with their GP, receive their lab results by email, social networking initiatives bringing patients and carers together, GPs using YouTube to educate patients on the use of medicines and so on.

But the digital revolution has not yet achieved scale in the NHS, even with the impetus provided by NHS Choices and by NHS Direct. I am convinced that the reason for this is related to scarcity of useful comparable searchable information, rather than lack of technological imagination. If the NHS could create reliable information about conditions and treatments and the services it provides, and ensure its wide distribution, then the digital entrepreneurs would have something to work with.

Just to give one example: when NHS Choices was commissioned in 2007, we discovered that the NHS was publishing basic data on its own services that was in large part simply inaccurate. Something like a third of GP information published by the NHS (such as their names and addresses) was simply out-of-date, incorrect, or misspelled. You cannot run a website, let alone a personalised digital health service, when the basic data is so poor. The answer is to make local NHS organisations and their professionals responsible for the accuracy of their own data, and then to serve this information up to anyone who wants to use it. The role of government is to make sure that this is done to a set standard, then to stand back and let the digital innovators get to work and watch a million websites and local digital services bloom.

\(^2\) www.nhs.uk
Once the data is out there, people will start to use and relate to it, they will start to personalise it, and the NHS will embark on a different kind of dialogue with its users. That is the future. It is how people will be able to find real answers to some of the most important questions they will ever ask in their lives.

The TV reporter who was making the programme on Stafford had once worked in the health service. While we were setting up, he said that nothing about Stafford really surprised him, thinking back to his past life: the reluctance to measure performance and be transparent. His tone is so familiar to me now: that resigned, shoulder-shrugging, "nothing I can do about this bloody mess" voice that so many people at the coalface of data and technology in the NHS have. Perhaps the frustration with it all made him leave; I don’t know.

The transformation of the modern health and social care system depends above all on the intelligent mobilisation of its data assets, but perhaps the biggest challenge is to remind the people who manage them of the extraordinary mission they have – to make this vital public service intelligent.

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Chapter 6

Healthcare beyond the NHS

Mikis Euripides, Assistant Director for Policy and Public Affairs at Asthma UK
Healthcare beyond the NHS

Moving healthcare provision away from the hospital and into the community is now an accepted direction of travel in public health policy. Since Labour came to power, successive government papers have reiterated this, starting with *Our Healthier Nation* in 1998. Healthcare should be less about the hospital and more about public health and health prevention. However, making this a reality needs more than just lip service and it is high time an integrated approach was taken to the provision of health – one that involves not just the NHS, but also schools, local authorities and private employers.

Across the UK the delivery of healthcare is changing. In March 2008, a GP's surgery opened in a supermarket in Blackley, Manchester, and more are planned: the idea is about convenience and fitting in with people's lives. Schools and pharmacies are increasingly recognising their role in tackling issues like obesity and long-term conditions such as asthma and diabetes. Then there is the individual. The drive towards illness prevention as one of the long-term answers to funding healthcare and alleviating the strain on the health service means we are all being asked to look after ourselves better.

To tempt us into this way of living, all manner of incentives are being considered and the private and voluntary sector is being co-opted on to new government initiatives, such as NHS Choices. A political consensus has been reached too. The Liberal Democrats have pledged tax breaks for gym membership\(^1\) and extending the cycle-to-work programme, while the Conservatives support improved public health incentives and a local structure for small and medium-sized businesses to improve the health of their employees as well as a new Investor in Health accreditation scheme alongside Investors in People.\(^2\)

The message is clear: the NHS does not have all the answers and nor should we expect it to. Sir Derek Wanless' report in 2002, *Securing Our Future Health: Taking a Long-term View*, looked at three different scenarios, including a “fully engaged” scenario in which the level of public engagement in relation to health is high, life expectancy goes beyond current forecasts, health status improves dramatically, use of resources is more efficient and the health service is responsive, with high rates of technology uptake. If this “fully engaged” scenario is to be achieved, the promising initiatives that businesses and communities have instigated should be seen as the beginning of a process that will need constant attention from public policy makers.

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1 Norman Lamb MP, Liberal Democrat shadow health secretary, speaking in September 2008
2 Andrew Lansley, at Reform event on 27 August 2008
The employer as provider

The *Choosing Health: Making Healthy Choices Easier* white paper in 2004 recognised the need for a partnership across communities, including businesses, but the employer as a provider of health is nothing new. In Sweden in the 1980s, high levels of long-term sickness persuaded authorities and companies to introduce early intervention and rehabilitation programmes to tackle the problem. But studies have shown that employers spend several times more on the indirect cost of poor health than they do on health benefits. The costs of poor health are particularly high for long-term conditions, such as respiratory disease, which cost the UK £6.6 billion in 2004 and had nearly 25 million certified sickness absence days related to it. The difference today is that employers increasingly recognise that comprehensive healthcare combined with effective health promotion interventions can reduce sick days and absenteeism and improve productivity.

Where previously companies would rely on the government or the individual to address healthcare needs, many now organise seminars for employees to attend during their lunch breaks on anything from sexual health to occupational asthma. But initiatives are not as embedded here as they are in the US and some parts of Europe, where the healthcare systems operate in a different way. Wellness Programs in the US include programmes that penalise employees who smoke by raising their health insurance premiums and some employers offer financial incentives and rewards for healthy lifestyles or carrying out risk assessments. Aircraft manufacturer Cessna, for example, has a programme that offers a financial incentive to employees who complete a health risk assessment and get a physical and blood screening and has a 70% participation rate. The programme has been designed with realistic goals – encourage employees to think about their own well-being first and then talk about addressing big issues, such as smoking and obesity.

In Europe, there are also examples of good practice. German company BASF has a long tradition of workplace health promotion, with annual health campaigns aimed at early disease detection and working with local doctors to design appropriate strategies. In 2005, BASF’s “Off with the Fat” campaign focused on obesity and how serious the issue had become globally. Over 1,300 overweight employees participated, with their colleagues acting as weight-loss helpers encouraging them to stay active. An additional financial incentive in the form of a €10,000 prize fund was offered to employees who were able to reduce their weight. Exercise and sports activities, medical checks and the availability of healthy menus in canteens resulted in participants losing an average of over 7kg.

Although such campaigns are time-consuming, they demonstrate how industry is willing

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to take on a significant role in their employees' well-being. The government would do well to embrace such initiatives and incentivise in particular SMEs – perhaps through the tax system – where resources and priorities will be understandably different. One option for small companies is the fledgling independent private GP sector, combined with an occupational health and health promotion service. The expansion of this sector, geared to cover pervasive issues such as back problems and RSI as well as annual flu and travel vaccinations, could provide a solution.

According to a 2007 study, wellness programmes are on the rise, with employers seeing them as a way of attracting and retaining talent and of increasing workplace morale and productivity. But they do not work if employees do not participate. The report found that the most widely used incentives are discounts or subsidies for gym membership, prizes or points, wellness class reimbursement, and cash. A PricewaterhouseCoopers Health Research Institute survey in the US has supported the need for cash incentives, reporting that employees are two to four times more likely to enrol in programmes that improve their health if they receive gift cards or other incentives.

If UK employers are to follow their US counterparts, they need to think of healthcare in terms of value and not cost, and if corporate social responsibility is about meeting more demanding social and environmental expectations then businesses need to implement processes that measure the costs of poor health so they can identify where problems exist and then develop targeted programmes. We know that people who do not have a written personal care plan for their asthma are four times more likely to need emergency hospital treatment. For the NHS it is a no-brainer, for businesses they acquire an enhanced reputation as employers with more motivated and efficient employees providing a better quality of work.

As mentioned earlier, progress is being made – the Chartered Institute of Personnel Development's 2007 absence management survey identified a significant increase in the proportion of employers having an employee well-being strategy, with smoking cessation services, healthy eating options and subsidised gym membership among the most popular benefits. The survey also said the market was set to expand further, with more than 40% of respondents planning to increase their well-being spend, but cautioned that continuous investment in employee well-being could be difficult to justify unless it was possible to demonstrate the return on this investment.

The school
From building design to the curriculum, schools should be run with the health of their pupils in mind. The recognition that a child’s health and well-being is equally as important as a child’s academic achievement is crucial. Schools should also accept that today’s generation of children expect more. Having grown up with mobile phones and the internet being central to their lives, children have different expectations about how to learn and work. Tackling major health problems such as obesity is society’s responsibility, and schools are uniquely placed to impart life skills to children, which include a basic understanding of nutrition, exercise and general well-being.

It has been argued that a “health champion” is needed within each school, with school nurses ideal for this role – they are good at encouraging children into healthy eating habits and are ideally positioned to help address childhood obesity. Also, they have a vital role to play in identifying and managing pupils’ long-term health and spreading good practice across schools through awareness programmes. The government has expressed enthusiasm for this idea:

School nurses are well placed to deliver many of the outcomes for children in Every Child Matters ... their public health role supports the public service agreement targets relating to child health and well-being, including obesity, sexual health, reduction of teenage pregnancy, emotional health and well-being, healthy eating, smoking, drugs and alcohol. They will also play a key role in initiatives such as extended schools and healthy schools.

To support this, the government white paper Choosing Health: Making Healthy Choices Easier pledged action on school nurses. Yet the 2006 NHS workforce census showed there were only 2,968 qualified nurses in England in the school nursing area of work and of these just 1,129 had a post-registration school nurse qualification, although an improvement over recent years, this is a long way short of what is required. A school nurse in every school and healthy living fully integrated into a retuned curriculum and assessed by OFSTED would be a positive step. In addition, reinvigorating initiatives such as Jamie Oliver’s school dinners and his Ministry of Food campaign, which after the initial fanfare have subsided, with take-up of healthy school dinners halving in some areas.

5 Stoate, H Challenging the Citadel (Fabian Society, 2006)
7 At least one full-time, year-round, qualified school nurse working with each cluster or group of primary schools and the related secondary school by 2010 (2004)
8 Parliamentary question from Andrew Lansley MP, 4 March 2008; answer from Ann Keen MP
An issue that needs particular attention is managing long-term health conditions in schools. With the right healthcare management and support from their family, schools and the wider community, there is nothing that should stop the vast majority of pupils with long-term conditions from leading full and active lives at school. Schools can help to ensure that all pupils are healthy, stay safe, achieve their potential and are able to make a positive contribution by ensuring that:

- the whole school environment is inclusive and favourable to pupils with long-term conditions, including providing extra support for pupils who have missed school due to their condition;
- all staff understand and are trained on the impact medical conditions can have and in what to do in an emergency, such as an asthma attack; and
- the school has clear guidance on the administration and storage of medicine.

Equal support should come from government to ensure that there is a stronger legal framework underpinning this need.

Dealing with medical conditions at school

Less than 60% of children with asthma and their parents are confident that class teachers know what to do in an asthma attack. Asthma UK has worked in partnership with Diabetes UK, the Anaphylaxis Campaign and Epilepsy Action to produce a policy pack to support schools in developing and implementing an effective school policy for managing long-term medical conditions.

To complement this policy pack, the charities have developed a resource for school health-care professionals to raise awareness of long-term conditions in the school environment. Over 5,000 policy packs and almost 2,000 copies of the professional resource have been distributed. Initial feedback is very positive, with teachers becoming more confident in supporting children with long-term conditions in the school environment.

Schools are ideal for managing pupils' health during the day, but parents need help to maintain healthy living after school. Extending the remit of schools so that they offer access to school sites for pupils, parents and the wider community and tapping into the voluntary sector's expertise is a worthy initiative, particularly in deprived communities where the school site is often the only accessible resource. After-school sessions that address basic skills shortages, such as preparing healthy meals and understanding the value of staying fit, and other health promotion initiatives also make economic sense.
The tax system can be adjusted too. In Canada, the Nova Scotia government (and later the federal government) has introduced a healthy living incentive that provides an allowable tax credit of up to C$500 per child to help with the cost of registering children and young people in sport or recreational activities offering health benefits. Children and young people aged 17 and under who are registered on an approved organised sport, physical recreation or physical activity programme will qualify for the tax credit. The initiative has attracted considerable interest and plans are being made to expand its coverage.

The community
Many of our healthcare professionals, such as health visitors and pharmacists, are in a good position to address the needs of their local population. Greater accessibility and flexibility means that pharmacists are ideally suited to interact and engage with a wide range of individuals in the community. Pharmacies often have close links with local people, comprehensive opening hours and informal settings, meaning that they can be among the most accessible services for disadvantaged communities so they potentially have an important role to play in both health promotion and tackling health inequalities. For example, pharmacists could help individuals and communities who may be reluctant to visit GPs with access to information and advice on long-term conditions but to fulfil their potential the profession could benefit from greater encouragement and support.

There is a greater opportunity for communities to organise around improving health outcomes. Local organisers can be encouraged to take a more aggressive approach to improving patient engagement where the emphasis is no longer "Should we or shouldn’t we engage?" but instead "How can we maximise participation?" But more accessible mechanisms are needed to allow people to influence provision of healthcare at a local level – few people are aware of the options available to them and fewer still actively participate. This was identified as a major barrier to reducing health inequalities in New Zealand at the start of the decade, leading to the establishment of health boards that included local people charged with improving public health and targeting seldom-heard groups, such as the Maori and Pacific Islanders, resulting in significant improvements in reducing inequalities.

As the political parties search for a compelling narrative, electoral reform as an issue seems to be gaining momentum. This could be applied to health and education at a local level, for example through the expansion of structures established in foundation trusts. As ever, effective communication will be needed if the arguments under way in Scotland at the moment are to be avoided. The government there wants health boards to be partly elected by the public but it faces resistance from those who feel that future direction will be dominated by "organised" patient groups and local lobbyists.
Before communities can actively engage in the delivery of healthcare, a major drive to improve health literacy will be needed. A recent information prescriptions pilot in a deprived part of west London managed by Asthma UK highlights the lessons to be learned when it comes to effective patient engagement. As a partnership of three charities and a primary care trust, signposting materials were designed for people with asthma, diabetes and arthritis that provided patients with details about local providers of information and advice. The original design was simplified after testing with patients in a working group, but when it came to implementation the solution would prove ineffective to those groups that needed help the most. The message was clear – patient information must be developed by and tested with patients in the same social marketing segment as the intended audience.

**Conclusion**

The success of workplace wellness programmes abroad and the willingness to adopt new initiatives in the UK should be a clear signal to the government that now is the time to smooth the transition for all sectors of the economy. Stakeholders from within these sectors have a role to play in highlighting the long-term economic benefits as well as showing the government that they can be trusted with delivering improvements in health at a local level. This and a meaningful government commitment to the business case for illness prevention, with more guidance and incentives for businesses, is now required.

A glance at the evidence reveals the problems that need addressing. A report in 2008 from Norwich Union Healthcare revealed a “guidance gap” and a lack of incentives in implementing workplace health programmes, with a third of employers not investing more due to a lack of government incentives and almost a quarter not knowing where to access occupational health information – for small businesses the figure grows to 43%. In schools, progress on the extended services programme is encouraging but broader engagement and better communication is lacking, as has been acknowledged by the government.9 Finally, in the community setting, a focus on health literacy is required before we can expect active participation in the delivery of health services by all communities.

Meeting healthcare need away from the traditional setting of the hospital remains one of the main challenges facing public policy makers in the foreseeable future. It is a challenge that requires an integrated approach and a change in ethos. Government has the leverage to drive change but it can only take it so far. Above all, any attempt to change perceptions of how and where health is delivered needs the participation of all sections of society as co-creators in their own well-being.

9 Beverley Hughes, children's minister, on 30 January 2009
Chapter 7

Leading innovation – a clinical entrepreneur

Dr Richard More GP, Principal and Director of Avanaula Systems
Leading innovation – a clinical entrepreneur

The case for change
If anyone believes that future healthcare provision will be like present healthcare provision, only more of it, are sadly mistaken. There is a coming tidal wave of chronic disease based on the toxic combination of an increasingly ageing population and rising obesity. When linked to the capability of modern medicine to intervene, this could lead to a monster capable of consuming 30% of GDP by 2040. As the rising demands of chronic disease management consume more and more of society’s resources, the pressure for change, which currently seems to be considered a luxury, will increase. The challenge is to take heed of these developing pressures and take steps to reconfigure and redefine services before, rather than after, they are overwhelmed.

This implies taking deliberate steps to ensure that healthcare provision squeezes every penny of value out of every pound spent. It is not important whether this is taxpayers’ money spent by the government or individuals funding their own care. It is, in fact, drawing from the same pot – the gross domestic product.

Our current health services are firmly rooted in the 1948 model based on a presumption that illness strikes individuals randomly and that a return to health requires the passive acquiescence of the individual with orders given by professional physicians barking their command in a Lancelot Spratt type manner as they stride the wards. This focus on expensive inpatient hospital care responding to an unpredictable illness will ignore the potential to intervene earlier (and more cheaply) in the disease process. This must change to ensure an efficient and effective healthcare system going forward.

This paper reflects further on the forces for change, debates the structures that may come to the fore and concludes how this might be actively shaped.

What is quality?
It seems that this question has already been answered in referring to “effective and efficient” systems. This seems so obvious as to barely require stating. Also, it is apparently obvious that the phrase “higher quality” can be replaced by the single adverb “better”, but this is not so.

Observation of the natural experiment in the way that the public seek out conventional medicine and alternative medicine shows that there are differing views within society on what “better” looks like. Evidence-based medicine is reductionist, with a focus on reproducible outcomes and a demonstrable superiority to placebo effects. Alternative
medicine is softer, with a focus on the individual and the singular perception of benefit. Both sectors have advocates who propose that their system is "better". The public frequently choose either/or, and on occasions both.

This natural experiment tells us that the public, who fund and support healthcare organisations now and in the future, will not accept a single, centralised view of what is "better". To meet their needs, and to continue to receive their support, emotional and fiscal, there must be a variety of differing types of healthcare. This diversity of type of healthcare can only be delivered by a diversity of healthcare organisations.

The debate becomes clearer if we abandon the scientific argument about what constitutes high-quality healthcare and adopt an approach used by the private sector in assessing quality in the service industries. This approach abandons the idea that there is an independent benchmark of quality, but takes the view that a high-quality service is a service that exceeds the customer's expectations, no matter what they are.

The choice exercised by the citizen in seeking out different sorts of healthcare has different implications for society at large. For example, the externally demonstrable morbidity and mortality of an individual who seeks out homeopathic care for diabetes will, on average, be worse than that of an individual who seeks out and secures medical care. This choice becomes a valid subject for public debate, as currently wider society is duty-bound by ethic and statute to support the homeopathically treated individual as they suffer the now predictable consequences of sick leave and complications. These complications could require very expensive renal dialysis and/or treatment of heart disease.

Society already has mechanisms for steering individuals' choices around behaviours and healthcare. For example, there are softer influences of taxation on alcohol and cigarettes and also harder legislation on the wearing of seatbelts.

Does this imply that we must support the development of a hybrid model? Where health behaviour has an impact on society at large, then society at large has a vested interest in the provision of services that will mitigate the impact of illness. These services will need to be both to support choices that reduce illness (this used to be known as health promotion) and also treatment to mitigate the consequences of illness. Currently, this post-event service is referred to as the "national health service". It would be more accurately named the national illness service.

The development of personal healthcare budgets appears to sidestep this difficult debate. It allows individuals to make choices on their priorities as they see them. The challenge is
how to support individuals who choose to make less cost-effective decisions. To put it bluntly, who is going to pay for the dialysis of the diabetic who chooses homoeopathy?

Personal budgets empower customers to spend their allowance how they wish. This means that they can seek out services that meet or exceed their expectations, rather than those that meet or exceed the provider's expectations. This sounds attractive, but for this market to work, as with all markets, there must be a free flow of information available to the consumer to inform the choices that they make. This is difficult in healthcare, where data is currently scarce and information more so. Will consumers choose to secure services that meet their implicit healthcare requirements, such as reducing morbidity and mortality? Will they be able to seek out explicit qualities, such as accessibility, location and premises? The reality will be that some will and some will not. This supports plurality of provision.

**The future situation**

The implications of rising demand for volume and variety of care requires a response provided by a variety of types of organisations. These organisations will exist in an environment where demand constantly threatens to overwhelm supply and must be very efficient, delivering the highest quality for the lowest cost. They must offer the benefits of reduction of variability in care, offering maximum benefit for the minimum spend at each consultation or contact. At the same time, in order to attract and satisfy the increasingly consumerist public, they must offer a service specified to the patient's needs. The ability to manage these two contradictory benefits is known in operations management terms as mass customisation.

Plotting a course from here to there requires an understanding of the current situation.

**The current situation**

Currently, healthcare spend in this country is dominated by the acute sector, with general practice a distant second. On the fringes, but developing fast, are the emerging community service providers developing out of the primary care trusts and the ambulance services that have long ceased to be merely taxi services. There are also some niche providers, offering a variety of specialist care services. These have frequently arisen either from the private sector, for example, the community respiratory service that I myself jointly founded, or from the charitable sector, of which the most common example is the hospices.

The mass of this model – acute care and general practice – dates back to the strategy from 1965 that set up the district general hospitals. At this time, there was a one-to-one linkage in that hospital treatment equalled specialist treatment and generalist treatment
equalled community treatment. This is no longer true. There is a demand for care based in
the community that calls for specialism of and within a multidisciplinary team, which
goes far beyond the provision of inpatient beds that dominated the 1965 model.

Kaiser Permanante, the Californian health maintenance organisation, organises its care in
a pyramid. In figure 1, this has been adapted to emphasise the importance of patient
groups and other care providers.

**Figure 1: The long-term conditions healthcare pyramid**

At the moment, the existing general practices dominate and service tier 1, and the hospital
sector tier 3. This means that the gaps in our provision that need development are at
tier 2 and tier 0 care.

It is tier 0 care that will need to be developed to be effective to mitigate the health
consequences of our changing society. The teams and organisations that promote well-
ness and prevent illness will be critical to the stability of our future healthcare system.

In past years, disinvesting in illness services in favour of health promotion services has
been difficult. As a general practitioner, I frequently explain to my patients that no one
has ever phoned me up to say: “Thank you doctor, today is the day I would have had my
stroke had we not worked together to control my blood pressure.” In a healthcare system
where spending is controlled or influenced by individuals that require frequent re-election,
it is not surprising that short-term objectives are ascendant. The problem with that is, in
the long term, the chronic disease time bomb is growing.
This is not to suggest that illness prevention should automatically gain precedence over illness treatment. Health economists are able to advise on which interventions will lead to least ill health for a given spend. Listening to this advice, and implementing it, will be essential, if unpopular.

Influencing outcomes at tier 0 is all about influencing the millions of day-to-day decisions people make when shopping, choosing how to spend their leisure time and choosing how to spend their money. People do not mind change so much as they do not like being changed. This implies that to achieve success a completely different customer-professional power relationship, compared with clinical practice, is needed. This is not an environment for a professional to make choices on behalf of an individual, but rather for society to make the healthy choice an easy choice. This implies that organisations tasked with delivering this beneficial change should not arise from the existing illness-oriented health providers but rather from other organisations with different cultures. Because society has a vested interest in its constituent individuals making beneficial changes (because society does not want to pay for the consequences of poor choices), it is right that society supports the involvement of schools, local authorities, and self-help groups to advocate health. Employers also have a vested interest in promoting health in that there is a non-value-added cost to having employees absent through illness and still drawing pay.

Historically, tier 1, the district general hospitals and the university hospitals, and tier 3, the general practices, covered the complete gamut of healthcare. As chronic diseases emerged to become the biggest burden of healthcare, it has become apparent that there can be superior outcomes when care is delivered by specialised services.

Because, historically, specialist services were linked with inpatient care, there is now a need for high-quality specialised ambulatory care. This is what we mean by tier 2, specialist-based care not linked to inpatient beds. In this sector, the phrase “high quality” means regularly and reliably offering interventions that give the sufferer the least chance of the condition worsening. Tier 2 is emerging as a health service structure, and as ambulatory care of chronic disease emerges over the next two decades to be the bulk of healthcare it may well evolve to be the dominant player. Tier 2 services can emerge either from a tier 1 service looking to be community-focused, for example community paediatricians, or a tier 3 service looking to develop and deploy more resources at a particular target group, for example community-based services for people with the lung disorder COPD.

These new community-based providers will need to develop new ways of working with general practice, and general practice will need to develop new ways of working with
them. It must not be acceptable for patients to "fall through the cracks". This implies seamless sharing of information, allowing organisations to build on each other's work rather than duplicating it. This is crucial to reduce waste, which is essential to deliver efficiency and effectiveness. It remains to be seen whether computer-based information systems can capture the richness and variation of clinical practice to allow this to happen.

The challenge going forward for 21st-century general practices will be to advise their patients on what can be done in the community, rather than what can be done within one practice. This implies a further strengthening of the signposting and advocacy role of general practice. Failure to capture every opportunity to offer the best care possible will result in variations in care and outcome. As resources become tighter, we simply will not be able to afford these variations.

**The direction of travel**

We have also seen from our example concerning alternative healthcare that the public can and will seek out models of care that are not supported by central government purchasing. If we empower the public to spend resources meeting their needs as they perceive them, rather than as their needs perceived by medical and nursing staff, this adds a whole extra layer of variability. The public will not be "the public" but more than 50 million individuals seeking out quality services as defined by themselves, not central government.

This change cannot be controlled, it can only be influenced. New systems and structures must evolve to meet differing wants and needs.

**Evolution not revolution (and definitely not a reorganisation)**

Logic shows that development of health service providers should be concentrated in the two areas discussed above. Unfortunately, lessons from large-scale change, such as the national programme for IT and any number of large company mergers and acquisitions, show that it is virtually impossible to impose an external will on a creature as large and varied as the NHS. This is an unattractive truth to individuals who believe in centralised control.

Therefore, rather than seeking a "big bang" prescriptive solution, interested parties should seek to stimulate high-frequency small changes. Most importantly, small changes that get closer to where we want to be should be nurtured and supported, and those that move in the opposite direction should be allowed to wither. This is an evolutionary process.

As a society, we tend to value healthcare professionals and healthcare organisations. The idea that an organisation such as a hospital may cease to exist often leads to extreme
reaction and can even influence the political process. The analogy here of natural selection is too harsh. To provide the massive expansion of healthcare provision predicted there will be no need to close down less effective units, but instead merely to develop the more effective units. The final result of this evolution will depend on the relative power of the centralised state purchasing system (seeking population-focused care) and of individuals to seek out care that they perceive meets their needs (individual-focused care).

These influences themselves will consist of a complex mix of types, including financial, ethical and motivational. Of course, there will be an influence loop where consumer expectations influence the perspective of politicians that then influence the perspective of the NHS. We can see the initial development of new providers in the independent treatment centres, in the commissioning of the GP-led health centres, and in a community-based respiratory disease service with which I am associated.

From where are the future organisations likely to arise? What makes them likely to be effective? What sorts of organisations are likely to be “better”? We have argued that evolutionary theory requires differing structures to develop to allow success to thrive. What are the successful structures likely to look like?

To tease out these factors we can compare and contrast the existing two major providers, the general practices and the acute hospital trusts, and determine what organisational design factors are likely to contribute to success in the future.

The vast majority of the general practices, as a result of contracting routes until 2003, are organised as unlimited partnerships. The majority of the partners are general medical practitioners, so the same individuals are, at the same time, the senior managers and the key workforce. This means that widely different roles have to be filled by the same individual. This has the advantage that there are no barriers to communication whatever between the owners of the business and the operators of the business, allowing almost instantaneous service changes in response to a decision. It has the disadvantage that the differing roles have to be filled by the same person but actually require very different individual capabilities. The consequence of this is that the general practices tend to be inward-looking and constantly reflecting on what they can do rather than what they could do.

The situation in the hospital sector is quite different. Here strategic decision making is undertaken by a board consisting of executive and non-executive directors, of which typically one is medically qualified and another nursing qualified, with no other healthcare professionals. This is a clear difference; instead of the organisation being owned and
led by professionals, the organisation is led by professional managers and owned by the state. This has the advantage of role specialisation, with the professional manager more easily able to take account of forces and factors external to the organisation, but leads to a division line between the key workforce and the organisation’s management.

Professional managers often have a systemised concept of clinical work, financial realism and accountability compared with medical staff, who typically have strongly individualistic conceptions of clinical work and are equivocal about financial realism and accountability. When this is factored in, there is the potential for two teams within the same organisation to be pulling in different directions, producing no net movement. And there are, of course, many other professionals equally vital to patient care.

New organisations will be passionate about their version of “better” care. Successful organisations will have their version of better care coincide with at least one powerful force, probably either state-directed expenditure or citizen-directed expenditure. This implies an alignment between clinical staff on the front line, identifying, articulating and advocating better care, and the management support to make it happen. This sounds like an organisation that is a hybrid between the managerially run acute sector and the clinically managed general practice sector. If an ability to innovate (that is evolve) is to be the key ability for evolutionary success, as is argued in the commercial sector, then the innovators must be the loudest voice in the organisation. This can happen either structurally – with the innovators in charge – or systematically in that managers systematically deploy the assets of their organisation to support innovation. This would imply that clinicians, as only they interact with patients, need to be structurally or systematically the most important people in an organisation.

This looks similar to the model that we described for clinically led general practice, but remember that general practice does not have the managerial capacity. Reflecting on this leads us to say, rather simplistically, that the acute sector structure does not support clinical innovation and the general practice sector structure does not support management innovation. Therefore, in order for change to occur either the existing major providers must change or new providers must develop. The evolutionary reality is that, if allowed, both will occur.

Brand-new organisations will develop around clinical entrepreneurs. These are individuals, who are often passionate about their area of expertise. This passion creates an attractive leadership message that allows them to motivate and develop innovative clinical teams around them. These individuals, who are experts in their field, perceive that the two existing structures do not meet the needs of service delivery. In the current NHS environment, they
need to compete for resources with the existing general practices and increasingly predatory foundation trusts. In order for choices to develop for the consumer in the future, we must not allow the existing organisations to strangle the nascent organisations at birth.

**The Somerset community COPD service – a worked example**

In spring 2007, a close colleague, Dr Robin Carr, and I realised that the care of the lung condition COPD (chronic obstructive pulmonary disease) was often suboptimal. Expert bodies had set out standards of good care but these were not always being met. Working within existing structures, for example primary care organisations – clinical governance-led, respiratory services-led – had not resulted in the improvements in care that we desired. So how else should we do this?

The expert advice was that systematic identification of sufferers, relatively simple risk stratification and intervention reduces sufferers’ chances of becoming so unwell as to require admission to hospital. Financial modelling showed that this intervention was cost-effective. This clearly calls for the development of an effective tier 2 service provision. The challenge was how to turn this talk into action.

Dr Carr and I are both general practitioners. However, this service required a concentration that meant that it would need to serve a population of approximately 500,000 to achieve critical mass. As this required a wider geographical spread and a narrower clinical focus than is found in any general practice, it was unsuitable as a "bolt on". A new structure was required.

Developing this structure would require time and money. As our new organisation was not in contract with the NHS in any way, the only place, at that time, that money came from was our own families. The options we faced at this stage were to work and hope that we would secure a contract to get paid later, or else to abandon the idea. By then, our studies had led us to believe that the case for change was so compelling that the prospect of abandoning hope of success was too bitter a pill to swallow.

As two general practitioners, we had clear ideas where and what the service would look like. Nursing colleagues would be pivotal in delivering care. We could either make capacity, that is recruit and train nurses, or we could buy capacity, that is contract for these professionals where recruitment and training would be done by another body. As we had already come across the organisation that is now known as Bupa Home Healthcare, and were impressed by their clinical ability, we set up as a new team in conjunction with them.

We now had a credible potential provider of community services. We felt that the best
model of patient care was to provide a wider team service, including local tier 1 hospital teams. Unfortunately, our approaches to the two foundation trusts that serve our county were rebuffed.

Our local practice-based commissioning group working in conjunction with the Somerset Primary Care Trust had identified that managing emergency admissions was a key part of its strategy. Accordingly, it embarked on a tender process looking to secure community-based COPD services. After an exhaustive process, we were selected as provider of choice.

After a year’s work, the doctors had the prospect of being paid. Up until this point, there was no suggestion that this would happen. This is an example of a force acting against evolution. Had the individuals not been in a position to take this personal financial risk, Somerset patients would not receive the benefits of our care, and society would have borne the costs. If successful organisations are to evolve, then this risk/reward balance needs to be aligned.

Our care pathway is all about systematically offering every patient with moderate to severe COPD the most up-to-date treatment. Clinical practice is continually evolving and we believe that our model of having two doctors and six nurses concentrating on this particular illness gives a higher chance of reducing variability in care than trying to educate all the doctors and nurses in 74 different practices. This is another advantage of setting up as a tier 2 service.

The payment-by-results structure means that hospitals are paid for the amount of work they do. Fewer admissions means less income. This means that the hospital sector when setting up an admissions-reduction systems faces a double hazard. It has to bear the burden of setting up a new service, but see decreased income as a result of success. Our service arises out of tier 3 and carries with it that community focus, so it has no such conflicts.

Historically, the tier 1 players are the largest. Some foundation trusts are acquiring other foundation trusts and becoming larger still. As they become even more influential, this hospital focus will become larger, and is completely contrary to the direction of travel required. Society has a vested interest in supporting community-based clinical entrepreneurs.

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1 www.WyvernHealth.com
The power of assertively intervening proactively in chronic disease management, rather than waiting for people to become unwell and react, is demonstrated in the decrease in hospital admissions even in the very early days of our service.

What steps can wider society take to ensure that success stories such as this flourish and are not strangled at birth by competing organisations and deliver all, not some, of the promises that modern medicine offers?

**Conclusion**

There will be rising numbers of people with chronic disease. They will seek care in a manner that meets their varying perceived needs. These needs will have to be met, implying an enormous variety of care. Our current care structures are based on a 1948 model and will not be able to offer the community-based care required.

Change is possible, but the current providers have an investment in the status quo. Innovation is possible, but who will support the investment of time and effort needed? Clearly, the taxpayer has an interest in the health service evolving. If society wishes to see organisations develop to meet new needs, then they must take active steps to nurture the emerging organisations and protect them from the existing blanket of healthcare providers. There is a large distance between where we are now and where we need to be and this action is therefore urgent.

New organisations need to be supported in their evolution, the learning from their evolution needs to diffuse, and we need to support the million incremental decisions to get from where we are now to where we need to be. To think that there is a single large decision that will secure our future healthcare delivery is simplistic.

One could simply rely on luck, but my recommendation is to give evolution a hand.
Chapter 8

Leading innovation in public health

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Leading innovation in public health

As the recent report from the World Health Organization’s Commission on the Social Determinants of Health (CSDH) makes clear, health inequities are a persistent and increasing global phenomenon.¹ In the UK, levels of health among the worst-off overlap with those in poorer countries. Despite our best efforts and real increases in funding in recent years, tried and tested ways of improving health and reducing health inequalities have not yet brought sustained benefits for the population’s health.

The key questions

Two questions arise for exploration in relation to this observation. First, to what extent is this related to public health policy focus, particularly in England, which, in the years since the publication of the Acheson report² has been on inequalities of health outcomes (life expectancy and infant mortality), rather than a broader focus on the social justice imperatives implied in addressing what the CSDH terms “the wider, distal determinants of health”?

Second, as the report emphasises, inequities in health are not confined to the poorest, but follow a social gradient – might it be that the pragmatic approach we have taken in the UK, based on targeted interventions such as those focused on the Spearhead group of local authorities with the lowest levels of life expectancy, are insufficient as a solution to the challenges we all face? In addition, assuming that this proposition has salience, to what extent does this imply the need for a new approach to public health, focusing on health equity, human rights and social justice?

Evidence and healthy public policy

To address the policy question first: although public health research has acknowledged that health is determined by multiple factors and “layers of influence, one on top of the other”, up to now most attention has focused on how the underlying influences manifest themselves in home and work environments and in the daily habits and choices of individuals and groups. As a result, we know much more about the effects of factors close to the individual than we do about factors that are close to the macroeconomic and social structure.

Among the individual influences, attention has focused on material, psychosocial and

behavioural factors. Material factors include the physical environment of the home and workplace, together with living standards secured through earnings, benefits and other income. Psychosocial factors include the life events and difficulties that create stress for individuals and families, and the social networks and supportive relationships that enable people to meet these difficulties. Among behavioural factors, diet, exercise and smoking have all been singled out. These proximate influences cluster together: for example, an individual in poverty and poor housing is likely also to be disadvantaged in access to social support and is more likely to have health-damaging habits, such as smoking.

Is culture to blame?
Underpinning all of these there is the often-unexamined nature of the pervasive impact of culture itself on health and well-being. Zygmunt Bauman’s work on the impact of globalisation on both individuals and society provides some suggestion that it is the emergence of an individualised and consumerist culture in which the “new poor” are particularly demonised and stigmatised that needs to be addressed. In a deeply stratified social context in which the poor may perceive themselves to be of little value, given contemporary cultural norms that value freedom of choice and “a long and fit life – the kind of life which allows the consumption of all the pleasures life has to offer – is today the supreme value and principle of objective life efforts”, there may be little effective response to the realities of life as it is experienced at the bottom of the social hierarchy, where choice is extremely limited. In such a context, Bauman suggests that the affluent also suffer.

The impact of social inequality
This assertion is borne out by the recent work of Richard Wilkinson and Kate Pickett, which emphasises that it is not only the poor who suffer from the effects of inequality, but also the majority of the population. For example, their survey found that rates of mental illness are five times higher across the whole population in the most unequal than in the least unequal societies. One explanation, they suggest, is that inequality increases stress right across society, not just among the least advantaged.

The different social problems that stem from income inequality often, Wilkinson and Pickett show, form circuits or spirals. Babies born to teenage mothers are at greater risk, as they grow up, of educational failure, juvenile crime and becoming teenage parents themselves. In societies with greater income inequality, more people are sent to prison, and less is spent on education and welfare. In Britain, the prison population has doubled

3 Baumann, Z Work, Consumerism & the New Poor (Open University Press, 1998)
4 Bauman, Z Consuming Life (Polity, 2007)
since 1990; in America, it has quadrupled since the late 1970s.

Sir Michael Marmot’s ground-breaking work points to the importance of psychosocial influences on health. Increasing evidence suggests that anything contributing to chronic anxiety is likely to worsen health in an unequal society such as our own.⁶

Health is wealth
The impact of the economic downturn and increasing “worklessness” can only intensify the challenges we face. There is clear evidence that population health status is also a key determinant of local and regional economic capacity – improved health enables full engagement with paid employment. Good population health affects local indicators of “human capital” and labour market productivity. Poor relative population health also increases costs to the local, regional and national economy through the avoidable costs of care. Recent EU analysis shows that inequalities-related losses to health contribute to 15% of the cost of social security systems and 20% of the cost of healthcare systems across Europe as a whole.⁷ The implications are clear. Improving the health of the population is both ends and means for healthy public policy in the broadest sense.

Creating health or preventing disease?
Since 1997, in England and other parts of the UK, the approach to improving health has involved strenuous efforts to achieve a level playing field in access to healthcare, preventive measures and health promotional activities. The consequences of focusing on this, rather than on changing the circumstances of everyday lives, is that we have not yet adopted measures and systems that address the full spectrum of causes of unequal health.

The global report has called for the embedding of health in all policies, systems and programmes. Current policy emphasises that health inequality targets are the responsibility of the whole of government and local partnerships, and there are multiple programmes and interventions in play at local and regional levels, all aiming to improve health. However, these efforts are not achieving the desired step change in all areas. To some extent, this may relate to entrenched systems barriers and, in particular, the fragmentation of responsibilities and understandings between agencies, the difficulty of framing an overall vision in a programme-driven and targeted approach, the consequent lack of a common language about the nature of the challenge and, critically, the need to grow a multi-sectoral workforce, capable of deploying the existing evidence into practice.

⁶ Marmot, M Status Syndrome (Bloomsbury, 2004)
Delivering the public’s health and well-being

One step forward?
This context has profound implications for the second question about the role of “public health” in the endeavour to improve health and well-being. Here we are faced with some perplexing contradictions. Health in the UK is improving in some areas and in relation to some conditions but is deteriorating in others. And the apparent gains may be unsustainable, particularly in a worsening economic context.

The *Choosing Health* white paper observes that, although there have been large improvements in health and life expectancy over the last century, improvements on this scale cannot be taken for granted. The UK faces new challenges to ensure that, as a society, we continue to benefit from longer and healthier lives. While the threats from many diseases have been reduced, the relative proportion of deaths from cancers, coronary heart disease and stroke has risen and these now account for around two-thirds of all deaths. These diseases, plus others such as diabetes and chronic obstructive pulmonary disease, are also major causes of ill health, preventing people from living their lives to the full. The burden of mental ill health is also increasing and is highly correlated with economic and social deprivation. Furthermore, the need to tackle the growing health gap is an ever-present challenge: even in areas where there have been overall improvements, there remain large differences in health between those at the top and bottom ends of the social scale.

Lest we appear too negative about the achievements, we can say that the skills inherent in a traditional public health approach have been highly important in providing us with a better understanding of the health challenge. Epidemiology, needs assessment, geographic mapping, the development and dissemination of a robust evidence base for a wide range of interventions and newer techniques, such as social marketing, are all vital weapons in the arsenal required to tackle the problems head on. However, these skills, when purely at the service of programmes and targets focused on high-risk individuals and communities, have three inherent risks.

Firstly, they may fail to make an impact on the health of the population as a whole. Secondly, they may actually bring about the unintended consequence of increasing levels of inequity, as those at highest risk may be least able to access services or to benefit from the range of interventions on offer. Moreover, with many of the interventions focused on specific geographies and spaces, we have yet to devise and systematically implement methodologies that take account of the fact that poor people, at risk of the poorest

health, do not all live in the same place. Thirdly, they may simplify and/or obscure our understanding of the complexity of the dense web of interconnected factors and relationships that impact on individual and population health and well-being.

Traditional attitudes and skills and professional silos have not assisted us in developing so-called ecological approaches to issues of great complexity, such as obesity. As the recent Foresight report into obesity pointed out, it is society itself that is obesogenic.\(^9\) We urgently need to find new ways of tackling this at a whole-system level, through the emergence of new, multidisciplinary conversations regarding our health equity and sustainability challenges, new forms of research design and much better information sharing across sectors and professions. In short, we need a new understanding of the goal of public health, a broader understanding of the potential health improvement capabilities of a broad swathe of workers in all sectors, including many who are not traditionally associated with “public health”, and sustained investment in developing this workforce capacity.

**The North West response to the health challenge**

Many of the challenges discussed above are present in our region of the North West.

In the North West, life expectancy has generally been improving as a whole, but our rate of improvement lags behind other regions. For both males and females, life expectancy remains significantly lower than the England average. Boys born in the North West can expect to live 76.0 years on average, some 2.9 years less than those born in the regions with the longest life expectancy (South East males live 78.9 years). Girls can expect to live 80.4 years, 2.5 years less than the best region (South West females live 82.9 years).

Internal health inequalities (within local authority boundaries) are also an issue of concern. Many of the non-Spearhead areas in the North West contain within their boundaries localities with much poorer average mortality than the district average; and, in several districts, these gaps have been widening in recent years.

In recent months, searching for answers and solutions to these local and regional health challenges, a number of senior clinicians and managers from the NHS and other sectors in the North West have participated in national and international dialogue about the underlying reasons. Whether in the UK, the US or parts of Europe, the same common features are identified as contributing to the problems. These include economic decline, loss of community and identity, and the overwhelming challenges that individuals face.

when attempting to navigate a way of being healthy in an environment that makes it easier to be unhealthy.

In addition, these underlying drivers are likely to be exacerbated by the national and international financial crisis. Irrespective of the social justice arguments for sustained, effective action on health determinants, there is also a business case to be addressed. In a worsening context, it is fair to assume that governments and citizens will be increasingly unwilling to pay more for less in terms of health outcomes. There is urgency about the drive to move forward to achieve better health and well-being.

In response to these challenges and operating within the current policy framework, NHS North West, working with regional and local partners, has framed an ambitious agenda for transformation in health and well-being in the region. There are two key pillars to the vision: firstly, a transformed relationship with individuals and communities in matters affecting health and well-being; and, secondly, the strengthening of public health capacity to deliver the needed change.

This vision is enshrined in a number of key strategic policies, including Healthier Horizons, the regional response to the NHS Next Stage Review led by Lord Darzi,10 the World Class Commissioning process, which is expressed in the development of a range of new initiatives such as Our Life, the newly launched co-operative organisation creating a social movement for health11 and already actively engaged in a new dialogue, for example on alcohol, with the public and industry in the Big Drink Debate.12

Similarly, across the region as elsewhere, local and subregional partnerships are engaged via local area agreements and other mechanisms in new forms of joint activities, focusing on the full range of health determinants, with some developing a health asset approach. We are developing an “investment for health” framework in the region to support the co-production of “more health” from public-sector spending. We are shortly to establish a North West Centre for the Transformation of Health & Wellbeing, which will stimulate and support much-needed new research into the health equity challenges faced by our populations, thus enabling accelerated social learning across the whole system and in so doing support the development of a modern public health workforce in the broadest sense.

Reform or transformation?
While we are clear that we need to maintain momentum in implementing current policy,
our ambition is to travel far beyond mere reform of the current system and services and to aim for transformation in the way in which health and well-being is understood. In so doing, we will be able to bring about a step change in the health of the population.

Three horizons
Our approach to transformation has been heavily influenced by research developing alternative scenarios for the future of health and social care, published in 2008.\textsuperscript{13} The development work for these scenarios, undertaken with many individuals and organisations in the region in 2008, utilised a "three horizons" model of longer-term change (see figure 1).\textsuperscript{14} The underlying premise of this model is that policy making and policy discussion tend to occur by default in the first horizon. It is about improving and innovating the current system in order to maintain it. Our scenarios are attempts to challenge the default notion of business as usual and to enable more radical envisioning of the future, where business as usual is neither feasible nor desirable.

\textbf{Figure 1: The three-horizons model}

The model itself is simple. The first horizon is the dominant health and well-being system at present. This horizon represents "business as usual". As the world changes, so aspects of our current business are perceived as neither robust nor effective.

We would argue that much of the current drive to bring about innovation in the health and well-being system is focused on addressing apparent shortcomings of the first-

\textsuperscript{13} http://www.northwest.nhs.uk/projects/strategic_scenarios/
horizon system. Hence, our efforts are giving rise to a second horizon. However, it seems clear that, at some point, these innovations may become more effective than the original system – this is the potential point of disruption. We are clear that much of what we are putting in place in the North West has this disruptive potential.

Meanwhile, there are other innovations happening already that may look marginal or irrelevant to today’s business. This is the third horizon. This is the long-term successor to business as usual – the radical innovation that introduces a completely new way of doing things. We believe that the unpredictable consequences of our work to develop new social movements for health and our “investment for health” work, among many other initiatives, are aiming towards the third horizon.

The model offers a way into conversations about the nature of the tensions and dilemmas between vision and reality, and the distinction between innovations that serve to prolong the status quo and those that serve to bring the third-horizon vision closer to reality. This is a mature and realistic perspective, which we believe is in place in the North West, that accepts the need both to address the challenges in the first horizon and foster the seeds of the third.

We accept the need to deal with today’s business, and, at the same time, the business of tomorrow when circumstances may be radically different. Nowhere is this more true than in relation to the need to remain focused strongly on efforts to address national policy in respect of mortality and life expectancy, while at the same time attempting to frame broader interventions aimed at addressing the social determinants of health. This has been described by the International Futures Forum as “redesigning the plane whilst flying it”.

Creating the enabling conditions

A transformational policy framework
The key challenge is how we can ensure that we make steady progress towards the creation of the enabling conditions for “third horizon”, large-scale and sustained transformation. For that, we need to look beyond the current policy framework and ask how this might enshrine larger ambitions.

Three key characteristics of an approach to creating the enabling conditions seem to us to be clear. Firstly, policy needs to encapsulate and address all of the causes of unequal health in our societies. We must hope that the findings and recommendations of the
Marmot review of health inequalities in England, which will report in 2009, will encourage and enable greater focus on the cross-cutting social justice and human rights determinants of the social gradient in health, particularly levels of education, economic status, work and power relations. This may require the implementation of population-wide policies and interventions that have progressive impacts on the social gradient and wider determinants, as well as those that are focused on risk factors and diseases. The use of health equity impact assessments may help to ensure the embedding of health in all policies.

Secondly, the policy framework must allow much more scope for local and regional context setting, dynamic learning and bespoke solution finding to the health challenge.

Thirdly, it needs to enable and support the development of an appropriately skilled and aware broad “public health” workforce to work alongside local communities in the health transformation effort.

**Conclusion**

While we have seen in recent years a great deal of innovation in the treatment and management of previously neglected diseases, it is also clear that problems of inefficiencies, fragmentation and poor health outcomes are omnipresent. We need to rethink what transformation in health and public health might look like. There is a clear requirement for a new mindset among professionals in the NHS and other parts of the public-sector system. We need new tools, and new ways of thinking about systems and then the implementation of an entire assemblage of new, third-horizon norms and technologies, including sustainable social technologies.

The aim must be for the development and embedding of disruptive innovation, capable of producing the best health and well-being from available resources. For this to happen at the scale and pace required to address our current health challenges, we require an enabling policy framework that emphasises the goal of sustainable health equity. The case is absolutely clear, and is further strengthened by the potential health impact of the global recession.
Chapter 9

Health literacy

Don Redding, Head of Policy at Picker Institute Europe, and Joan Walsh, Policy Research and Campaigns Manager at Picker Institute Europe
Health literacy

Over half of England’s adult population have literacy skills below level 2 – the level of skills needed to discuss a condition interactively with a doctor or specialist.¹

Definitions

The concept of health literacy is intuitively obvious, though it resists snappy definitions. Being health literate means having “what it takes” – whatever it takes, as circumstances change – to maintain and protect your health and well-being.

Some definitions focus on “information” as the central element:

The ability to access, understand, evaluate and communicate information as a way to promote, maintain and improve health in a variety of settings across the life-course.²

Others emphasise cognitive and practical skills and talents, including the ability to interact successfully with healthcare services and systems. For example:

Health literacy is the ability to make sound health decisions in the context of everyday life – at home, in the community, at the workplace, the healthcare system, the market place and the political arena. It is a critical empowerment strategy to increase people’s control over their health, their ability to seek out information and their ability to take responsibility.³

Introduction

Interest in the concept of health literacy is growing in the UK. A basic connection has been made – that the level of people’s health literacy corresponds to health inequalities and health status. But beyond this, the question of how to tackle health literacy remains a puzzle.

In this contribution we suggest that an understanding of health literacy issues is most pertinent to prevention of preventable ill health, and to supporting people with long-term conditions in managing their own health. We examine what health literacy is, the evidence base for the effectiveness of interventions, and recent reform policies that have been tried by the NHS in England.

¹ Department of Health website: http://www.dh.gov.uk/en/Publichealth/Healthimprovement/Healthliteracy/DH_095382
² Canadian Expert Panel on Health Literacy, 2008
³ Professor Ilona Kickbusch, speaking at the Bad Gastein European Forum in 2005
For the future, we argue that the health service itself needs to become more health literate – understanding where its customers are starting from and redesigning services and interventions to be more tailored and fully inclusive.

**Health literacy – what is it good for?**
As yet, we know too little about how the relationship between health literacy, health outcomes and health inequalities works. In particular, available evidence can only demonstrate that there is a consistent and positive link between health literacy and health outcomes.

However, if we accept that there is, to some extent, a causal relationship, then health literacy interventions have the potential substantially to improve health outcomes and reduce demand for health services by:

- preventing preventable ill health – an agenda for public engagement in health; and
- enabling people to manage their long-term conditions more safely and effectively – an agenda for patient engagement in care and treatment.

**Health literacy and health inequalities**
People whose health literacy is "good enough" experience better health outcomes than people with limited health literacy. "Not enough" health literacy adversely affects people's access to health information and services, their experience of healthcare and their satisfaction with services. It also compromises patient safety by increasing the risk of miscommunication, errors and adverse events.

The population groups most likely to have inadequate health literacy have much in common with the "seldom heard" and the "hard to reach", in that they are disproportionately:

- aged over 65;
- living with chronic conditions and/or disabilities;
- from ethnic-minority communities;
- with limited local language skills;
- from lower socioeconomic groups;
- with lower educational levels and qualifications; and
- with cognitive impairment, including age-related cognitive decline.

That much we know. We also know a fair amount about the interventions tried so far to target and tackle health literacy issues.
Health literacy interventions for patients – evidence of effectiveness

Although prevailing understandings of health literacy emphasise skills as well as knowledge, most health literacy interventions for patients have focused on providing information or education.

In 2006 the Picker Institute produced an overview of the best available research evidence on patient-focused interventions.4 We summarised the evidence on the effectiveness of patient information and education for self-care as follows:

- Information – whether in written, audio, video or interactive formats, can increase patients’ knowledge and confidence.
- Information and education help people more, the more they are targeted, tailored and intensively provided – for example, condition-specific education is much more effective than generalised courses.
- Active education, teaching practical skills, is always more effective.
- Longer-term and more intensive information and education programmes tend to have longer-lasting effects.
- Information providers need to deliver the information patients want – such as how to deal with the condition in their daily lives, or where to get help and support services or financial advice.
- Information- or education-only programmes have little impact on inequalities in health literacy or health outcomes.
- Healthcare professionals are crucial to the effective use of information and education – delivering it, helping people to make sense of it, and supporting people to continue making use of it in their daily lives.

Recent reform policies – opportunity costs

Since 2000 the government has recognised and invested time and resources in the information and education components of healthcare. So do these programmes accord with the evidence base? What sort of impact have they had on health literacy?

Information for choice

National information programmes have been closely tied to “choice” policy – specifically, patients’ choice of hospital provider. Such initiatives have included, for example, information prescriptions, the NHS Choices website and publication schemes for hospital, surgical and other provider performance information.

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Education
The government invested heavily in the Expert Patient Programme for people with long-term conditions. By the end of 2007 around 40,000 people had attended courses.5 The programme is now managed by a community interest company.6

Critique
These national programmes do not appear to reflect the evidence base:

- Information schemes do not always accord with patients' own priorities. Patients do not strongly identify their interests with policy on choice. More important is the quality of their information exchange and decision making with healthcare professionals.
- The Expert Patient Programme is generic, relatively short, lay-led, and rarely linked into the provision of mainstream health services.

This means the programmes can be ineffective and therefore risk opportunity costs. For example, the 2006 independent evaluation of the Expert Patient Programme pilot phase found that it had very modest effects,7 with little impact on how people use health services, and recommended that resources should not be "concentrated in a single resource [but] directed at a variety of systems and interventions".

Finally, and perhaps critically, these programmes may have unintended adverse consequences. The provision of information and education alone is likely disproportionately to benefit those who are already in a better position to use it. This further disadvantages people with lower health literacy.

This was highlighted in the Expert Patient Programme pilot phase evaluation, which found that the courses:

... tended to draw in people who were already committed to self-managing and who tended to be white, middle class and well educated ... [with] the potential to increase inequalities.8

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8 Ibid
Likewise, although the evaluation of the information prescriptions scheme found positive effects, people from more affluent areas were much more likely to benefit than people from disadvantaged areas – despite the considerable efforts made by the pilot providers to anticipate and overcome such inequalities.9

Preventing preventable ill health
This requires “generic” health literacy knowledge and skills – recognising a healthy diet and eating it, knowing the importance of doing enough exercise and doing it, knowing what to avoid and not doing too much of it, knowing when you need help and seeking it.

The first challenge for preventive health literacy interventions is to reach beyond the “unworried well” – who have acquired the foundations of good-enough health literacy from their family, social support systems, communication media and formal education – to those most likely to have poor health literacy or to be least able to put theory into practice.

The second is to find ways of working effectively with people whose poor health literacy reflects multiple disadvantage and social exclusion, and for whom “improving my health literacy” is not any kind of priority.

Despite a long history of public health interventions and campaigns, there is not a robust evidence base in the health literature for the effectiveness of health literacy interventions in this domain.

In England, such interventions are relatively recent and focus largely on children and young people (for example, Skills for Health and Change4Life). We must wait to see the impact of these on health literacy, outcomes and demand for health services.

Health trainers
Since 2007 a new component of the health workforce has been introduced across England. NHS health trainers are lay people recruited from local communities to provide personal advice and support to people to improve their health-related behaviour. The Health Trainer programme focuses on people from hard-to-reach and disadvantaged groups, who can self-refer or be referred by a health professional.10

Social marketing
In 2006 a report commissioned by the Department of Health found that there was evidence

for the effectiveness of "social marketing" approaches to changing people's health-related behaviour.\textsuperscript{11} The department now backs these approaches and primary care trusts are increasingly expected to use them to improve public health.

Social marketing aims to use sophisticated marketing techniques to go beyond generalised health campaigns, by targeting smaller segments of the population, defined not just according to their demographic or health characteristics but also by their opinions, beliefs, attitudes and susceptibility to change. It generates behaviour modification interventions.

Critique
Health trainers may well meet some of the evidence-based criteria for effectiveness discussed earlier: personal interactivity, continuing support, and the capacity to link into the patient's continuing course of care. A Picker Institute research study on behalf of one primary care trust found that potential users strongly backed the approach and thought it appropriate for people with long-term conditions, unhealthy lifestyles, stress and depression.

However, people would also expect that the trainers should build an in-depth knowledge of their personal health history and status. It remains to be seen whether that can be achieved by a lay workforce. It may simply recreate the need for frequent referrals to doctors (as has happened to a large degree with nurse-led walk-in centres and NHS Direct).

Social marketing may in practice target similar individuals and communities, but through very different techniques. At this early stage it is seen as an instrumental tool, whose outcome is expressed as a percentage of people changing a behaviour, thereby contributing to meeting "vital signs" targets. Unlike health trainers, it is not currently intended to initiate continuing engagement with individuals, or to support people with low health literacy.

Going beyond information- or education-only approaches
The prevalence of low health literacy suggested at the top of this article is clearly a major barrier to achieving the Wanless "fully engaged" scenario,\textsuperscript{12} which is considered by all parties to be essential to the sustainability of health services.

Given the population groups for whom health literacy is a challenge, we have to consider which policy direction is likely to have most impact on engagement.

\textsuperscript{11} National Social Marketing Centre \textit{It's Our Health: Realising the Potential of Social Marketing} (2006)
There is undoubted room to improve information and education programmes in line with the evidence base. But we will still face the problem that information and even education alone will not necessarily improve people's health behaviours or capacity to manage their health status. So should interventions continue to be focused on efforts to improve people's health literacy – a task of considerable magnitude for the health service?

Or should the emphasis be on developing more health-literate health services? And what would the latter mean?

**Forging health literacy in health policy and health services**

It seems unlikely that today's inequalities in health literacy among the patient population will be ironed out in the foreseeable future. Even if longer-term educational initiatives to increase health literacy levels are successful, there will surely always be people with "not enough" health literacy. And, as information and healthcare technologies keep advancing, the goal posts of "good enough" keep shifting. Inequalities in health literacy may increase.

A more health-literate health service is the key to countering low health literacy and the health inequalities that accompany it. A health service that works developmentally – starting where people are, consistently recognising and compensating for limited knowledge, skills and abilities, and redesigning itself to meet people at their level.

The concept is of a service that itself becomes geared as an engine of engagement with people for whom engagement represents a challenge.

**Front-line networking**

Any community health worker or practitioner in primary care may need to be primed as an "agent of engagement"; and colleagues in other public services likewise. At every potential contact point with the relevant individuals and groups, the service must be ready to identify them, pick them up, put support underneath them and help them move into a more engaged position. Primary care trusts need to demand and commission this approach. This calls for much greater team working and networked approaches in community and primary care.

The risk for health trainers, for example, is of marginalisation and not being part of "the team". When potential users say they could discuss long-term problems with a health trainer that they could not bring to their GP, this points to the greater challenge: not of providing an add-on workforce, but of how GP services need to change to engage.

At the same time, this networked front-line care must not lead to diffusion of responsibility,
because individuals in these groups say that what they most want is a single point of contact who knows them and their health history, stays alongside them, and helps them with the crucial problem of navigation – how to get what they want and need out of the confusing array of local services.

Commissioning
In its submission to the NHS Next Stage Review, the Picker Institute argued for:

• a clear statement of the purposes of patient and public involvement in the local NHS; and
• a coherent framework for measuring and evaluating the effectiveness of local patient and public involvement work against the statement of purposes.¹³

If and when these are developed, it seems reasonable to expect that commissioners will need to be able to demonstrate that patient and public involvement has contributed to reducing health inequalities in the local population. Commissioners will need to understand that their clients are not objects manipulated to meet targets, but subjective individuals for whom many of the barriers to changing behaviour or better self-management are created by the unfitness to engage of services themselves.

At the core of these changes will be enlightened commissioners (broadly understood – these could be formal commissioners from primary care trusts or practice-based commissioning, or indeed could be the people leading a service to a client group). Commissioning must be patient-focused, and must recognise and overcome the impact of low health literacy on people’s willingness and ability to be involved in accessing, evaluating and redesigning services.

Countering the effects of low health literacy means investing commissioning resources in learning from low health literacy groups, and developing and maintaining a close understanding of their needs, perspectives and priorities – throughout the commissioning cycle.

Pathways – either to preventive services such as screening, or to care and treatment – must be commissioned to allow the time and space to appraise people’s degree of health literacy and build their care accordingly. This means time to understand the patients’ perspective and preferences, and any factors in their lives that are holding them back; and time to reduce their fear and improve their confidence.

¹³ Picker Institute Europe Policies for Patients: Submission to the NHS Next Stage Review (2008)
To give an example: breast and cervical cancer screening promoters in Wales faced a persistent problem that people with learning disabilities did not access their services. They spent time with the client groups finding out why and discovered that all the words and concepts involved were not understood or were misunderstood. They then overhauled all their information, finding alternatives to words like "breast", "cervix" and "screening"; created new pathways that enabled nurses to spend time with the patients explaining these and demonstrating equipment; and changed their training packs for the nurses to make sure these steps were followed.14

Figure 1: The patient-focused commissioning cycle

Source: Picker Institute

The workforce agenda
All the evidence shows that for people with lower health literacy, it is the quality and continuity of engagement with health practitioners that makes other interventions most effective.

Healthcare professionals are also key to maintaining patients' gains in knowledge, confidence and skills over time. Active and proactive support from professionals or allied practitioners, for example through patient-centred telecare, does help people manage their health more effectively.

Patients want a continuing floor of support as they struggle to manage their conditions and keep up their changed behaviour – not a cut-off point where a vital-sign target is

14 Picker Institute Europe Improving Patients' Experience Factsheet No 12: Improving the Experience of Healthcare Screening for Patients with Learning Disabilities (2007)
achieved, or a referral away from support and advice when a person has begun to gain more control. This demand for continuing engagement may seem costly, but will be less costly than allowing old patterns of depression, failure to cope, and unplanned referrals to reassert themselves.

Where health literacy is concerned, government needs to move past its agenda of big policy-driven programmes and focus on its leadership of a workforce. There is an enormous agenda here for workforce planning, education and training, standard setting, awareness raising, and skills development – to enable the “patients and professionals as partners” approach that the prime minister has spoken of as the next great advance in healthcare. The nexus between the Department of Health and the leadership of professions and allied staff, and the development of cohorts of advanced practitioners in health-literate approaches, will be critical to sustainability.

In the end, a health-literate health service requires a health-literate workforce.

*Health care practitioners literally have to understand where their patients “are coming from” – the beliefs, values, and cultural mores and traditions that influence how health care information is shared and received.*

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15 Speech on the NHS, 7 January 2008 (http://www.number10.gov.uk/Page14171)
Chapter 10

An open health service?
Counting on accountability

Harry Cayton, Chair of the National Information Governance Board for Health & Social Care and Chief Executive of the Council for Healthcare Regulatory Excellence
An open health service? Counting on accountability

Over the past decade we have seen an extraordinary shift in the health service in England from secrecy to openness. As citizens and patients, we now have 24x7 access to help through NHS Direct. On NHS Choices we can find local services: names of staff, opening hours and clinics provided by our primary care practice. By looking at the registers held by the regulators, we can know if our nurse or pharmacist is registered, when they qualified, if they have any specialist qualifications or whether if they have any conditions on their practice.

We can find out how the Care Quality Commission rates hospitals on such things as safety, standards, waiting, dignity and respect and what our care should be like and what to expect from it. In a (so far unique) commitment, we can find out how any individual cardio-thoracic department has performed and how its survival rates compare with others.

In agreeing which treatment might be best for us, we can decide how the evidence for different options stacks up and check the safety and unwanted effects of medicines. If we want to know more about a particular condition, patient organisations such as Macmillan Cancer Support, the Alzheimer’s Society or Diabetes UK provide help-lines, information sheets, chat-rooms and on-line answers.

If and when we have absorbed all that technical and professional advice, we can see what other patients and service users think about the care they received or the facilities at the service they used, and we can leave our own opinions on interactive websites to help others. Our opinions will soon be augmented, as part of the quality accounts being introduced in the 2009 Health Bill, by patient-reported outcome measures. Quality accounts will provide information on quality – defined as safety, outcomes and experience.

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1 NHS Direct: www.nhsdirect.nhs.uk
2 NHS Choices: www.nhschoices.nhs.uk
3 For example, the General Medical Council (www.gmc-uk.org) or the Royal Pharmaceutical Society of Great Britain (www.rpsgb.org.uk)
4 The Healthcare Commission merged with the Commission for Social Care Quality and the Mental Health Act Commission on 1 April 2009 to become the Care Quality Commission.
5 Healthcare Commission: www.healthcarecommission.org.uk
6 Map of Medicine: www.mapofmedicine.com
8 NICE (www.nice.org.uk), Cochrane Collaboration (cochrane.co.uk), NHS Evidence (http://www.nice.org.uk/aboutnice/nhsEvidence/)
9 Medicines & Healthcare Products Regulatory Agency: www.mhra.gov.uk
10 Patient Opinion: www.patientopinion.org.uk; I Want Great Care: www.iwantgreatcare.org
11 Health Bill 2009: http://services.parliament.uk/bills/2008-09/health.html
for patients, clinicians and managers – with the explicit aim of improving local accountability for services.

There has never been more information available to help us to decide what we want to do or to hold our healthcare providers to account.

It is suggested that some people are overwhelmed by modern life, claiming information and choice are all too much; they just want a good local hospital, a consultant chosen by their GP, a GP who tells them what’s good for them and that they don’t need to worry. No choice? That’s fine. No choice is still available from a doctor near you. The problem is you still have no real choice of a GP, so you can’t choose a GP who will guarantee you no choice. But that will come.

No one needs to exercise choice or to use all or any of these information sources. But they are there. That is really the point about information, choice and accountability. If public information exists, accountability follows. It is because better information leads to stronger accountability that very little of this information has been willingly opened up for public scrutiny by health and social care service providers themselves.\(^\text{12}\)

Health information has been dragged into the light by many forces: government requirements, patient organisations, sceptical researchers, internet entrepreneurs, freedom-of-information campaigners, journalists and the public themselves. Shameful refusals remain; some pharmaceutical giants still refuse to publish negative research reports and many doctors still resist the publication of comparative performance information and object to patient surveys.

Some information sources, even publicly available sites such as the NHS Information Centre, are surprisingly hard to search, while others, such as the NHS Institute for Innovation & Skills, limit access to registered professional users. Some major research institutions still want identifiable patient data for research without accountability to patients for its use.\(^\text{13}\) Nevertheless, the new openness of health data is part of the modernisation and transformation of healthcare. Once information is freely available, there is no going back.

There have been several parallel influences on the information revolution in healthcare. Pioneering health professionals and researchers were perhaps in the vanguard; committed

\(^{12}\) With the honourable exception of the Cardio-thoracic Society, which under the leadership of Bruce Keogh opened up its performance on an individual basis to public examination

\(^{13}\) Mark Walport, on Guardian Unlimited, 21 November 2008 (www.guardian.co.uk/commentisfree/2008/nov/21/nhs-health)
to evidence-based medicine, to public scrutiny, and to best practice, they wanted to get the debate about what works out of the common rooms of the Royal Colleges and the universities and into the public domain. They were right, and those who want to undo patient engagement in research in the interests of efficiency have missed the reality of the new information debate.

They found partners and supporters in patient organisations and in the Labour government and its NHS Plan in 2000, the first chapter of which was titled, "Our Vision: A Health Service Designed around the Patient" – surprisingly radical at the time. So, for a moment, progressive health professionals and managers, patients and politicians were aligned – as they were in 1944 – in a revision of the relationship between the state, the medical profession, people and patients.

Finally, social and technological innovations have drawn down change; as the users of health and social care have demanded more, information technology has delivered it and will continue to do so.

It is not surprising in this healthcare evolution that independent people and organisations have led the way. The Cochrane Collaboration was involving patients and the public in its assessments of research in the mid 1990s, as its director, Iain Chalmers, pursued his vision of honest clinical research and informed and engaged patients. Recently GP and journalist Ben Goldacre has brilliantly popularised that scrutiny with his newspaper column and book *Bad Science*.

Dr Foster, founded by journalist Tim Kelsey in 2001, transformed public access to information about the health service by using available information but packaging it in an accessible and meaningful way. Dr Foster's original series of publications such as the *Good Hospital Guide* caused consternation and protests from managers and doctors and were greeted with relief and enthusiasm by patients and the public. From its original paper publications, Dr Foster moved rapidly on to the web, creating usable, patient-friendly and critical analysis of health data.

The website Patient Opinion, set up by GP Paul Hodgkin, pioneered the idea of on-line communities of patients and service users sharing experiences, whether good or bad, of

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15 The NHS Plan (HMSO, 2000)
17 Goldacre, B Bad Science (Fourth Estate, 2008)
18 Dr Foster "The Good Hospital Guide 2008" (www.drfosterhealth.co.uk/features/hospital-guide-2008.aspx)
health providers. Good ideas of course stimulate imitators and developers. New websites with similar information services exist, including the Department of Health's own NHS Choices, an important and valuable attempt to modernise official health information but which struggles with a paternalistic and overcautious mindset.

There have been three significant areas where accountability has increased through access to information. These could be expressed simply as: what works; what's available; what's good.

First and perhaps most important has been access to information about treatments, about options, risks and effectiveness. In this context, despite the overblown protests of those whose new drug or innovative treatment has been rejected, NICE\(^{19}\) is truly the patient's friend. NICE has focused on what is effective for patients and justifiable for the health service. It has over time become increasingly open about its evidence and decision-making processes. It has pioneered public engagement in the tough decisions that healthcare planning brings, such as whether a price can be put on patient safety, and whether decisions about availability of treatments should take age into account.

NICE's "social value principles"\(^{20}\) are an important model of public accountability for decision making. NICE sets out its ethical principles and approach in a public document, and in particular the principle of "accountability for reasonableness":

For decision-makers to be accountable for their reasonableness, the processes they use must have four characteristics; publicity, relevance, challenge and revision and regulation.\(^{21}\)

What derives importantly from this approach is not that all decisions will have universal approval but that they will be sustainable in the real NHS because of their reasonableness. Other statutory bodies, such as the National Information Governance Board, also publish the ethical basis and principles on which they make decisions, allowing public scrutiny and challenge.

The second area of importance is information about services. Perhaps the strongest influence for this change has been government policy on choice. Choice has been seen both as a desirable public good and as a driver for quality. Early attempts to promote choice were hampered by lack of comparative information; quite simply, if you don't know

\(^{19}\) National Institute for Health & Clinical Excellence: www.nice.org.uk
\(^{21}\) These characteristics are explained more fully in: Daniels, N and Sabin, JE Setting Limits Fairly; Can We Learn to Share Medical Resources? (Oxford University Press, 2002)
what options are open to you, you cannot make a choice between them.

The third area, strongly linked to choice, is information about quality. The 2001 Kennedy inquiry into the management and care of children receiving complex heart surgery at Bristol Royal Infirmary22 made many important recommendations, which have shaped the NHS subsequently. One was the recognition of the role patients (and in that case parents) have in safety and the monitoring of quality, a role that is increasingly recognised and which has also underpinned Sir Liam Donaldson's commitment to safety during his time as chief medical officer for England. The National Patient Safety Agency23 has made the public reporting of safety data a fundamental principle and the new Care Quality Commission will have quality and safety as a core task.

Dr Harold Shipman's murders came as a shock to the General Medical Council and the other regulators of health professionals. Far greater accessibility of the registers held by regulators, more transparency of their content and a refocusing of health professional regulation on the promotion of patient safety and well-being have been among the results. The white paper Trust, Assurance & Safety24 proposed specific accountability changes for the regulators by bringing in at least 50% members of the public on their governing councils.

The NHS Constitution for England might be thought to be another strand of this trend towards holding the NHS and those who work in it accountable to the public. In setting out in one document (actually several) what patients may expect, it goes some way in the direction of a public statement of accountability. The NHS Constitution is, however, marred by its misguided attempt to reconfigure the NHS as a rights and responsibilities contract rather than to restate its original basis as a consensual public service drawing on social solidarity.25

If accountability has real utility, it is as a line of responsibility that travels in one direction only. Of course, reciprocal accountability is possible: "I will do this if you do that, and if you do that I will do this." Reciprocal accountability flourishes in a shared social contract. Unfortunately, the NHS Constitution is not a negotiated agreement of reciprocity but a set of rights for and commitments to citizens and service users. Setting conditions on those rights undermines the promise to deliver them.

22 Bristol Royal Infirmary Inquiry Learning from Bristol: The Report of the Public Inquiry into Children's Heart Surgery at the Bristol Royal Infirmary, Cm 5207 (TSO, 2001)
23 National Patient Safety Agency: www.npsa.nhs.uk
24 Trust, Assurance & Safety: The Regulation of Health Professionals in the 21st Century, Cm 7013 (Department of Health, 2007)
Let's consider the responsibilities that the NHS Constitution requires me to hold as a patient in exchange for my rights: apparently I have a responsibility to look after myself, to behave myself, to do what I'm told, and to take my medicine. Regrettably, the word "consent" does not appear anywhere either in the "principles" of the NHS set out at the beginning of the Constitution or in the "values" listed at the end. None of my obligations are enforceable by the NHS, any more than my rights are enforceable by me. The NHS Constitution is a paper tiger, brought out to be waved for the admiration of the crowds. Rather than improving the accountability of the NHS to the public, the tiger-waving, finger-wagging tone of the Constitution will only serve to confuse both those who work in the NHS and those who use it.

The ambivalence contained within the NHS Constitution is an ambivalence reflected in other aspects of government use of electronic data. At the same time as the internet is giving everyone direct access to a huge range of information and ideas, the state is collecting, storing and using personal data on a vast scale with very little public oversight or scrutiny. This slide into surveillance has recently been criticised in a report from the Joseph Rowntree Reform Trust as expensive, disproportionate and unnecessary, with non-consensual databases such as ContactPoint and the police DNA database singled out for particular criticism. New technologies give us new tools for both freedom and repressive control, which is why consent and openness must be fundamental to their value and public acceptability.

Clarity of public information and commitments do result in public accountability. Indeed, there is a legitimate virtuous circle: transparency of reporting builds public assurance, which in turn builds accountability, which supports transparency. The very fact of public reporting, though not sufficient in itself, makes public services more accountable.

So a tension exists between the control of information and public access to information. Real openness and thus real accountability will only come about when public ownership of our information and of its use in the public interest is made explicit and comprehensive. Despite the progress made, there is still a vast amount of useful information that is available in the healthcare system for politicians, civil servants, managers and researchers – much of it about us as citizens and service users – which is not available in public or is available in such an inaccessible form that no ordinary person could find or use it.

One of the long-fought-for legal principles of England, a country without a constitution, has been the implicit assumption that the state is accountable to the people. The

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26 Department of Health *NHS Constitution* (2009)
27 Joseph Rowntree Reform Trust *Database State* (2009)
surveillance society, with its every growing demand for personal data to be used in secret, is creating a situation where the people are accountable to the state.

As so often, as patients and citizens, we stand confused by government policy. On one side, the present government has an admirable track record of freeing information for use by citizens to enable choice, transparency and accountability. On the other side, in the Coroners & Justice Bill the government wanted to give itself almost unlimited powers to use our identifiable information without our consent for government-defined "public interest" purposes, including medical research.\textsuperscript{28}

On 27 February 2009, in response to growing public opposition, the minister for justice, Jack Straw, defended “information-sharing orders” in \textit{The Guardian} but rightly reminded us that, in a democracy, the government is ultimately accountable to the people.\textsuperscript{29} Less than two weeks later, he announced that the proposal for information-sharing orders would be removed from the bill.\textsuperscript{30} Transparency of information and public debate mean that accountability works.

\begin{thebibliography}{9}
\bibitem{Coroners} Coroners & Justice Bill 2009
\bibitem{JackStraw} Jack Straw "Our Record Isn’t Perfect; but Talk of a Police State is Daft" in \textit{The Guardian}, 27 February 2009 (www.guardian.co.uk/commentisfree/2009/feb/27/freedom-of-information-straw)
\bibitem{JackStrawDrop} "Jack Straw Drops Data Sharing Plan" on www.publicservice.co.uk, 10 March 2009 (www.publicservice.co.uk/news_story.asp?id=8841)
\end{thebibliography}
Chapter 11

Changing public behaviour

Martin Dockrell, Director of Policy and Research at ASH
Changing public behaviour

Tobacco remains by far the greatest cause of premature death and health inequality in the UK. Yet with smoke-free legislation tobacco control has claimed one of the first great public-health triumphs of the 21st century. Blending fiscal policy, pharmacology, behavioural psychology and commercial-style marketing has reduced the harm smokers cause themselves and those around them. With taxation, we have tipped the balance away from smoking and in favour of quitting. Through education, we have protected our children from second-hand smoke and through legislation we have protected colleagues and customers.

Smoking rates in the UK are now the lowest since records began. As recently as 1978, four out of 10 UK adults were regular smokers, but by 2008 smoking prevalence had halved to one in five. Despite this success, the cost of smoking remains high – not just to the NHS, which spends £2.7 billion on smoking-related illnesses every year, but also in human suffering, causing more deaths each year than alcohol, illegal drugs, obesity and road traffic accidents combined.

Are there lessons that tobacco control can offer to other fields of health, or is the nature of tobacco so unique that the learning can be transferred only at the most abstract level? Certainly, the success of the remedy is due in part to the scale of the problem. The enormity of the global burden of smoking-related death and disease has both concentrated the minds of policy makers and provided researchers with easy access to large-scale clinical trials. Political priority and clinical evidence have proved to be two out of three of the essential ingredients of the success of tobacco control, but surely there are also lessons to be learned from both clinical- and population-level interventions to reduce tobacco use.

Tobacco control's special challenge

It would be a great mistake to glibly “cut and paste” tobacco control techniques into other fields. Each area of public health has its special challenges and complexities: communicable diseases can be the product of rapidly mutating, treatment-resistant viruses, so that each time we think we have the answer the question changes; teen pregnancy is a product of young people's near irresistible yearning for adventure and affirmation; in the struggle against obesity we face a condition of affluence that paradoxically seems to hit the poorest hardest.

Influencing smoking behaviour is just as unique; after all, food and sex are basically good things – the very stuff of life, things that we need yet that risk causing us harm. Tobacco, by contrast, is simple: it is addictive and it is lethal. The pathogen in AIDS is a virus, the survival of which depends on its ability to adapt and multiply; in doing so it infects its
host and – left untreated – kills it. The “pathogen” in tobacco control is an industry whose business model depends on addicting its host when young and keeping them dependent until half of them die from their addiction.

Every year, the UK tobacco industry needs to find over 100,000 new smokers to replace those who quit or die; as few smokers start smoking after the age of 20, the industry must recruit our teenagers. The industry’s future survival depends on its ability to sell cigarettes to those too young to buy them legally and to provoke relapse in those who try to quit. And, of course, viruses do not employ lobbyists.

In other areas of health, businesses can make themselves part of the solution, not just part of the problem. Carpet makers can produce dust-resistant products for asthmatics, cars are made safer for their passengers, and food can be processed with less fat, sugar and salt. Tobacco manufacturers also experimented with this approach, designing “safer cigarettes”, but soon found that inhaling smoke was so intrinsically unpleasant, that without the reward of nicotine people were not interested in their product. Their answer was to create the illusion of a safer cigarette, marketing “light” and “mild” brands, which misled smokers into thinking they were less harmful.

**Historic challenges and recent success**

It is widely believed that smoking tobacco has been a part of our culture since Elizabethan days. In fact, the smoking epidemic only really got under way when cigarette manufacturing was industrialised. Mass military service in the First and Second World Wars provided the ideal environment for smoking to reach epidemic proportions as a near universal practice among those of Europe’s young men lucky enough to return home. Indeed, in the event of one of their command being wounded, officers would routinely provide them with a cigarette. The change, since then, has been so gradual it is easy to miss its significance. Whereas once male smoking was near universal, now it is often not even considered “normal”; indeed, in many settings it is exceptional. Over a period of decades, a fundamental change has occurred in our society’s attitudes towards smoking, very much the kind of societal change that we aspire to with unhealthy patterns of eating and drinking.

It would be a mistake to suggest this change has been universal. As with all social change, it is led by “early adopters”. The first to stop smoking were doctors – to a point where now only around 3% of doctors in the UK smoke. Other well-off smokers followed and the health inequalities in smoking-related disease began to grow. By 1973, smoking among the wealthiest in British society had fallen to 42% while among the most deprived it stood at 72%. By 2006, smoking had fallen to just 14% among the most affluent while remaining
stubbornly at 65% among the most deprived. Until recently, the wealthier you were the more you were likely to have benefited from the fall in smoking prevalence.

Youth behaviour is a precise barometer of cultural change: it not only magnifies the changes in society but also forecasts future behaviour. Youth smoking has proved difficult to influence, with smoking levels static at around 10% for a decade, but this too has fallen sharply in the most recent surveys. That we can make such detailed and long-term analyses illustrates the confluence of two of tobacco control's success factors: sustained political commitment has resulted in prevalence data stretching back decades on a scale adequate to give detailed geographical and demographic “granularity”.

The ingredients of success
The success in reducing smoking rates is not a product of these two factors alone. True, reducing smoking rates has been a high political priority nationally and globally and the public health response has an almost uniquely strong base in evidence both for need and effectiveness. But, critically, the past 10 years have seen concerted effort across government, with a proper plan, and, more than anything, it was this plan that restarted the stalled decline in UK smoking rates. Indeed, if there is one lesson to learn from tobacco control it is that no single action, however bold, will deliver health gain as well as a well-constructed and sustained strategy.

Political priority and public attitudes
Tobacco control has not always been the top public health priority – in the past 20 years, HIV infection, alcohol and drug misuse and, most recently, obesity have all concentrated the mind – but the sheer burden of death and disease has ensured smoking has never dropped off the political agenda altogether. After all, smoking causes 5 million deaths around the world every 12 months, enough to wipe out the entire population of Scotland in a year and of England in just a decade. However, there was nothing inevitable about the priority given to smoking.

Manufacturers long contested the health effects of smoking – even disputing that smoking causes lung cancer. Later, they sought to buttress their claim that smoking is an adult choice, freely made, by investing in research that disputed the addictive nature of their product. More recently, they have even argued that smoking is good for the economy, increasing revenues through taxation and decreasing expenditure by killing off smokers before they become a burden on the state.

We have seen how falling smoking rates and a stronger public understanding of the harmfulness of tobacco and the misconduct of the tobacco companies have all combined to
transform public attitudes towards the industry and its products. More than anything, this shift in public attitudes was consolidated by the debate on smoke-free public places. I can offer a personal example. In the 1990s, I worked for an HIV charity in which I – and all but one of the other staff members – smoked. The one non-smoker was asthmatic and, even so, it was considered burdensome not to smoke during meetings or in the open-plan office. Just five years later, second-hand smoke was increasingly understood as more than a nuisance but a threat to health, and not just for the UK’s 4 million adults with asthma. Indeed, just over 50% of the population supported a ban on smoking in all enclosed public places. As the debate attracted media attention, opposition to public smoking increased, and by 2005 two-thirds of English adults supported a ban. By the eve of the law coming into force, almost three-quarters of voters supported the legislation, and one year later four out of five adults were in favour. Even smokers’ views shifted and most now perceive smoke-free laws as good for the health of workers, the public and themselves.

**Figure 1: Support for smoke-free legislation in England (%)**

![Graph showing support for smoke-free legislation in England](image)

**Figure 2: Smokers’ and non-smokers’ support for tobacco control (%)**

- Fixed penalty notice for retailers found to have sold tobacco to under-18s: Smokers 82%, Total 93%
- Make quitting medications easier for smokers to get hold of: Smokers 75%, Total 84%
- A licence to sell tobacco which can be removed if retailers are caught selling to under-age smokers: Smokers 76%, Total 90%
- Ban retailers convicted of under-age sales for a number of years: Smokers 71%, Total 90%
- Vending machines only on premises restricted to over-18s: Smokers 67%, Total 82%
Support for smoke-free places spilled over into support for wider tobacco reform. Proposals in the Health Bill to end displays of tobacco products at the point of sale are supported by 59% of adults, and proposals to end the sale of cigarettes from vending machines are supported by 66% of adults. Even among smokers, fewer than half oppose the ban on vending machines, which many perceive as exploitative, with a vending pack costing, typically, 20% more but containing 20% fewer cigarettes.

This seismic shift in public attitudes is not confined to non-smokers; even smokers seem to be falling out of love with their suppliers. Perhaps because 70% of smokers say they want to quit, many support better help for quitters and tougher penalties for under-age sales. Breaking up the cosy relationship between the tobacco industry and the smoker will be critical in helping many more smokers to quit, as they come to perceive the industry as not their friend but their oppressor. This is not an anti-capitalist fantasy; it is proven fact. Virtually the only youth tobacco campaign to make a significant impact on teen smoking did not even mention the health consequences, instead it focused on the behaviour of the industry and its role in child labour, environmental harm and marketing manipulation. In short, in engaged with young people’s innate sense of social justice.

Public health advocates’ ability to deliver and demonstrate public support for tobacco control has been critical to maintaining political momentum, but so too has its ability to deliver evidence of success. Across social policy we find that the need to demonstrate success clearly and memorably catches us in an “evidence trap” where we find ourselves valuing what is measurable rather than measuring what is valuable, the result being a tendency toward reductionisms and the stifling of innovation. Tobacco policy has not completely evaded this problem but it has been lucky enough to find a way through it.

Mobilising the evidence
It is just possible that, like a pathogen provoking an immune response, industry attempts to kill the link with cancer only made it stronger. In 1950 Hill and Doll published their paper *Smoking & Carcinoma in the Lung*, provoking industry-funded scientists to object, and pointing out that correlation does not imply causation. Some 15 years later, Doll set out the nine criteria of causation, which remain the standard to this day.

The connection to an array of respiratory and circulatory diseases and cancers, first with smoking and then with second-hand smoke, have put the relationship between cause and effect beyond reasonable doubt. What is more, many studies have demonstrated that reducing exposure to smoke radically reduces the risk of harm. Having proven that smoking kills and that quitting improves health, the public health community had identified a single behaviour that needed to be influenced. The next task was to demonstrate that that
behaviour could be consistently and enduringly influenced.

This may seem straightforward enough to anyone who has never been a smoker, but those of us who have can tell stories of doggedly quitting and repeatedly relapsing until, eventually, we succeed. Long-term studies have provided us with an indication that quitting for four weeks gives a reasonable indication of likely long-term success. The adoption of the target of the “four-week quit” has undoubtedly presented problems with, for example, some services expelling those who relapse just once and refusing readmission for six months. None the less, it has provided a credible standard that is easy to measure and validate.

In the 1990s at the health charity GMFA, we developed a group work programme for safer sex not unlike the sessions we already provide for smoking cessation. If only we had been able to imagine an equivalent standard for measuring success. Defining the problematic behaviour was not so straightforward. Would it be penetrative sex? Unprotected penetrative sex? Would unprotected sex with a regular partner be acceptable? Would four weeks of abstinence be sufficient? How would we validate the service users’ self-reported good conduct? The entire approach was selected and designed to appeal to policy makers by lending itself to a randomised control trial but the numbers were small and the outcomes complex and, in the end, we may have demonstrated only that not all that is worthwhile can be measured by a control trial.

The way in which the Scottish government has evaluated smoke-free legislation is an example of public health evidence gathering at its best. Well before the legislation was in place, an impressive, multifaceted evaluation strategy was developed. The objective of the law was never to engage in the doomed project of coercing smokers into stopping – although it would certainly help many of those smokers who wanted to – but rather the purpose was to reduce the harm caused by the exposure to second-hand smoke. The response was to monitor compliance with the legislation, measure the impact on the quality of air in Scotland’s pubs, test the level of exposure in the population (completed easily and reliably by saliva cotinine tests) and, ultimately, to measure the impact on the health of Scottish people. The law was abided by, the air cleared, exposure tumbled and so did the admissions for heart attacks in Scotland’s hospitals. The experience of Scottish smokers was even documented in a revealing and sensitive ethnographic study. All this is possible when the government and the people see a public health intervention as a matter of national pride.

On its own, the experience of Scotland would prove little, but it joined other studies from Italy, Ireland, New York, Montana and Ohio, all of which found comparable results. The
second level of “the evidence trap” can be summarised as “you must not act until you can prove your action will cause your goal to be achieved”. There is a logical inconsistency here, as it is not possible to prove an outcome without first provoking it, and experimental evidence is often rejected even though it is more reliable than so-called “real world” experience. However, through sharing globally the outcomes of legislation first from small jurisdictions, such as the towns of Bowling Green Ohio and Helena Montana, the worldwide tobacco control community was able gradually to build momentum.

Amassing evidence and building momentum are not the same thing. The tobacco control community is a community in the most literal sense. Long before Facebook, tobacco control created Globalink, its own closed networking site that allows professionals anywhere in the world to call on the advice of others. The community shared the evidence but made sure that it gained currency beyond the learned journals and academic conferences, discussing the evidence in the press, on talk radio and in the pub.

A proper plan
Priority and evidence were both essential but insufficient to ensure the success of tobacco policy. A two-legged milking stool will always fall over but add a third leg and it becomes a tripod, the most stable and adaptable structure known to man. The third leg of this policy tripod is the plan.

The campaign for smoke-free laws illustrates the power of the plan. Ireland and New York went smoke-free at about the same time, and in doing so they were both pioneers. In Ireland, as across the UK, the policy objective was to reduce exposure to second-hand smoke, not to reduce smoking prevalence, and in this they were successful, with very high levels of compliance. Smoking prevalence also fell impressively, but without the fiscal and behavioural support smoking rates began to creep up again. In New York, helping smokers to quit was always part of the plan. Going smoke-free was accompanied by a five-point tobacco control plan, including increased taxation, smoke-free workplaces, public education, cessation services and rigorous evaluation. In just four years, smoking rates fell from 21.5% to 17.5% or, put differently, for every five New York smokers there were in 2002 there remained only four in 2006. The bold action of the Irish was no substitute for the proper plan of New York.

You can be sure that you have fallen into the evidence trap when you think you can take an intervention proven in one context and crudely graft it on to another. If it is axiomatic that health behaviours are socially determined, then it follows that attempts to change behaviour must understand the workings of that social context. Quit groups based in the workplace work well – at least they do in small workplaces but not, it seems, in larger ones.
One of the reasons for this may be that the powerful social reinforcement derived from quitting with workmates is diluted if the only thing you have in common with the group is that you work for the same corporation. Similarly, the quit groups conducted by GMFA can be contrasted with the NHS groups on which they were based. It is notoriously difficult to recruit to NHS quit groups, despite the greater chance of success than with individual efforts.

Attrition is also a problem, and it seems difficult to motivate people to keep coming to a group at the health centre filled with people with whom you share only the desire to quit. On the other hand, GMFA quit groups for gay men have long waiting lists and much lower attrition rates; sometimes group members call one another between meetings, go for a drink afterwards, and often continue meeting after the group has finished. Why? Because GMFA groups work with the grain of an indigenous social network, whereas all too often the state tries to graft “community-level” interventions on to crudely synthesised pseudo-communities.

Demands for an evidence base should not be allowed to stifle our innovation. We must be as clever in our use of social dynamics as the tobacco industry, which has skilfully manipulated people’s identities and aspirations to make “communities of brand”. One cigarette is much like another but the brand you smoke tells other smokers who you are. In schools today, brands, be it trainers, tracksuits or tobacco, make strong statements of belonging and assist young people in avoiding the catastrophe of the wrong brand choice. How far can we evolve “health brands” that speak equally powerfully and credibly to young people? Even if we can, it may not be enough to emulate the tobacco industry’s clever marketing as we have now begun to do. If marketing and brand is the industry’s most powerful tool in recruiting young smokers-to-be, it may be time to strip away the branding from tobacco packaging, and this is a measure being actively considered around the world.

We may be some way off justifying a call for plain packaging for alcohol and fast food but, in common with cigarettes, these products make great use of the “price promotion”, where they apply unsustainable discounts to capture new business. It is a practice that is fundamentally dishonest precisely because it is unsustainable and which is disproportionately attractive to the young and the least well-off. In this at least, there is something for all of us to learn.

It may be, however, that health policy’s own “price promotion” is already with us in the form of voucher incentives to young expectant mothers to help them quit. These have proved highly effective, and a professor of social marketing, Gerard Hastings, has suggested
that the reasons for the success may be more complex than would first appear. These women live in communities where up to 70% of their peers smoke; indeed, many of their own mothers will have smoked throughout their pregnancy. It may be that the voucher scheme gives their decision to quit a social legitimacy that health alone lacks: they are not saying they are better than mums who smoke but they have found a way to get something extra from the state. Not perhaps the justification we would have wanted, but what matters is that it works with the grain of these women's communities.

Figure 3: Smoking prevalence among adults in England 1978–2006 (%)

Source: General Household Survey

The steep decline in smoking prevalence that England had seen since the 1950s stalled in the early 1990s, as the smoking rate snaked between 25% and 30%, then in 1998 the government published *Smoking Kills*, the first white paper on tobacco policy and the UK's cross-governmental smoking strategy. Ken Clarke, previously health secretary and later director of British American Tobacco, had been the first chancellor to declare a role for the Treasury in helping to reduce smoking. *Smoking Kills* placed the Treasury among a range of government departments, under the leadership of the Department of Health.

*Smoking Kills* was rare among 10-year government plans in that it achieved almost all it set out to do, much of it ahead of time. When the plan was complete, several important steps were taken that went beyond the plan. Smoke-free legislation was one, but it coincided with a new fiscal twist: as well as using tax to keep the cost of smoking high, a reduction in VAT on nicotine replacement therapy made quitting cheaper.
But the 10-year plan is now 11 years old and a replacement is eagerly awaited. The one tragedy of Smoking Kills is that it did not include a plan to evaluate its impact and the impact of its varied components. The UK has certainly benefited, and we have calculated that the reductions in smoking prevalence have saved the NHS around £400,000 per year, but the true legacy could have been much greater if we had been able to pinpoint, for example, the long-term benefits of the tobacco ad ban or the invention of a national smoking cessation service, providing robust real-world evidence for other countries and other fields of health improvement.
Chapter 12

Devolution – limits and possibilities

Professor Scott L Greer, University of Michigan School of Public Health and Senior Research Fellow at London School of Economics
Devolution – limits and possibilities

MEDICAL APARTHEID: Another life-extending drug joins list of medicines given to Scots but denied the English.
Daily Mail, 20 October 2006

PRESCRIPTIONS FREE FOR EVERYONE: But only if you live in Wales.
Daily Express, 26 January 2007

MEDICAL APARTHEID: The National Health Service is 60 this year – but don’t break out the bubbly and party poppers just yet. Once the envy of the world, it is unable to guarantee the same level of care for everyone in the UK. Yet this was one of its founding principles when Labour set it up in 1948.
The Sun, 10 January 2008

Was it a problem at the sub-editors’ desk at the The Sun? Its article on devolution and health services spoke of the “the” NHS, which is something that has never existed in legislation. Scottish and Northern Irish health services have always had different laws and organisation, and Wales has had a separate health service for decades. It’s hard to break up something that was never unified.

But The Sun is in good company. Prime minister Gordon Brown also speaks of “the” NHS as a unifying British institution, as do many ordinary citizens, patients and professionals in the four health services of the UK. The confusion even extends to the web; the website www.nhs.uk is one of the very few UK addresses that lack a modifier such as “.gov” or “.org”; that is a small category shared with a few other British institutions including parliament, the Ministry of Defence and the British Library. But www.nhs.uk directs visitors to a site called “NHS Choices”. A user who asks for directions to a hospital in Aberdeen is told it is not a valid “postcode, location, or name”. At the bottom we find a few buttons for the other NHS systems: Northern Ireland, Scotland and Wales.

So what is “the” NHS? A unified British service? A unified British service that is being broken up? A kind of health system found in the UK? Four health systems? A Sun-reading, Labour-voting Scot in front of the computer could be forgiven for being confused.

Therein lies the political challenge of devolution in health policy. Devolution permits and creates divergence. Divergence creates opportunities for learning, experimentation, competition ... and resentment, conflict and mutual ignorance.
The fragile divergence machine

Devolution in health policy is a part of the larger politics of devolution, a political story decades long, and one in which political concerns bigger than health often explain developments. Devolution politics shapes health policy possibilities. It rarely works the other way around. And so understanding the future politics of devolution and health means starting with devolution.1

Law and money

Power, for a devolved government, lies in two places: in its legal framework and in its finances. Legally, the UK system is a benign one for divergent health policy. Scotland has broad formal legal powers: save for a few issues (professional regulation, abortion, xenotransplantation), the Scottish parliament can choose the health policy it wants. The Northern Ireland assembly's health provisions are close to those of Scotland; its constraints are do to with stringent equalities requirements, the "North-South" imperative to co-ordinate some policies with the Republic of Ireland – and with the limited and patchy character of devolution, which has been in operation for only a short time since 1997 and which has only appeared at all solid since 2007.

Under the remarkably complicated legislation governing devolution for Wales, primary legislation must be passed by Westminster, making (sometimes very obscure) details of Welsh policy contingent on the agreement and goodwill of Westminster figures who are often either overcommitted (time in parliament being scarce) or underemployed (and therefore free to investigate Welsh affairs in depth). This complexity aside, the Welsh assembly enjoys an impressive degree of autonomy on health because so much health policy is in secondary legislation or management decisions. In short, all three devolved governments have a considerable ability to make their own health policies.

The situation is the same with money: there are specified areas in which devolved autonomy is nearly total. Scotland has the right to vary the income tax slightly. Control over local government taxation creates significant revenue powers. But the overwhelming bulk of money comes from the UK budget via the Barnett formula. Barnett starts with changes in the English budget and then gives the devolved administrations a fixed percentage reflecting their share of UK population. Barnett's great virtue for devolved autonomy is that it is a block grant: London has no ability to tell Scotland or Wales how much to spend on health, education or anything else (although it does influence their capital expenditure levels).

Much of the debate about the formula focuses on its perceived unfairness (a regional breakdown shows Scotland and London to have far better per-capita funding than the rest of the UK, but many analyses suggest that Northern Irish and Welsh funding, as well as funding to much of England, is inadequate). An equally important issue is the arbitrariness of the formula: it is essentially a Treasury convenience that has become very rigid but could still be changed by the fiat of the UK government.

Political divergence
There are good reasons to expect policy divergence – something often overlooked in politics over the past decade, and still overlooked by many health policy experts despite the fact that the societies, politics and health services of the different systems have long been different. One is simply the difference in the political agendas, climate and issues in the four capitals. The morning media, questions and mailbags in Belfast, Cardiff, Edinburgh and London raise different issues. If the four systems’ health ministers are usually dealing with different issues on any given day, they will over time make decisions that cumulate into different policies.

More importantly, the politics are different. The UK has remarkably complex party politics. England, Scotland and Wales have “Labour and” systems: the Labour party is the only party capable of winning a plurality of votes in all three systems. Its principal opposition in each jurisdiction is different. What this means is that the lines of political conflict vary. If nothing else, England is the only part of the UK where the Conservatives are the opposition to Labour.

Different policy debates magnify political differences. The “feel” of politics, and perhaps the values of different health systems, vary. Issues, language and policy options are different. These differences can be traced, in large part, to the policy communities – the people who follow and participate in health policy in the four capitals have different backgrounds, training and sense of what is possible and desirable.

The fragile divergence machine
The result is a fragile divergence machine. On the one hand, the legal regime for health policy is quite open to divergence. There is little or nothing keeping the devolved administrations from innovating in health policy, and the four capitals’ different party
politics, political agendas and policy communities propel divergence.

But it is a fragile machine, one held together until 2007 by Labour dominance. Its financial system is unpopular and under UK government control, the Welsh settlement is unsettled, and there are few serious mechanisms to resolve intergovernmental disputes. Devolution is weakly institutionalised, not thought out, and not well set up to control any political conflict that emerges as a result. Even politicians who do not try to create conflict will find that they create friction at their borders in areas such as professional education, and divergent services underpinned by an unpopular funding formula are a ready political target.

**Main changes and story to date**
The politics and institutional characteristics of devolution, more than diseases or cultures, explain the patterns of divergence and convergence since 1998. On the one hand, there has been limited divergence in the social citizenship rights and levels of entitlement. That is because the devolved administrations have limited financial resources. On the other hand, there have been substantial changes in the organisation of the health systems, and in their quotidian priorities.

**Changes in provision**
Changes in provision – in the list of services provided by the health services – get a lot of press. They get more press, in fact, than they really ought. That is because they are relatively small parts of health policy. The most prominent decision, early in the career of devolved Scotland, was the decision to create universal long-term personal care for the elderly. This decision, taken under first minister Henry McLeish, created a distinctive social policy: in Scotland alone, the health budget would fund long-term personal care for the elderly, while in the rest of the UK it would be paid for by the person, their family, or as a means-tested benefit administered by the UK government. This was Scotland’s highest-profile and most expensive policy divergence, and one whose effects are felt by many non-poor elderly Scots as well as the local government and NHS staff whose budgets and roles are affected.

After that come prescription charges. Scotland and Wales have free prescriptions for everyone; England does not. For most purposes, this is about symbolic politics and the deep significance of a clear commitment to universalism. That is because so many people were already entitled to free prescriptions. When the British Medical Association, for

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5 Trench, A. “Devolution in Scotland and Wales: Muddled Thinking and Unintended Results” in Unlock Democracy (ed) Unlocking Democracy: Twenty Years of Charter 88 (Politico’s, 2008)
example, campaigns for free prescriptions around the UK, its best arguments are symbolic. But free prescriptions are probably good policy; the UK has a very good record of medicines compliance, and that appears to be a result of its free prescriptions. Paying anything for medicines, even a very small sum, seems to be a disincentive to getting them.7

And, finally, there are parking charges. No politician can avoid hearing about NHS facility parking charges; they seem to be especially annoying, and they do have real policy consequences by imposing a particular burden on the poor, on people who require multiple visits to the hospital, and on people who lack good public transportation. Scottish Cabinet secretary Nicola Sturgeon won much applause when she eliminated parking charges on non-PFI hospitals at the end of 2008.

Those are popular, egalitarian decisions taken by the devolved administrations. Decisions about the effectiveness of medicines and treatments are less predictable and sometimes politically explosive. The decisions are usually taken by authorised groups well away from the ministers: the National Institute for Health & Clinical Excellence (NICE), the All Wales Medicines Strategy Group and the Scottish Medicines Consortium all are charged with making the cost-effectiveness and cost-benefit decisions. Quite often it is their decisions and ways of working that create comparative headlines; on a slow news day, it might be newsworthy to play up an otherwise obscure treatment available in only part of the UK.

Changes in organisation
Devolution gives the devolved administrations enormous latitude to organise their health systems as they wish, which includes the right to ignore English policy innovations. Furthermore, organisational change is, on paper, cheap and can always be justified by the promises of savings later. Add in the pressure in all four jurisdictions, but especially in England, to make the NHS an efficient user of its massive new resources and there is ample incentive for divergent policy decisions.

English health policy has been by far the most activist, changeable and diverse: if we had to pick a theme for English health policy, the truest and first answer would be "activist". Two very effective Blair government figures, Simon Stevens and Michael Barber, cast this as a learning process: the government tried relying on professionals and didn't get value for money; it added command and control and got some value for money, but at an unacceptable cost in political energy; it then added competition and contestability in

7 Hirth, RA, Greer, SL, Albert, JM, Young, EW and Piette, JD "Out-of-pocket Spending and Medication Adherence among Dialysis Patients in Twelve Countries" in Health Affairs no 27 (2008), pp89-102
order to create a self-improving system by creating incentives to improve and harness local knowledge. This last agenda item gave coherence to a huge number of policy initiatives: payment by results, foundation trusts, Monitor and the other regulators, primary care trust divestment of services, practice-based commissioning, and so on. They all created contestability, in other words competition.

Choice is more a theory of English public management than a goal. It is directly a theory of public management when it is used as a tool to increase efficiency and customer satisfaction: why waste resources on performance management when patients’ own decisions can reward or punish NHS providers? The idea is that competition for patients and commissioners will be the best way to get better performance. Choice is also indirectly a theory of public management: it holds that giving patients more power will increase their satisfaction with their services.

The question is whether choice, as a top-down policy, will produce the attentiveness and customisation that would improve both care and the reputation of the NHS. There are credible arguments that good professionals, well managed, will provide this, and the problem lies somewhere in management or training. There are also good arguments that choice is an argument best suited to basically healthy people with either sporadic health issues (obstetrics and injuries, for instance) or very manageable chronic problems, and that building a system on choice, which means emphasising the moments when patients can choose care, will undermine the individual-level and system-level co-ordination that makes much healthcare possible. In other words, argue the most coherent critics, choice and contestability undermine the coherence of the system, without producing enough benefits.

The last few years have seen a deflation of the ambitious policy agenda that came out of this thinking. The problem was partly policy contradiction. PFIs, for example, are not a good fit with competition: what happens if a trust with a PFI loses patients? The government has to make the PFI costs good anyway. The main problem, though, was simple political energy and resources. The kind of thoroughgoing NHS reforms that the Blair government was proposing by 2003 required enormous pressure to get anywhere, and the Brown government, with less money and more problems, cannot match that pressure. Stabilisation, more than any theory of public administration, will guide English health policy for some time to come. Stabilisation is certainly a plausible theme to read into the

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8 Barber, M Instruction to Deliver: Tony Blair, the Public Services, & the Challenge of Delivery (Politico’s, 2007); Stevens, S “Reform Strategies for the English NHS” in Health Affairs no 23 (2004), pp37-44
9 The debate is well captured by two books: Le Grand, J The Other Invisible Hand: Delivering Public Services through Choice & Competition (Princeton University Press, 2007); Hunter, DJ The Health Debate (Policy, 2008)
Darzi report;\textsuperscript{10} we can see the choice of author, process and outcome as an effort to refocus on management and clinical matters rather than on expensive and unpredictable organisational change.

Scotland never incurred the political and administrative costs England paid because the Scottish executive and government have not been under the same kind of political pressure and have operated in a policy community that has long been more open and responsive to professionals. As a result, it comes down firmly on the side of integration and service planning.\textsuperscript{11}

Even before devolution, the Labour government in Scotland radically reduced the power of autonomous hospital trusts, and thereby put Scotland on its road, one marked by integration (rather than fragmentation), networks (rather than competition), and running political debates about responsiveness to local needs. Abolishing trusts and integrating the whole system into a few health boards was a logical development, and one that reduced both competitive incentives and managerial power.

The Scottish healthcare system stands out for its lack of central managerial tools. It has one tool that England will never have, which is constant, direct ministerial contact with any important figure in NHS Scotland. But Scottish ministers otherwise have many fewer strings to pull; without competition and England’s range of regulators, they have less ability to reach into the system. Scotland gets the benefits and costs of entrusting public services to their professionals and managers.

While outsiders routinely task NHS Scotland with a lack of management, productivity and consumer responsiveness, the real political problem in Scotland has been local responsiveness, above all the issue of responsiveness to communities. “Reconfiguration” is never fun or easy, but in Scotland long-term problems with a number of facilities flared up in 2006–07 and led both Labour and the SNP to commit to direct election of health boards. There are major conceptual problems with direct elections to bodies wholly funded by government, because it is a perfect formula for blame-shifting politics. The issue’s persistence is a manifestation of the main tension in Scottish health politics: between local community responsiveness and professionalism.

Wales after 1998 was like England: radical. English health policy was radical because it attacked the traditional, comfortable way that the health service worked. Welsh health

\textsuperscript{10} Darzi, A. \textit{High Quality Care For All: NHS Next Stage Review Final Report} (Department of Health, 2008)
\textsuperscript{11} Kerr, D and Feeley, D “Values in NHS Scotland: A Tale of Two C-words” in Greer, SL (ed) \textit{Devolving Policy, Diverging Values? The Values of the National Health Services} (Nuffield Trust, 2007)
policy was radical because it attacked the traditional, comfortable idea that the national health service should be a national sickness service focused on treating the ill. The first Welsh health plan deserves to stand out in public health history as one of the few (only?) governmental proposals to organise policy around health, including health policy, and then list the contribution of every policy field to health.

The problem was that the tools to influence sickness are usually not in a health minister’s toolbox; they are in the portfolios of the education, transport and local government ministers in Wales, or in the hands of the chancellor and secretary of state for work and pensions, or in the hands of global financial markets whose capacity to shape all of our fates is hard to doubt. So what was the health minister to do? The answer was: reorganise NHS Wales. This meant creating local health boards that would be responsible for primary care and commissioning, making them coterminous with Wales’ 22 unitary local governments, and obliging the local health boards to work with local government. The idea of connecting local government and the NHS in order to improve integration and local responsiveness is not new, but the national assembly for Wales tried particularly hard to pull it off.

The problems emerged quickly: finding management for 22 local health boards; getting local government interested; overcoming the obviously greater power of hospital trusts. Overcoming those problems did not make a communitarian public health focus any easier, and the promise of cross-government, locally integrated working receded into the bus-side advertisements of Health Challenge Wales. By 2007 the entry of Plaid Cymru into a coalition with Welsh Labour created a much-needed opportunity to imitate Scotland and integrate NHS Wales into a few, clearly accountable, regional health boards. At the time of writing, that reorganisation is advancing.

Finally, Northern Ireland: how often does anyone hear “Northern Ireland” and “health policy” in the same sentence? The politics of Northern Ireland have been about religion and the Union, not health. It is a tribute to the sensitivity of health policy that it can lead to cross-community campaigns in defence of local hospitals. For decades, Northern Ireland has been under “direct rule” by ministers from Great Britain, representing not just constituencies but also parties outside Northern Ireland. Even when devolution was functioning, it was hamstrung both by the complexity of Northern Ireland government (which represents every party so well as to make it difficult for any to rule) and by the need to develop policy skills and interest among local politicians. For both direct rule and

13 National Assembly for Wales Improving Health in Wales – A Plan for the NHS with its Partners (2001)
devolved ministers, health was a bad issue: prone to create much grief and strife, but unlikely to win any votes. The Belfast Agreement and its successors exacerbated the problem by putting almost every party in government, with neither collective responsibility nor effective opposition likely.

The result was the health system that many in Great Britain say they want: one without reorganisation. Someone had to run Northern Ireland health and personal social services, and the people who stepped forward were a group of remarkably thick-skinned managers who were willing to operate without political cover or coherent policy but who enjoyed great local autonomy. The fact that they ran an astonishingly large number of organisations – relics of the Thatcher government’s efforts to create markets – and had many unsafe or expensive local hospitals to run, merely created a consensus that change would come. It did not create the change. There were reviews arguing for closure of the Omagh hospital in the early 1990s, huge fights over the issue around 1998-2003, a decision to close it … and it is still there.

The UK government lost its patience around 2005 and started to reorganise. It developed a basic plan that merged trusts (19 into six) and created large health boards to commission services. Restoration of devolution in May 2007 slowed the plans, when the new minister called for another consultation. But at the time of writing they are being debated in the Northern Ireland assembly and are likely to come up for a vote. The result of passage will be fewer organisations. The direct-rule Appleby report’s call for better management is the one to watch:14 Northern Ireland’s health service will have really changed when we see its suggestions, or something else about performance, influence policy.

Conclusion

Enough time has passed for us to identify Labour’s legacies for the future. Two stand out – two policies to change the health services of the UK now and in the future. One is devolution, which by creating four autonomous political systems – laboratories, perhaps – has ensured that the UK will always have four different health systems, along with the tension, complexity and perhaps learning and competition that decentralisation produces.

The other is, simply, spending. It is easy to forget just how much new money went into the health services of the UK as a result of the spending decisions of the Blair governments. The numbers for England are enormous. Much of it was undoubtedly wasted

14 Appleby, J Independent Review of Health & Social Care Services in Northern Ireland (Department of Health, Social Services & Public Safety for Northern Ireland, 2005)
on administration and the administrative confusion born of multiple policy initiatives in conflict. But the scale of hiring, buying and building in the English NHS, and the Barnett-consequential expansions in devolved health systems, is still a remarkable thing to behold. The decisions taken over the last 10 years – such as where to site hospitals, what kinds of staff to hire and what research to commission – will be the constraints that affect future governments in all four capitals. Among its other consequences, the spending meant that the early years of devolution would be transformative: small differences in the priorities and management theories of the different governments, multiplied by the new money, had bigger effects than they will in the next, straitened, years.

That money also gave devolution a good start – everything is easier in politics when there is abundant money. We can only hope that the good relations, or at least goodwill, will mean that the legitimate and unsurprising differences among the UK's four governments will be good for health policy experimentation and competition, rather than destructive and obstructive. We cannot, though, hope to avoid the tensions between governments, and the need to manage divergence, which were always going to be a part of devolution.

Perhaps it is also possible to draw a lesson about health reforms. It would be a sombre one: change is hard. There were two great experiments in post-devolution health policy. England experimented with the conversion of the NHS into something resembling a market, and, with tremendous political determination and large budgets, made some headway. But the obvious legacies are staff hired and hospitals built, not cultural change or competition. Wales tried to refocus its NHS on ensuring health rather than treating sickness, and has ended up back in NHS management and bus-side encouragements to quit smoking. England tried to change the fundamentally public-sector orientation of the NHS, Wales its focus on healthcare, and in both cases the results have been disappointing.

The disappointment of the grand plans suggests that the essence of a good health system lies in capable professionals and good management focused on treatment, managing illness and promoting public health through teachable moments when people are ill. Achieving that from the impossible heights of government remains the most difficult task any minister faces.
Chapter 13

On the road to world-class healthcare?

Anna Dixon, Director of Policy at the King’s Fund
On the road to world-class healthcare?

There has been a tendency to see the NHS as a unique health system, a one-off, with no match anywhere in the world. This view can lead to introspection and a tendency to dismiss the policies and approaches adopted in other countries because they would not be transferable. Of course, caution must be exercised when making comparisons of performance, because data is often collected and reported differently, and when importing policy ideas, because context matters.

The Labour government’s reforms over the past 10 years have been, in part, inspired by developments in other countries: foundation trusts (from Spain), patient choice of hospital (Denmark and Spain), polyclinics (Germany, the US) and the chronic care model (the US).1 Ambitions have also been set that explicitly put the NHS on the global stage. Tony Blair, as prime minister, promised to raise spending on healthcare to the EU average. The Department of Health wants commissioners to be world class. In his forward to High Quality Care for All, the prime minister, Gordon Brown, sees the latest set of reforms as “a tremendous opportunity to build an NHS that provides truly world-class services for all”:

So is the NHS on track to be world class? Are the current reforms likely to secure a world-class NHS?

This chapter defines world-class health and then examines how the NHS measures up. It reflects on the current NHS reforms in light of developments in other health systems and highlights where we might turn for inspiration in future. Despite historical differences in our health systems, we have much to learn and much to gain from sharing experiences of facing common challenges.

What is world-class healthcare?

There are a number of ways of judging health systems. Commonly, judgments are based on comparisons of how much they cost, how healthy the population is, whether access to care is fair, and the outcomes of medical care achieved. In 2000, the World Health Organization controversially tried to rank healthcare systems.3 The OECD regularly produces comparative reports covering aspects such as health status, expenditure, resources and

1 Wagner, EH “Chronic Disease Management: What Will It Take to Improve Care for Chronic Illness?” in Effective Clinical Practice no 1, vol 1 (1998), pp2-4
utilisation and, most recently, quality of care. It also produces assessments of individual countries' healthcare systems. The National Institutes of Health defined six dimensions of high-quality healthcare: equity, timeliness, patient-centeredness, efficiency, safety and effectiveness. These provide a useful basis for examining whether the NHS is world class.

Is the NHS world class?

Historically, the NHS viewed from abroad scored well on equity (providing universal coverage and charging few co-payments), but badly on timeliness (stories of people waiting were widely known). English patients were considered to be more "patient" than their US and European counterparts. Low expectations are thought to have contributed to high satisfaction levels. The lack of choice was often seen as a sign that the NHS was not patient-centred and the high levels of hospital-acquired infection an indicator that safety was not a priority for the NHS.

Its comparatively low spend on healthcare as a proportion of GDP was seen as a marker of efficiency. Input prices, such as drugs and labour, were generally lower than in other countries due to the dominance of the NHS as purchaser and employer. The NHS was seen as a slow adopter of technology and had poor outcomes in areas such as cancer. Many of these perceptions are slow to change, even though the performance of the NHS has changed in many aspects. How does the NHS compare in 2009?

Equity

The NHS is a fair system of healthcare. The way we finance healthcare predominantly through general taxation with few co-payments means that most people receive access to care regardless of their ability to pay. Coverage on the basis of residency means that, in effect, no one is uninsured. It has taken social health insurance countries many years to achieve near universal coverage and the US has 42 million uninsured and rising. The role of GPs as gatekeepers to specialist care has meant that inequalities in access to specialist care are less biased towards the rich in the UK than in other countries.

4 OECD Health at a Glance 2007 (2007) (http://www.oecd.org/document/11/0,3343,en_2649_34631_16502667_1_1_1_1,00.html)
6 Institute of Medicine Crossing the Quality Chasm: A New Health System for the 21st Century (2001)
7 van Doorslaer, E, Masseria, C and Koolman, X for the OECD Health Equity Research Group "Inequalities in Access to Medical Care by Income in Developed Countries" in CMAJ vol 174, no 2(2006), pp177-183
Yet there remain socioeconomic and ethnic inequalities in access and treatment, even after adjusting for need. Access to GPs is known to be more difficult in areas of deprivation. These variations in care exist in most health systems. The fact that they are documented and the focus of policy attention suggests we are one step ahead on the equity agenda compared with many other systems. The NHS must not be complacent in future but ensure it strives to improve equity of access for different groups.

**Efficiency**

The UK has lagged behind other countries in terms of spending, hence the commitment to bring expenditure in line with the EU average (see figures 1 and 2). The US is a world leader in spending on healthcare, and spending is projected to double by 2020. But this is not a position we should seek to emulate. A system also needs to be affordable – that is, the public expenditure commitments need to be contained. At current rates of growth, the US health system is far from affordable and there is no sign that the authorities have the ability to bring it under control. In contrast, the UK can reduce NHS spending in line with the available public revenues.

While the ability to control costs at the macro level is envied by other countries that have struggled to contain the overall rise in healthcare expenditure, this does not translate into efficiencies at the operational level. The important issue is not how much one spends but how much healthcare one receives in return. Much of the increased spending in healthcare in recent years has gone on higher labour costs (a combination of employing more staff and paying them higher wages). Productivity has fallen, suggesting that the efficiency of the NHS has declined. There is an urgent need to increase productivity by encouraging providers to adopt more efficient working practices and reducing inappropriate activity.

Historically, the NHS has had relatively low administrative costs compared with more complex systems where billing transactions, marketing activities and the distribution of profits have added to the overall cost of healthcare. Reforms such as commissioning and contracting and the introduction of diverse providers may mean that transaction and administrative costs will rise. As yet there is little expenditure on marketing, but this will inevitably increase as the NHS begins to compete more actively for patients and referrals from GPs.

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The inevitable squeeze on public expenditure likely from 2010-11 will be painful for the NHS and will mean that there will have to be dramatic improvements in productivity. The NHS is in a strong position to control spending at the macro level, but there will have to be checks within the system to ensure that primary care trusts are able to control expenditures particular with choice of referral. Referral thresholds, demand management and utilisation review may become the norm for elective care. Input costs will have to be restrained, a careful watch kept on non-clinical costs associated with increased administrative and transaction costs, and pay rises limited.

Patient-centredness
Comparative data on patient-centred care suggests that the NHS fares badly. On six dimensions of patient-centred care – quality of doctor-patient communication, access to alternative sources of information and advice, provision of preventive care and advice,
informed choice of provider, risk communication and involvement in treatment decisions, and support for self-care and self-management – the NHS fared worse than some of the other countries. Particularly concerning was the fact that the NHS came out worst on opportunistic advice from doctors on prevention and lifestyle and on the number of patients who had a clear plan with goals for self-management.

Figure 2: Total health expenditure as a percentage of GDP in the UK and selected countries 1990–2007

Source: OECD OECD Health Data 2008: Statistics & Indicators for 30 Countries (2008) (http://www.oecd.org/document/30/0,3343,en_2649_34631_12968734_1_1_1_1,00.html)

Data from national patient surveys suggests that patients continue to have high levels of trust in the professionals who care for them and that some aspects of care have improved. However, the NHS fails to provide active support for patient engagement – patients are not sufficiently involved in decisions, are not given enough information or support with self-care.

The NHS still has much to do to be a world-class provider of patient-centred care. Patients are becoming more demanding, with higher expectations of the care they receive. In part this is due to generational changes but it is also because 24-hour access to other service providers, such as banks and travel companies, via the internet and telephone is revolutionising people’s experiences. Increasingly, patients expect similar levels of convenience and technology from the NHS, yet it has been slow to make use of information technologies. The NHS needs to embrace fully information technologies that can improve the patient’s experience and ensure that professionals working within it are trained and skilled at supporting patients in decisions about their care, self-care and self-management.

Safety
Patient safety was given global recognition when the WHO launched the World Alliance for Patient Safety in 2004, chaired by Sir Liam Donaldson, chief medical officer for England. However, the incidence of iatrogenic disease and preventable medical errors remains a problem in England. Comparative data on adverse safety incidents is scant. An international survey of adults in seven countries found that 9% of adults in the UK, the Netherlands and Germany had experienced a medical or medication error in the past two years, lower than the numbers in Australia, Canada, the US and New Zealand.

Recorded levels of healthcare-acquired infections (specifically MRSA) suggest that the UK has one of the highest rates in Europe. While the exact reasons for the differences are not known, the NHS has adopted some of the more aggressive search-and-destroy approaches used in Sweden and the Netherlands and rates are beginning to fall. Failure to deliver safe care not only has high personal costs for patients and their families, but also costs the NHS. In future, the NHS needs to demonstrate it is a world leader in delivering safe and reliable care. This will require a concerted focus on patient safety from board to ward, the implementation of standard protocols and processes, effective team working and communication, and redesign of care pathways.

Effectiveness
Life expectancy in England has continued to rise in line with the average for the EU-15, from around 75 years in the mid 1980s to 79 years by 2007. Measures of cause-specific mortality show improvements, with reductions in line with other EU countries, and in some cases the rate of improvement exceeds that in other countries. However, the UK mortality rates for cancer and heart disease remain higher than most other countries. While a proportion of mortality is amenable to healthcare, these differences may reflect differences in the wider health of the population rather than the performance of the health system.

Systematic comparative information on specific clinical outcomes is relatively rare. The Eurocare study is one of the few to have produced time series data on survival rates for different cancers. While the data suggests that trends have been improving everywhere, outcomes continue to be worse for the UK. One reason for this that has been suggested is the late stage of diagnosis in the UK, something that the two-week urgent cancer referral has sought to address. This does not address delays caused by late presentation to a GP, or issues to do with identification and appropriate referral by GPs.

The focus on quality in High Quality Care for All and its commitments to collect and report outcome data, the requirement on boards to present quality accounts and the new payment system, which rewards quality improvement (the Commissioning for Quality & Innovation – CQUIN – scheme) should ensure that the NHS is more focused on the effectiveness of the care it funds and provides. If the NHS is to achieve world-class outcomes, it will need to ensure that quality measures are in place in primary care and across care boundaries. There remains a need to implement evidence-based care as set out in the National Institute for Health & Clinical Excellence guidelines and the national service frameworks.

Timeliness
The ability of patients in England to access care in a timely way has been a major focus of government policy and targets since 1997. The unremitting efforts to reduce waiting times in England have been incredibly successful on the whole. Latest data suggests that the majority of NHS providers will meet the target from referral to treatment of 18 weeks. The median wait for inpatient care is now below eight weeks and the wait for outpatients nearly four weeks. In addition, there is an "operational standard" that 98% of patients spend four hours or less from arrival at A&E to admission, transfer or discharge. The A&E target has been met recently or only narrowly missed.

Waiting times to be seen for emergency care appear to compare favourable with other
countries such as the US, Australia and Canada, at least according to surveys. The Netherlands and Germany are world leaders, with more than 90% of patients reported as being treated within two hours or less, compared with less than 70% in the UK.\footnote{Schoen, C, Osborn, R, Doty, M, Bishop, M, Peugh, J and Murukutla, N “Toward Higher-performance Health Systems: Adults’ Health Care Experiences in Seven Countries, 2007” in Health Affairs (web exclusive, October 2007)} While long waits are becoming less common in England, we are not yet world class. For patients in Germany and the US, short waits for elective or non-emergency treatment are the norm. Canada continues to experience problems with waiting times for elective care and, interestingly, is looking to the NHS to learn lessons.

The question for the NHS in future is whether it brings any further benefit (and at what cost) to continue trying to reduce waiting times in elective surgery. At 18 weeks, waiting times remain slightly higher than those experienced by patients in some other countries but may be acceptable and not impact on the outcomes. Indeed, unless more explicit decisions are taken to set referral and treatment thresholds, and to support patients to be more involved in the decisions about their treatment, there is a danger that falling waiting times might be accompanied by increasing levels of inappropriate intervention. The pilots of patient-reported outcome measures suggest this may already be happening in cataract surgery. Perhaps the focus of world-class care should be to ensure timely access to appropriate care and to ensure shorter waiting times in other areas of care, which have, to date, not been measured or subject to targets such as speech and language therapy, psychotherapy and such like.

In summary, the performance of the NHS has improved significantly, but it is not yet a world leader in every aspect of care.

**What are the remaining challenges and what can we learn from other countries?**

In looking to the future, the NHS needs to recognise that the problems and challenges it faces are not unique. It has much to learn from the policies and reforms that are being pursued elsewhere.

The economic downturn will require health systems worldwide to reduce waste, increase productivity, reduce inappropriate variations, and make sure the right care is delivered every time. The causes of waste are many – duplication of tests, inappropriate use of medications, delivering care that evidence suggests has no effect (or does more harm than good), preventable emergency admissions for conditions that can be managed in the community, and intensive treatment of people at the end of their lives. The NHS needs to stop doing some things as well as doing those things that evidence suggests are
cost-effective. Increased availability and use of palliative care services for all those who have life-limiting conditions, not only cancer patients, is also needed.

In such tight fiscal times there will no doubt be calls that the NHS is not sustainable and that funding sources need to be diversified. The next government should strongly resist any calls to move away from taxation as the predominant source of funding. The evidence from the rest of the world is that single-source funding is easier to control. Despite historical differences in the funding and delivery of healthcare, health systems across Europe are converging and developments in the EU may accelerate this process.

Productivity efforts are also focused on making better use of technology. President Obama's reforms for US healthcare include a significant investment in IT in the hope of using these data to drive quality and efficiency. In the NHS, the investments so far that have gone into IT will need to realise benefits. The system for storing and transferring electronic images from x-rays and scans is starting to deliver benefits. But the signs from one of the pilots at the Royal Free Hospital in London are that the ambition to introduce individual electronic health records linked to a national spine is way off course. With growing pluralisation and electronic patient records already widespread across general practice, it may be time to switch to a more decentralised model with the emphasis on interoperability. The NHS is unlikely to be able to match the productivity gains achieved by the Veterans' Administration in the US as a result of its investments in IT.18

The growing problems caused by lifestyle behaviours and the rise in diseases caused by obesity will require healthcare systems to become more focused on prevention. This will mean every patient contact being used as an opportunity to provide advice and motivation to live more healthily. It will also require health systems to take a wider societal approach to create a shift in the health of local populations. The NHS is well placed to be a world leader – primary care trusts have relatively stable populations in geographically defined areas where prevention and health promotion efforts are more likely to have a payback. In countries where there is competition among purchasers, the payback of such investments will be less as the enrolled population changes more rapidly. In future, primary care trusts will have to work more effectively with local authorities and make innovative use of social marketing techniques if they are going to achieve world-class health outcomes.19

Healthcare systems worldwide are often dominated by institutions that developed to treat acute illness. They have not been designed to deal with the complex problems of those living with chronic conditions. Health systems need to be more proactive by making more sophisticated use of data to predict who is at risk and then reaching out to those people. Care needs to be reorganised around the needs of patients. Many countries are working out how to establish multi-professional team-based care in the community, the so-called "medical home" in the US. These are similar in ambition to some of the proposals for polyclinics. An alternative model for the NHS may emerge from innovative practice-based commissioners integrating with new community service organisations.

Many countries are also trying to address the growing care needs of the elderly by finding sustainable financing solutions. This is a challenge that the UK government will have to address in the green paper on social care funding.

The incentives for both organisations and individuals within health systems need to be aligned as far as possible with the overall objectives of the system. In systems that pay a fee for service (for example, the US), the incentive has been to over-treat, whereas those with per-diem payments (for example, Germany) tend to keep people in hospital for longer. Increasingly, hospital payments systems in many countries have adopted payment per episode of care (based on diagnosis-related groups). Similar to the tariff in the NHS, these give providers incentives to increase activity (but to reduce over-utilisation and increase efficiency). They do not provide incentives to improve quality. Many health systems are developing pay for performance both for individuals and for organisations.

So-called value-based purchasing is what many purchasers of care aspire to. If primary care trusts are to be world-class commissioners, they will need to demonstrate the value (in health terms) that they are able to achieve for the money they are allocated. The NHS has already begun to experiment with performance-related pay schemes, such as the quality and outcomes framework within the GP contract and the CQUIN scheme. These will be watched with interest by other countries seeking to find ways of paying for the outcomes achieved. There remains a need in future to focus on the intra-organisational incentives for individuals and teams working within larger institutions.

Underpinning any efforts to pay for outcomes, there is a need for appropriate measures of quality. The routine collection of patient-reported outcome measures in the NHS from
2009 will set the NHS out as a world leader. But the NHS can still learn from other countries that have developed and implemented quality measures.

The NHS is not yet delivering world-class care, but many of the reforms that it is implementing hold out the promise of addressing some of the key challenges faced by health systems worldwide. The reformed NHS is well placed to reap the benefits of the investments made since 2000 and to ride out the economic storm without returning to the bottom of the healthcare league. Yet the world does not stand still, and it will be important for the NHS to continue to benchmark its performance internationally so that we can identify areas where we are falling behind and do something about them.

If the NHS is to be world class, it needs to demonstrate how it can deliver high-quality care in a cold economic climate, by harnessing the benefits of technology and data, being proactive in supporting people to live healthier lives, organising care differently for those with chronic disease and paying for the outcomes that healthcare providers achieve. Addressing these issues will not be easy but we have much to learn and much to share with other countries facing many of the same challenges.

Additional reference
The Smith Institute

The Smith Institute, founded in the memory of the late Rt Hon John Smith, is an independent think tank that undertakes research, education and events. Our charitable purpose is educational in regard to the UK economy in its widest sense. We provide a platform for national and international discussion on a wide range of public policy issues concerning social justice, community, governance, enterprise, economy, trade, and the environment.

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