

health innovations:

more for less in
healthcare

Edited by Neil Churchill



health innovations: more for less in healthcare

Healthcare is a top policy priority for the new government and the opposition. However, despite promises to protect the health budget, the pressures of growing demand, rising costs and minimal investment mean that radical reform is no longer a choice but now a necessity.

These essays explore innovations and new approaches that can help meet the productivity and cost challenge in a fairer way. The authors identify some significant opportunities for ensuring that recent progress can be carried forward. Although many of these solutions seem feasible, even in the current climate of fiscal austerity the biggest challenge may well be gaining the support of health professionals, patients and citizens.

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Paul Hackett, Director, The Smith Institute

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Introduction

Neil Churchill, Chief Executive of Asthma UK

The scale of the productivity challenge facing the NHS is well understood. Health professionals and NHS managers have now had a year to prepare for the cold financial climate we are about to enter. In fact, many argue that the service is well placed to make significant productivity gains after record years of investment.

Incremental change is not going to be enough, however, to yield the necessary £20 billion savings implied by growing demand, rising costs and flat revenues. Technical efficiencies are undoubtedly needed, but reforms will have to go further and consider what services are offered, by whom and in what locations. An underlying assumption, already reflected in the tariff for 2010/11, is that more care will be provided closer to the patient in the community and less in acute hospital wards. Much rides on getting this transfer right. If beds are lost before new services are in place, then patients will suffer. And Professor Chris Ham of the King's Fund points out that the squeeze on admissions will either galvanise action to strengthen preventative healthcare or create financial difficulties and large job losses for hospitals.¹

Many share a vision for better-quality care provided at lower cost. This vision builds on the work that clinicians are now doing to adopt modern technologies and spread best practice, managers' efforts to commission and reward care pathways that result in fast, safe and efficient treatment, and what patients can contribute through being more self-sufficient and in control of our health. Such a vision implies that the right interventions are delivered first time in the right settings for the right people, and is based on principles of patient education, risk management, telemedicine and rapid response to urgent need. And yet the services that underpin this vision are available only piecemeal, at small scale. Rapid replication of what works is now required.

Will the optimistic or pessimistic scenario come about? Much depends on the interplay between policy, practice and politics. Matthew Swindells, Kingsley Manning and Elizabeth Leroy of public-sector services consultant Tribal in their contribution to this publication explore three options open to a new government seeking to reduce health spending: introduce charges, reduce services or improve productivity. Charges are likely to be counterproductive, they argue, deterring the poorest from seeking help until their needs are acute. Reducing services will also be hard in an era of published waiting times, clinical quality and patient satisfaction. Consequently, the health service needs to make

¹ Chris Ham, writing in *BMJ*, 2 January 2010

an unprecedented annual 4% real improvement in productivity, a transformation that will require innovative commissioning and targeted use of the private sector.

Does the NHS have the incentives it needs to foster greater efficiency? Management consultant and former director of commissioning improvement and innovation at NHS London Professor Paul Corrigan, in his chapter, takes stock on the journey so far. For the service to be technically efficient, he argues that there must be real consequences for failure and for success. But going further, there also needs to be greater allocative efficiency so that patients are treated in whichever part of the health system provides greatest value for money in that particular case. So instead of patients with long-term conditions being treated in accident and emergency departments, many more would use walk-in and urgent care services.

Changes on this scale and of this nature will ensure that policy remains inherently political as well as managerial. I believe there are three political questions running through the essays in this volume. First, how can we maintain the quality that patients demand and health professionals want to deliver while significantly cutting costs? Second, what constitutes fairness, both in terms of the decisions we make about our own health and the consequences of those decisions and in terms of the way change will impact on the health of the poorest and most vulnerable? Third, how can we deliver change at a time when there is a mismatch between what managers believe is affordable, what clinicians believe is quality and what patients expect the NHS to deliver in their local communities.

To address the first big question, then, how we can reduce cost while improving or at least maintaining quality? For expectations have fundamentally changed. On the one hand, health professionals want to maintain the focus on quality and avoid a return to covert rationing, through either queues or other means. And on the other hand, the "patient contract" (whether that be purely psychological or more formal) is placing ever greater expectations on the NHS, whether that is for new drugs or for speedy access to care. Detaching efficiency from quality would also result in a haemorrhage of professional and patient support for change.

What are the opportunities for improved clinical productivity? Dr Rob Wilson of the Royal Brompton Hospital shows how medical technology and greater longevity are the major drivers of increased cost. To an extent, the challenge facing the NHS is the challenge of success: what were once life-shortening diseases are now chronic conditions we can live with for years, and most of us are living a lot longer. Greater rationing, better prevention and a closer link between the pharmaceutical industry and clinical scientists may be required to offset or afford the constant increase in demand. Some of the greatest gains, concludes

Wilson, may be from better integration between services. Hospitals may need fewer beds, but instead they will offer new services such as rapid assessment units to improve diagnosis and pulmonary rehabilitation to prevent admissions.

Two chapters then explore the potential for the private sector to boost NHS productivity. Alison Clough of the Association of the British Pharmaceutical Industry sets out the contribution to productivity that she believes can be made by the pharmaceutical companies. She examines recent initiatives to improve access to drugs, such as flexible pricing and the innovation pass for new medicines, but concludes that take-up of new medicines in the UK lags behind that in most other European nations. She also describes how the industry is seeking to move beyond sponsorship to work more in partnership with the NHS, citing examples of GlaxoSmithKline helping to improve the management of chronic obstructive pulmonary disorder in primary care and Pfizer and Eisai speeding up the implementation of the national dementia strategy.

Pharmaceutical and healthcare consultant David Pruce then makes the case for pharmacy. A number of policy papers in recent years have described how pharmacies can become “healthy living centres” offering screening, information and advice, support for people managing long-term conditions, and NHS treatment for many minor ailments now managed by GPs. Yet this vision has stubbornly failed to materialise. The pharmacy contract, Pruce argues, should incentivise improved health not just dispensed medicines, and commissioning needs to take a more long-term view. Electronic prescriptions and repeat dispensing would help lone pharmacists make the most of their time with patients, but we may also need to establish “superpharmacies” or hub-and-spoke dispensing to achieve greater specialisation and economies of scale.

A second major question is how we make sure the policy response is fair. The Marmot review on health inequalities has been recognised by all the main political parties, although their policy responses differ. We know that the burden of ill health falls disproportionately on the poorest, and lifestyle factors such as smoking play an important part. Policies are therefore needed, as Professor Theresa Marteau of King's College London points out, to shift the social pattern of behaviour as well as make the NHS more accessible where it is needed most.

Fairness is, however, likely to be one of the most contested areas of debate in coming months. Greater use of co-payments or user charges in public services has been advocated by organisations as diverse as the Commission on 2020 Public Services,

chaired by Sir Andrew Foster, and Reform, the free market think-tank.² And yet Swindells, Manning and Leroy argue in this volume that charges or co-payments are regressive and can deter the poorest from seeking help until their needs are acute. Richard Reeves has elsewhere asked to what extent government should intervene in the choices and behaviour of individuals in order to promote their health. He suggests that strong intervention to promote children's health is justified but also argues that informed, capable individuals have the right to exercise free choice, including when their choices cause harm to themselves.³

Others would go further in advocating a role for active government. In this volume, Ruth Hussey, Sheila Marsh and Maria Duggan of the Department of Health North West take a critical eye to commissioning. In a previous Smith Institute publication last year, *Health Futures*, they made the case for a shift in mindset from treating illness to living well, which they described as being like "redesigning the plane while flying it". Professional practice in public services, they note, is geared to reacting to problems rather than preventing them in the first place: for every problem, the service provider's answer is "more of me". In this follow-up chapter, the authors describe the NHS's efforts to improve population health in the North West through the "living well" policy framework, which involves local government, employers and the voluntary sector. Initiatives have included prominent public campaigns on alcohol. Their innovative approach to measuring success captures wide-ranging factors that underpin well-being, such as employment, income, exercise, social participation and civic engagement.

Mikis Euripides of Asthma UK in his chapter adds to the argument about how the workplace and the classroom can contribute towards preventing illness. He cites examples of companies that have achieved cost savings of over £500,000 through reduced absenteeism and enhanced productivity and schools that have improved their pupils' dietary and exercise habits. The fact remains, however, that many of these improvements have benefited those in higher-status employment, yet it is those in lower-status jobs who suffer worse health and lower life expectancy. "More of the same" in policy terms will not be enough for these sectors of society to assist the health service in reducing the burden of disease.

Finally, we must consider the politics of change. There is a widespread assumption that spending will need to shift away from hospitals and into the community, the essence of which is captured in a recent report from the think tank Policy Exchange:⁴

2 Glennerster, H *Financing the United Kingdom's Welfare States* (2020 Public Services Trust, March 2010); Bosanquet, N, Haldenby, A, Hurley, L, Jolly, F, Rainbow, H, Sikora, K *Making the NHS the Best Insurance Policy in the World* (Reform, September 2008)

3 Reeves, R *A Liberal Dose? Health & Wellbeing – the Role of the State* (Department of Health, February 2010)

4 Policy Exchange *Controlling Public Spending: The NHS in a Period of Tight Funding* (January 2010)

Crucially, productivity and efficiency gains do not release cash savings unless capacity can be taken out of the system. This means facing the charged political debate of closing wards, imposing recruitment freezes, reallocating staff and in the longer term closing hospitals.

Such service reconfigurations are a hard sell, however, because people understand what GPs and hospitals do but know little about the new NHS services that lie in between, such as minor injuries units and walk-in centres. Jonathan Nicholls and Anna Quigley of Ipsos MORI in their chapter explore what drives public anger about hospital closures. For although there are economic and clinical reasons to close or downgrade district general hospitals and concentrate on specialist clinical services, proposals for change often lead to thousands taking to the streets in protest.

Worrying for ministers and NHS managers, Nicholls and Quigley believe that the public simply do not appreciate the scale of the challenges facing the NHS in the light of the financial downturn and do not foresee the need for significant changes that will affect their relationship with the NHS, although the authors do have tips for managing conversations about change. Andrew Dillon, of the National Institute for Health & Clinical Excellence, agrees that most of us take the view that "if it works, it should be available, regardless of cost".

The approval and availability of new drugs will probably become an even more contested area of decision making. In his chapter, Dillon sets out the way that NICE works to optimise the use of billions of pounds of clinical and public health practice through its guidance and through new resources such as the quality standards, to be published from summer 2010, and NHS Evidence, which synthesises and assesses research evidence.

Yet additional demands will be placed on patients beyond accepting change and limits to healthcare resources. As well as being asked to support service reconfigurations, we will be encouraged to be more self-sufficient for our own health and well-being. For as the value chain for health changes, community services will do more of what hospitals now do, and we as patients must do more for ourselves. While there is an undoubted appetite among many people for more control over our own healthcare, this feeling is not shared by everyone. Will we patients do our bit?

Marteau notes that most people value their health but persist in behaviour that undermines it. The challenge is most acute for the poorest cohorts of society, who are more likely than average to smoke and less likely to exercise. Efforts to inform people

of the risks of alcohol, smoking or obesity, however, have little effect. Instead, she argues, we need policies based on the drivers of human behaviour, and her chapter explores promising approaches such as financial incentives and environmental adaptations. With less than 1% of health research spent on evaluating behaviour change interventions, we have a limited evidence base on which to build.

However, there are clear signs of patient altruism. We may expect to be treated as consumers of healthcare, but I hope to see a resurgence of recognition of others' interests, active engagement and volunteering in healthcare too.

I would like to thank the contributors to this volume, my colleagues at the Smith Institute and our sponsors Napp Pharmaceuticals and GlaxoSmithKline. I hope you enjoy the essays.

Chapter 1

A step change in productivity

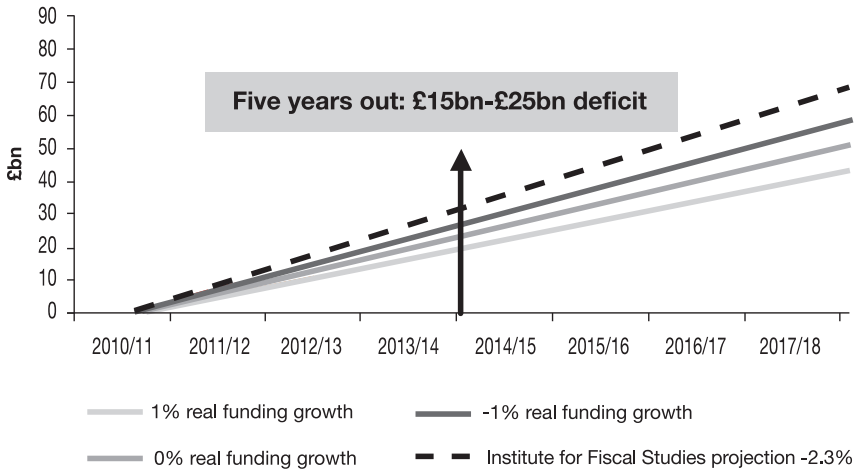
Kingsley Manning, Director of Business Development for Tribal Health,
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A step change in productivity

In the UK the reform of health services (and indeed all public-sector services) will be a priority for the next government, of whatever colour. Given the practical and political limitations on increasing resources or reducing the scope of services, the focus will have to be on achieving an unprecedented improvement in productivity. A marginal or incremental improvement in performance will not be enough; nothing less than a transformation in the way in which services are delivered will be sufficient.

The Department of Health's 2010/11 operating framework, along with the pre-Budget report, marks a watershed in NHS funding, and in particular acute hospital funding. The NHS budget in England after 2011/12 will at best increase in cash terms only enough to keep pace with inflation, and after the forthcoming general election even that position may not be maintained. Figure 1 shows the level of financial deficit that the NHS is likely to experience in the coming years under various funding scenarios; even if NHS funding is "protected", the underlying, systemic growth in demand for services means that the NHS will face a £15 billion-£20 billion deficit in five years' time.

Figure 1: Projected real NHS funding deficit, 2010/11-2017/18



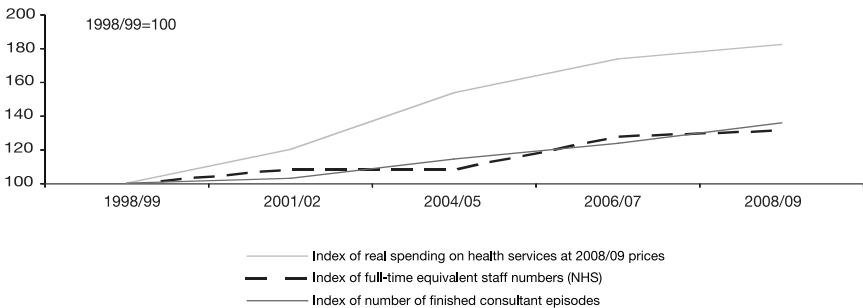
Source: Appleby, J, Crawford, R and Emmerson, C *How Cold Will it Be? Prospects for NHS Funding 2011-2017* (King's Fund/ Institute for Fiscal Studies, July 2009)

In order to fill the projected financing gap and maintain standards, an annual 4% real improvement in productivity (defined as the same or increased outputs for lower cash and human inputs) is required. Achieving this will need a significant change in the structure of health services themselves, rather than the incremental, financial measures around the margins that we have seen in the past.

The experience of the past decade is not, however, encouraging. Over this period in the English NHS, while output – as measured by the number of finished consultant episodes of care – and the number of staff (measured as full-time equivalents) have both increased by around 35%, real funding growth has risen by 82%. This is shown in figure 2.

While some may argue that this crude measure of productivity fails to take into account such benefits as shorter waiting times and improved user satisfaction, these have little direct financial impact, either for taxpayers or for the NHS.

Figure 2: Trend in real NHS funding growth, staff numbers and output 1998/99–2008/09



Sources: NHS Information Centre (NHS workforce statistics); www.ukpublicspending.co.uk (health spending by central and local government); www.statistics.gov.uk (RPI indices); Department of Health

Options for finding more resources

Faced with the relatively fixed costs of staff – nearly 70% of NHS costs – and the virtually immovable expectation of users and voters, it would be reasonable to look for options to increase the available resource, even if some of them are politically unpalatable. But the evidence is not encouraging.

Co-payment

For example, extending co-payment from its niche in such areas as prescriptions could be one option to increase resources and perhaps constrain demand. Many other countries have implemented co-payment models where the cost burden is shared between the patient, the private sector and the state. The most intensive users and/or the wealthiest users will pay the most; so in theory healthy people will no longer need to pay such a high tax burden to support those who are ill.

However, research shows that there are a number of problems with co-payment models, resulting in people on lower incomes and those in younger age groups being disadvantaged. A Commonwealth Fund study in 2008 found that those with chronic conditions – inevitably the heaviest users of health services – are more likely to experience problems accessing health services in countries with co-payment systems than those in countries with a 100% state-funded system (see figure 3).

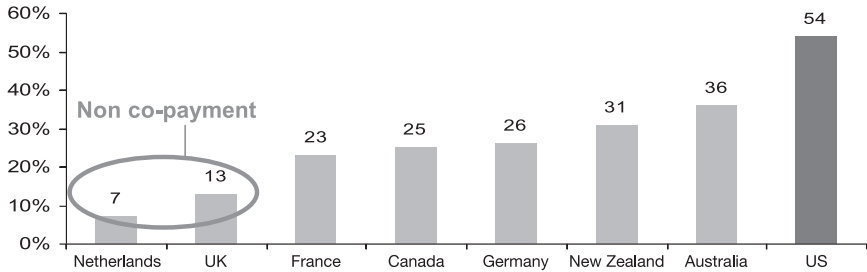
Failure by users such as these may not only raise significant political problems but also, through inadequate treatment, simply shift costs to other parts of the health and social care budget. Furthermore, given the state of the public finances, it is likely that co-payments would be additional rather than a substitution for tax funding, so that users might well see them as simply additional taxation on the sick. Finally, given the British tradition of means testing, almost inevitably a large proportion of the NHS's prime users – the old, the young and the poor – would have to be exempt from payments, as of course is already the case for prescription charges.

Service charges

A blunter approach is the selective introduction of service charges. Putting even a modest price on a service could have the benefit of not only raising resources but also encouraging more "appropriate" user behaviour. The evidence is not, however, straightforward. For example, Germany introduced charges in primary care in 2004. From 1 January 2004, all adults (aged 18-79) paid €10 for their first physician visit in each three-month period, except for vaccinations and preventive services.

The introduction of charges certainly had the effect of reducing GP visits, with up to 70% of some groups reporting in quarterly surveys that they had avoided a consultation due to cost. But the shift in behaviour was not straightforward, for although between spring 2004 and autumn 2006 some 27% delayed a physician visit and 18% avoided a visit, 25% made an additional visit, doubtless feeling that having paid they might as well get their

Figure 3: Effects of co-payment systems on patients with long-term conditions
Percentage of adults with any chronic condition in 2008 reporting access problems due to cost over the preceding two years



Definitions: Due to cost, respondent did not fill prescription, or skipped doses, or did not visit a doctor when had a medical problem, and/or did not get recommended test, treatment, or follow-up. Data taken from the Commonwealth Fund International Health Policy Survey of Sicker Adults (2008).

Source: Schoen, C et al "In Chronic Condition: Experiences of Patients with Complex Healthcare Needs in Eight Countries, 2008" in *Health Affairs* web exclusive, 13 November 2008

money's worth. And a further 30% did not report any change in their behaviour due to the practice charge.¹

At the positive end of the spectrum, avoiding or delaying a physician visit due to the fee was seen most often among younger and healthier adults. However, overall the charge created unhelpful behaviours, with those in the lowest income group being more affected than the better-off. Those with a chronic condition in the lowest income group were 2.5 times as likely to avoid or delay a consultation compared with similar patients in the highest income group.

Charging patients for primary care appears to deter the most vulnerable groups from seeking medical advice, whereas the "worried well" feel justified in seeking more as they have paid for it. This is clearly inequitable and acts as a form of regressive taxation; as with co-payments, this type of simple service charge may result only in shifting costs rather than delivering incremental resources. Indeed, across the whole UK, charging £10 a time for every GP visit would raise only about £1 billion a year, less than 1% of the NHS budget, but at an almost immeasurable political cost.

¹ See: Ruckert et al "Are German Patients Burdened by the Practice Charge for Physician Visits ('Praxisgebuehr')? A Cross-sectional Analysis of Socio-economic and Health Related Factors" in *BMC Health Services Research* no 8 (2008), pp232

Healthcare service transformation

If changes in the funding mechanisms, such as co-payment or user charges, offer little benefit, then inevitably government will seek to limit or reduce the scope of services offered. In practice the ability to withdraw services in healthcare is very limited; staff are pretty much fixed in their delivery mode and patients fixed in their expectations. While it may be possible to curtail the introduction of new services – though the experience of the National Institute of Health & Clinical Excellence (NICE) has shown how difficult this is – it is virtually impossible to close a current service, even when there is good evidence of poor clinical outcomes.

Attempting to improve productivity by cutting costs that reduce provision and quality, as occurred during the period of financial hardship in the 1990s, is therefore no longer possible. The government publishes waiting time, quality and satisfaction data on a monthly, quarterly and annual basis, and the national media are always ready to expose unsafe hospitals and falling standards. If waiting times start to rise, there is no doubt that they will be back on the front page, as will MRSA, *C. diff* and trolley waits.

The focus therefore inevitably returns to the performance and productivity of the service. And in the UK the fundamental structure of healthcare provision has remained largely unchanged since the creation of the modern public service state after the Second World War. Although over the past 10 years the NHS has shown dramatic improvements in output and quality, these service improvements have taken place without any increase in productivity.

The pressure for service reform is not, however, simply a question of increasingly constrained resources but also one of growing doubts that the model of public service delivery, essentially unchanged in decades, is no longer appropriate to meet the new challenges. Even at the most basic level of performance – the availability of information, opening hours, response times – services remain largely rooted in a bygone, pre-consumer era. At the same time, patients increasingly seek out information about their GP or hospital and are making choices about their care.

Furthermore, the historic model of service provision has had a perverse impact on the distribution of healthcare resources, limiting the system's ability to achieve core goals in reducing health inequalities. For more than 30 years the inverse relationship between the distribution of resources and the pattern of need has been well recognised.

The variation in funding per head does not reflect the ill health of the population. For instance, Westminster and Manchester receive the same funding per head, despite the mortality rate being 72% higher in Manchester. Wigan receives only 22% more funding

per head than Harrow, despite a 55% difference in mortality rates.² Not surprisingly, however, there is a good correlation between the distribution of resources and the historic pattern of healthcare, and particularly hospital services.

Key actions to transform health services

Any transformation will have to start with the basic design principles underlying the delivery of health services. This will apply at all levels – government, commissioners and NHS provider organisations – and is very likely to mean greater involvement of the independent sector.

The key actions required to bring about a rapid improvement in the short-term performance of the NHS are, however, already known; the technologies already exist, and the working methodologies are already understood. Either within the NHS or internationally, someone is already applying the approaches that the NHS needs to adopt universally. But, despite the evidence, the drivers of high performance are neither universally pursued nor are the tools generally applied. If we build on, share and generalise what we know works, rather than inventing new answers, service transformation will have common characteristics across the health service:

- **targeting** to deliver services where they can have the greatest impact;
- **co-design** so that services are more likely to be taken up by the user community;
- **network solutions** that are detached from place and cut across conventional organisation boundaries;
- **service diversity** with a much greater degree of heterogeneity in service models and content;
- **technology** that shifts the location, timing, periodicity, content and resource requirements for service delivery; and
- **workforce redesign** with professional barriers becoming more permeable and the development of new types of multidisciplinary professionals, supported by technology.

The key role of commissioning

This process of transformation needs, however, a catalyst – an agent of change. Competitive transformation, commonplace in most industries, with the parallel failure of old and creation of new organisations, will not work in the NHS; the barriers are simply too high. The transformation process needs a guiding hand, using

² Data taken from Department of Health programme budgeting data 2007/08 and all-age, all-cause mortality data 2005-2007

both competitive and collaborative levers and based on the key principle of the generalised adoption of best practice.

Providers and commissioners need to work together to realign whole health economies to ensure that money is spent to maximise health gain, rather than simply in commissioning the services that were delivered last year, and the year before ...

The four key areas of focus for this realignment will be:

- demand management, putting in place referral protocols and admission avoidance schemes;
- rationalising care at first contact, such as GP and community services, so that an increasing proportion of patient treatment episodes are completed at the initial contact;
- complex and continuing care, often for long-term conditions, shifting both the location and style of care away from acute hospital-based models; and
- health maintenance, promoting self-care and well-being, often using new technologies.

The critical tools that the system will need to underpin this shift of focus will be population segmentation, risk stratification and proactive targeting of patients to help them manage their illness better.

Using the independent sector wisely

To deliver the scale of the transformation required, this process of realignment or redesign is not simply about making current service models work better. Completely new and innovative ways of delivering services need to be developed and deployed – a process in which the public sector has had little previous success.

In the UK the urgent need to transform public services will inevitably therefore mean a greater involvement for the independent sector (both the private and third sector), irrespective of which party forms the next government.

The independent sector's contribution to health services reform will be driven by:

- **higher labour productivity** – reflecting the increasing disparity between public and private employment costs and the proven track record of the private sector in delivering improved working practices;
- **innovation** – both in the redesign of the workforce and in the adoption and implementation of technology, the available evidence suggests that the private sector is

- is significantly faster in adopting new technologies and working methods;
- **receptivity to consumer requirements;**³
 - **rewards linked to outcomes** – which drive improvements in productivity and quality and devolve delivery risk to the private sector;⁴
 - **multi-sector experience** – delivering a coherence of service provision, clear accountability, pan-regional overhead absorption and incentivisation.

Inevitably there will be resistance; the established suppliers will defend their position, not least on the grounds of safety and quality. But there is no evidence that there is any negative impact on the quality of services when the private sector delivers these changes. Indeed, studies from the National Consumer Council suggest that voluntary-sector and/or private-sector involvement at the very least maintains the service quality consumers should expect.⁵

The independent sector is already a significant provider of public services in the UK. The government's review of the UK public service industry⁶ found that the overall industry, including commercial and third-sector providers, was worth some £79 billion in 2007/08. Although this only represented just over 13% of the total government spend, it was estimated that the market had grown by 126% over the previous 10 years, with growth particularly strong in health and education.

Conclusion

The NHS is about to go through one of the biggest upheavals in its history. This time, it will be driven not by political decisions but by hard economics: persistent and rising demand, underpinned by consumer expectations and political reality, colliding with limited resources, starkly exposed by the financial downturn and limited tax revenues. In the face of these pressures, governments will look for major improvements in the performance of the health services and for a scale of improvement that cannot be achieved by incremental managerial changes but only through a transformation in the way services are designed and delivered.

Increasing the skills of commissioners to purchase the best services most appropriate to the needs of the local population is part of this, as are changes in the structure of

3 Mulgan, G *Ready or Not? Taking Innovation in the Public Sector Seriously* (National Endowment for Science, Technology & the Arts, April 2007)

4 National Audit Office *The Operational Performance of Prisons* (June 2003)

5 National Consumer Council *Delivering Public Services: Service Users' Experience of the Third Sector* (June 2007)

6 Department for Business, Enterprise & Regulatory Reform *Understanding the Public Service Industry: How Big, How Good, Where Next?* (July 2008)

local health economies to manage demand and to make sure services are delivered in the most patient-centred, efficient and cost-effective way possible.

If politicians, clinicians and the public are determined to defend the status quo, protecting every bed, every building and every service, the inevitable consequence will be for the books to be balanced by service reduction and rationing. The NHS will retreat to becoming a residual service, and the affluent will buy themselves out of NHS services through private health insurance. This is the very threat that Tony Blair warned the public about in 1997.

If, however, bold leaders in parliament and the NHS grasp the nettle, this financial crisis could be the catalyst that the NHS needs in order to reform itself and demonstrate that a tax-funded, comprehensive health system is a viable model for the 21st century.

The investment in healthcare means that the NHS has excess capacity. Now is the moment to close the weaker services and ensure that everyone has access to the best. Past failure to reform working practices means that the opportunity exists in the future. Creating a multi-skilled workforce that can work in hospitals or the community, face to face or by telephone, will allow more care to be delivered by fewer people at lower cost. The NHS's purpose is to protect lives, not outdated working practices.

The fact that the NHS has remained primarily a "sickness service" means that the transformation into a service that proactively intervenes to keep people well will represent a new era in the NHS, with the opportunity to improve health and reduce the reliance on expensive hospitals occurring simultaneously.

Ultimately this financial crisis will lay down the challenge to the NHS and the public about what it really cares about. Does it want a "public-sector" NHS that manages a diminishing number of old-fashioned buildings and services as a memento of its founding zeal, or a new NHS that is more interested in buying the services from the best provider (whether from the public, private or voluntary sector) that are needed to improve health and reduce inequalities, regardless of who provides them and what buildings they use?

Chapter 2

Sharpening NHS incentives

Professor Paul Corrigan, Management Consultant and Executive Coach

Sharpening NHS incentives

The NHS likes to think of itself as a single organisation, and indeed in 2010 that view is reinforced by having someone who is called the chief executive of the NHS: since the NHS has a chief executive, it must logically be a single organisation. One could play an interesting game in trying to identify similarly large organisations, the most popular and telling examples perhaps being the Indian railways and the People's Liberation Army in China.

This feeling of being a single organisation is apparent when people who work within the NHS are asked who they work for and they respond that it is the NHS. In fact, of course, no one actually works for the NHS. They work for a hospital or a mental health trust, they work in a doctor's surgery or in a few cases for the primary care trust, and some even work for the Department of Health, but no one is employed by the NHS.

This gap between myth and reality is at the heart of the issue of building incentives into the NHS. Since the NHS is in reality a system, it contains a variety of different organisations; it is the way in which those organisations interact that creates the major incentives in the system.

If everyone is in the same organisation, then one of the main ways in which an organisation can work is through the management of performance. The chief executive instructs his board members, who – in the case of the NHS in 2010 – instructs the strategic health authority, which then instructs the hospitals and the primary care trusts, and they in turn instruct their staff. The individuals are all in a chain of command, and activity is developed through that management chain.

The old NHS, and indeed much of the new, worked like that. It believed that it created a single culture with a single chain of command, and when it liked this it would call itself a values-driven organisation: one that did not need incentives because we all had the same values and approach to the world. When people did not like this approach, they would call it a command and control organisation.

Actually the NHS was never a command and control organisation; it was a command organisation with very little control – lots of shouting but, in terms of clinical activity, very little control. What the development of incentives has achieved is the ability of different parts of the organisation to move and improve, not in response to shouted commands from the top but to a set of structured incentives.

First, incentives are not entirely new

Let's be clear: some incentives were built into the NHS from the very beginning. In 1948, when the NHS was created, the staff of course worked for wages and salaries. They did not come to work for free, and complex webs of payment incentives were built up. From the very beginning, for hospital doctors there was a contract to work for the NHS which also allowed the doctor to work privately. This interaction between the amount of time the NHS hospital doctor could work "for the NHS" and the amount they could earn money in private medicine was a matter for intense discussion for 60 years.

Every discussion about a new contract for the consultants would resonate about this. There were very few doctors who only worked for the private sector, and most hospital doctors mixed up the incentives structures between the two.

In the era of long waiting times, one of the stories that most angered the public were those in which hospital doctors were reported as saying, "If you have this done on the NHS this operation will be done in a year's time, but I could carry it out privately in a week's time." Here, long waiting times for NHS patients were being used as an incentive for the patients to "go private" and pay for their operation. Indeed, much of the private market in hospital and the incentives for hospital doctors to work for private health were incentivised by those long waiting times.

So, as in any large system service or industry, incentives are a major part of why people go to work. They have a big impact on why they work hard and can help make the whole system move in a certain direction. But until recently financial incentives were not used to try to make the NHS system work differently.

Improving transparency about how money flows round the system

As we shall see, finances are only one part of an incentive structure, but unless it is clear how the money flows round the system then it is not possible to identify the pressure points at which exerting force for change will be most effective. So the biggest issue that we must work on if we are really to understand how to use finances as an incentive is the need for much greater transparency about how and why money flows round the system.

While the transparent flow of funds is hardly a riveting part of NHS reform, without it we can make very little new happen. That means that the most important single reform within the NHS has been creating a distance between those that buy (commission) healthcare and those that provide healthcare.

The importance of this is shown by the fact that one of the pledges in the 2001 new Labour manifesto was that 75% of the resources that would flow round the NHS was to go from the Department of Health straight to primary care trusts. And for the first few years of that government one of the main challenges for the Department of Health was getting that amount of resource to flow straight to the trusts. The Department of Health enjoyed having its own amounts of money to hand out – and of course still does. It recognises the power of money to incentivise action down the managerial line. So getting much of that money to go transparently through primary care trusts was one of the first activities of reform.

The second challenge, which is still incompletely met, was to separate off those buying (commissioning) healthcare from those providing that healthcare. In the past, health boards distributed the money within themselves. Of course there were incentives contained in how the money was distributed here, but it was never clear what those incentives really were because we could not really see them. The separation between commissioning and provision in the area of community health is allowing a more transparent picture to emerge.

Creating incentives for success and fear of failure

One of the great and abiding ways in which inefficiency was incentivised was that if as a hospital you ran out of money in January you would get some form of winter allowance to make sure you got through the year. Think what this would mean for those that stupidly worked hard to keep within their budget. They were not rewarded with extra money, while those that had spent their budget before the end of the year did receive such additional funds.

I want to linger on this issue because it is still a major part of the NHS culture. Improving efficiency is hard. It usually involves some difficult discussions with medical professionals about changing the way in which they work. To carry out the hard work of change, there needs to be some form of incentive structure to encourage institutions to do this hard work.

If you spend a whole year doing this hard work, and then organisations that have failed to do it get bailed out at the end of the year, it seriously undermines your motivation to do the hard work next year. Organisations that do badly, indeed organisations that do badly year after year, are never allowed to fail.

In the language of reform, this is called not having a failure regime. Organisations have to feel that there are consequences for them if they fail to improve their efficiency, and the worst consequence is failure.

If NHS providers know that there are no consequences for organisations that do not manage to increase their efficiency – if they believe that no one will ever agree to their closing – then they will not struggle to do the hard work of increasing efficiency. Therefore one of the biggest incentives to encourage efficient behaviour is the existence of real consequences for inefficiency.

And the reverse is also true – there need to be real, positive consequences of efficiency. If my organisation works really hard at improvement, if we manage to improve our financial position by 3% in a year, but then someone simply takes that money at the end of the year – where is my motivation for achieving that financial saving? This is the rationale behind foundation trusts. If an organisation has the autonomy to keep the resources that it creates through greater efficiency, that is in itself a good incentive for efficiency.

The equivalent for primary and community health organisations – that is, the right to keep the finances that they create through efficiency – will have an impact on all providers.

Devising a tariff to boost allocative efficiency

Organisations that face consequences for inefficiency and keep rewards from their hard work on efficiency will improve the technical efficiency of all organisations. However, the NHS needs to go beyond this and create a much greater allocative efficiency for the NHS as a whole. While technical efficiency has an impact on the way in which each individual organisation develops value for money by bearing down on costs, allocative efficiency has an impact on the way in which resources are used across the system. Allocative efficiency needs the system to allocate the resource for treating the patients to that part of the health system that can at that moment provide the greatest value for money in the whole system.

To use an example: a secondary care provider with an accident and emergency department can make that department much more efficient by improving the way in which it is organised. By doing this, it can improve the technical efficiency of that department. However, the health economy as a whole could be going bankrupt because thousands of people who do not need to go to accident and emergency are going there. The fact that within the hospital they are being treated with great technical efficiency is of less importance than the fact that the system is inefficient because thousands of people who do not need an accident and emergency department are being treated there. Those people's healthcare needs could be much more efficiently dealt with by a better out-of-hours service or an urgent care centre.

Allocative efficiency needs incentives that work across organisations to maximise the amount of care that is carried out in the most efficient locations. At the moment the tariff is primarily used to pay an organisation for the work that it does. What we need is a tariff that encourages the creation of a patient pathway and makes the greatest cost saving by keeping people away from expensive care.

This can best be explained with an example of long-term care. It has been estimated that about 50% of the cost of diabetes care comes from complications and emergency admissions, both of which require hospital admissions. Obviously it is important for people with diabetes to know that they can enter hospital when they need to, however expensive that treatment is.

However, the patient and the system as a whole do not want patients to be regularly admitted as an emergency. It is disruptive to their lives and expensive for the system. So the patient and the healthcare system need a patient pathway that encourages as much self-management as possible, and, when patients feel they may not be able to manage themselves, has a strong and fast primary care intervention to keep those patients out of hospitals.

We need a form of tariff that, for example, looks at the whole cost of a year's diabetic care and encourages the provider who is managing that year with the patient to keep the patient out of hospital. Some 75% of the NHS's expenditure goes on long-term conditions, and so it is long-term conditions that provide the biggest opportunity for the use of a tariff that will incentivise allocative efficiency.

This is why commissioning is so very important to the future of the NHS. While it is important to have these incentive tools within the pricing mechanism, we need competent and active commissioners to drive that process forward. They need to have a much better understanding of the economics of how an incentive system would work.

Using contracts to improve efficiency

While the main incentives that I have talked about so far have been about the nature of the pricing system within the NHS, there are other forms of financial incentive that are having an impact.

In a Smith Institute seminar in May 2009, a GP succinctly and honestly outlined the traditional business model of GPs. He said: "We sit in a room and wait for people who think they are ill to come in and see us." As a recipe for running an efficient health service, the passivity of this model does leave a lot to be desired. And yet for most of the 60 years of the NHS GPs

have been paid not for actively doing anything but for simply having people on their lists.

The GP contract of 2003 changed that. From that date, GPs have also been paid for specific actions that concern patient groups. They have been incentivised to go out and seek for and test people with diabetes, and to ensure that there are vascular risk assessments of those people who are likely to need it.

The new contract pays them more for being active. It is still, unfortunately, the case that you can make a lot of money as a GP by sitting in a room and waiting for people who think they are sick to come in and see you, but we do have a payment system that has started to incentivise proactivity.

Having started this with GPs, we now need to use contracts to incentivise activity for all healthcare staff.

What we cannot do in the NHS with incentives

Other systems that involve families, employers or individuals paying for their healthcare can use the prospect of paying a little less to encourage individuals to look after themselves and stay healthy. In the UK there are private insurance packages that allow individuals to save money on premiums if they, for example, join a gym. Some US insurers go further and provide the insuree with the opportunity to download their exercise programme from the gym's machines to decrease their premiums.

Since one of the hallmarks of the NHS is that we do not pay for treatment at the point of need, we cannot use this motivation. But the issue of incentives for patients and the public goes beyond that of payment. What the very best staying-healthy programmes do is to individualise the incentive for the person.

Why should I give up smoking? Why should I lose weight? In so many other areas of life, the incentive to change our behaviour comes from this individual vision of our life. In 2010, stop-smoking adverts controversially have children asking their parents to think of them and stop smoking. It is this personalisation of health that will unlock the incentives for individuals improving their health. We all need our own personal reason for doing this to provide the incentive.

Conclusion

We are only partly through the NHS journey of developing incentives. While in 2010

there is transparency for a lot of the hospital spend, there is insufficient openness about the cost of community health and primary services. In the next year or two tariffs will emerge for all these services and technical efficiency will be incentivised.

The same will be true for the development of much more granular prices for such activities as a year of diabetic care, which will allow the commissioners to incentivise allocative efficiency across the system.

These mechanisms provide the opportunity to drive much greater efficiency within the continuing principles of the NHS. They enhance rather than inhibit the principle that everyone should have equal access to healthcare free at the point of need.

Chapter 3

What price clinical innovation?

Dr Robert Wilson MD FRCP, Chairman of Asthma UK and Consultant Physician and Director of the Lung Division at the Royal Brompton and Harefield Hospitals

What price clinical innovation?

During the past 12 years spending on healthcare in the UK has risen from £36.4 billion to an expected £102.8 billion in 2010. The NHS now employs more doctors, nurses and other healthcare professionals than ever before.¹ Demand for healthcare has rocketed – even without any adjustment for improvement in quality, the amount of healthcare provided in 2006 was 50% greater than that in 1995.² This investment has achieved real improvements in our health, as judged by important measures such as life expectancy and infant mortality.

The NHS is now facing fresh challenges. While the threat from infectious disease has reduced, deaths from cancers, coronary heart disease and stroke have risen and now account for two-thirds of deaths. These diseases, as well as others such as diabetes and chronic obstructive pulmonary disease (COPD), also have a major impact on people's health, stopping them enjoying a good quality of life and leading to lost time from work. The burden of mental health is also increasing. All these conditions are more common as we get older, and therefore demand for healthcare is set to accelerate with an ageing population. At the same time, the financial climate means that public resources will become more constrained. Between 1949 and 1997 NHS spending grew at an average of 3.5% per year, whereas in the near future we are looking at zero growth in public spending, which will amount to a real-terms reduction.³ While the NHS may do better than most areas of public spending, it will not avoid restrictions in budget.

Clinical innovation should be an important tool to help provide us with some of the answers to these challenges. However, the major driver for the increase in the cost of healthcare is the widespread adoption of new medical technologies and drugs, which leads to greater cost per episode of care. Looking at advances in care at my own hospital, non-invasive nasal ventilation in motor neurone disease and muscular dystrophy, omalizumab – a monoclonal antibody against immunoglobulin E – used in severe asthma, percutaneous cardiac valve replacement and ventricular assist devices all provide improvement in the length as well as quality of life of patients for whom previously we had little to offer. They can now enjoy everyday activities, but they continue to need input from specialist medical services, so the costs escalate. Healthcare changes are occurring in an environment where demand is constantly threatening to overwhelm the budget available, and new discoveries usually have the consequence of expanding the envelope of what we can offer to our patients.

1 Department of Health *Department Report 2009 – Annex* (2009)

2 Office for National Statistics *Public Service Productivity: Healthcare* (2008)

3 *Ibid*

Zero growth in funding means that current models of care are unsustainable. Our aims must be to deliver better outcomes for the same cost, the same outcomes using fewer resources, or ideally better outcomes for lower cost. Variations across the country in terms of length of stay and frequency of emergency admissions to hospital, for conditions such as asthma, suggest sub-optimal care and inefficiencies. Improvement will mean a reduction in this variability of care, but rather than aiming for adequate healthcare for all we should aspire to attaining the highest standards possible.

Excellence is present in individual parts of the current service, but is not embedded in the system as a whole. Patient choice and competition between healthcare providers were introduced to try to improve standards. Surveys have repeatedly shown that ease of access is a very important criterion for patients, but in most cases this will restrict choice. The information systems needed to guide choice are not yet available, and even if they were I am sceptical whether patients would access them appropriately. I believe we have to look for alternative solutions. In this essay I will look at what our options are for delivering increased productivity at a time of economic scarcity and how clinical innovation can deliver excellence in NHS services that is affordable.

Rationing and disinvestment

There is unlikely to be public appetite, or political will, to fund growth in healthcare by increased taxation. An alternative approach to contain escalation of costs is to increase rationing. The National Institute for Health & Clinical Excellence (NICE) is our first line of defence against growth in costs driven by new technologies and treatments. Its judgements about which treatments should be funded by the NHS are rigorous and well respected, and NICE should be credited with the development of transparent methodology to measure comparative cost-effectiveness. At times NICE decisions have been controversial, and the national press, and probably the public too, have not accepted that the budget for healthcare has to be finite and therefore the clinical gains achieved by some treatments are insufficient for them to be introduced.

I am sure that more open and honest debate about this issue would enable the public to get a better understanding of the dilemma we face. In the current financial climate the cost ceiling that NICE applies, £30,000 per quality-adjusted life-year, could be made more strict, and possibly the role of NICE should be widened to recommend areas for disinvestment. One criticism of NICE that must be addressed is the time required to make its decisions.

We must constantly challenge existing services and treatments, and drop them when there is no evidence for benefit or they have been superseded by a new development. A decision to implement change is easy when an existing service can be redirected. An example of this would be physiotherapy, which provides no measurable improvement for patients with osteoarthritis, but through pulmonary rehabilitation can improve quality of life in COPD and keep people out of hospital. Taking funding away from less successful activities meets more resistance because it involves a major change in staff working patterns or even redundancy, but such decisions are essential if we are to divert funds elsewhere.

Lessons from large-scale projects such as the national IT programme have shown that it is virtually impossible to impose major change on an organisation as large and varied as the NHS. Therefore rather than seek "big-bang" solutions, I would advocate that change should be achieved by an evolutionary process which nurtures and encourages high-frequency small changes that get us closer to where we want to be. The "productive ward" scheme that has been utilised widely to empower nurses to drive improvement in productivity is a good example of this.

NHS research and the pharmaceutical industry

The NHS is ideally positioned to provide a large resource for clinical trials, but it has not yet fulfilled this potential. We are potentially on the verge of a revolution in clinical practice during which diagnostics and therapy will come together. The NHS should be an ideal testing ground for these studies, so that it is in pole position when they are subsequently introduced. The creation of biomedical research centres and units will, I hope, exploit the unique opportunities the NHS has to offer.

The pharmaceutical industry needs to work together with academic clinicians and scientists. In recent years concerns about industry exerting inappropriate influence have restrained interactions, whereas innovation would be more likely to arise from joint ventures. There is also a need to increase academic expertise in primary care, because at the present time GPs with a special interest find it impossible to make time for research, and have difficulty analysing and presenting their work. The amount of administration surrounding research has increased enormously – much of it appropriate, concerning ethics and good clinical practice – but the paperwork and processes must be streamlined. Government should also retain a percentage of funding for "blue sky" research, from which discoveries sometimes lead to major advancements in science.

We need new medicines that are better than those currently available. This usually means new compounds or techniques, but in some cases might mean a new application for an old treatment. At present this avenue is rarely explored because of patent expiry. The mindset

of the pharmaceutical industry is to use large sales forces to drive prescribing by marketing brute force. If this could be changed, resources might be redirected into producing medicines for conditions in which there is an unmet medical need, and then rely on that need to drive sales.

Government needs to work with the pharmaceutical industry and introduce legislation to enhance the prospects for innovation. Many compounds with potential are not pursued because of weak patent and intellectual property protection. Input from NICE and other sources is required to produce guidelines on how to evaluate upfront the expected benefit from a prospective compound, in order to reduce the risk of research investment coming to nothing. Consideration should also be given to providing incentives for industry to undertake research in areas of clinical need.

Prevention and early identification

At present most resources are invested in medical care of illness once it has occurred, rather than intervening earlier in the disease process. In the future we need to consider channelling more resources into public health to increase emphasis on prevention in healthcare. Cigarette smoking, alcohol abuse and obesity are three key areas. Similarly important are immunisation and screening targets, educating patients to follow recommended therapies – such as persuading asthmatics to take their preventer inhalers – and prenatal care.

Unfortunately, we lack understanding of how to effectively get people to change their behaviours and adopt healthier lifestyles. This is an important area for future research in the primary care setting. Increased funding for prevention, while a laudable investment for the future, provides no immediate savings and therefore in the short term it costs more. This must not deter us from committing increased resources to prevention. The “Wellness” programme in the US is a template from which we can learn.

There are 17.5 million people with long-term conditions, and they take up 70% of the NHS spend. At present most of the care of chronic conditions occurs in hospital. The best avenue to improve people’s health is via primary care. Primary care can most effectively deliver preventative strategies such as smoking cessation and influenza vaccination; it is also the main portal for early detection and screening of diseases such as breast, prostate and colorectal cancer, cardiovascular disease and diabetes. Hospital referrals and admissions occur more frequently in areas poorly provided with general practices; this is because strong primary care prevents unnecessary and

costly hospitalisations for conditions such as congestive cardiac failure, diabetes, hypertension and pneumonia, all of which can be managed adequately in the community.

Medical advances mean that more procedures can safely be provided outside the hospital environment. Models of care with general practice at the hub need to be developed for the management of chronic conditions. Clinical leadership will be essential for their success. Primary care should be the site where chronic conditions are diagnosed at an early stage when intervention can slow or stop progression, as well as being proactive in identifying acute deterioration so that early treatment can avoid hospital admission. Patient groups at highest risk can be targeted.

In order to achieve these improvements, clinical skills in primary care will need to be increased. Education programmes, many of which could be online, and formal assessments of knowledge will have to be put in place. If this does not occur, then simply shifting activity out of the hospital will result in greater expense, because there is a danger that losing consultant input will lead to more investigations and less effective management. In order to avoid this, the barriers between hospital and general practice need to be removed, with hospital consultants reaching out into the community and general practitioners developing areas of interest by attending hospital clinics. GPs who are a speciality lead will then cascade the experience they have gained to their colleagues.

Asthma is a good example of a chronic condition in which better diagnosis and provision of a written care plan can avoid complications leading to lost time from school or work and hospital admission. Patients need more support to learn how better to manage their condition, the importance of regularly taking their preventer inhaler, and when to begin taking oral steroid tablets. A patient's care plan needs to be regularly reviewed, and when a complication has occurred questions should be asked about whether this was avoidable, what might be changed and whether fine-tuning is required. A nurse specialist, a GP with a special interest who has links with the local hospital, and a consultant specialist visiting the practice at intervals provide tiers of care that can be accessed appropriately. Patients who have required emergency hospital admission or frequently need oral steroid prescription can receive special attention.

Inequalities in service provision throughout the country must be addressed. Smoking is the biggest single cause of preventable illness and premature death, and is a good example of health inequality. Overall in the UK, smoking prevalence has been reduced from 45% in 1974 to 21% in 2007. However, there has been little impact in the low socioeconomic strata, and the differential in smoking prevalence between social classes persists and is

widening. The only way to address such inequalities may be to provide financial incentives for primary care providers to move into areas of greatest need.

Reorganisation of healthcare delivery

A much greater role for general practice in prevention is one part of the widespread changes in delivery of healthcare proposed by Lord Darzi.⁴ These include educating patients in the management of their own condition, focusing services on individual needs, and whenever possible delivering care outside hospital. While the local hospital will remain the main provider of acute services, patient care will be shifted into the community, where enhanced multidisciplinary services (general practitioners, nurses, midwives, emergency care practitioners, mental health practitioners, social care staff and a strong interface with community services) will be grouped together in polyclinics or systems.

Specialist care such as trauma, stroke, angioplasty, lung failure and less common cancers will be centralised in fewer, designated hospitals that are staffed and equipped to diagnose and manage the most severe cases. For example, an advanced lung disease unit would bring together intensive care specialists, respiratory physicians, infectious disease specialists, physiotherapists, dieticians and so forth in facilities to deal with acute lung injury, provide non-invasive ventilator support to avoid mechanical ventilation and facilitate weaning, and offer pulmonary rehabilitation. The centre would have a retrieval team to safely transfer patients, and agreed protocols for repatriation when appropriate.

Niall Dickson, chief executive of the King's Fund, rightly said "real cultural change will be needed in the health service if the vision is to be translated into reality". This is perhaps the most fertile ground for clinical innovation in the next decade, and its success will, I believe, depend on our ability to develop clinical networks that span organisational boundaries.

At present patients flow from general practice into hospitals, and if local primary care is inadequate then patients bypass the GP and attend accident and emergency departments at the hospital. GPs refer patients because they do not have the expertise to reach a diagnosis, or because investigations are not available to them to achieve a diagnosis; treatment options may not be available in the community, and referral may be defensive because of fear of missing a diagnosis, or to avoid the "nothing we can do" conclusion.

⁴ Darzi, A *High Quality Care for All: NHS Next Stage Review Final Report* (Department of Health, June 2008)

These issues must be addressed in the reorganisation of healthcare delivery, partly by education, but largely by integrating services. The money to upgrade primary care services will need to come from savings made by reducing hospital admissions, and this will save money only if there are bed closures. Funding streams will need to provide incentives for different models of care, service reconfiguration and changes in workforce planning. As the care of patients becomes more complex, there needs to be a seamless sharing of information between the different components of the new system, allowing organisations to build on each other's work rather than duplicating it.

Approximately 500,000 people die in the UK each year, and about 58% of these deaths occur in NHS hospitals. Twenty percent of acute care admissions to hospital relate to end of life, and many patients come directly from nursing homes. Currently there is no consistent approach for organising the complex array of care that people who are approaching the end of their lives need and want. There is a lack of co-ordination between care providers, and poor communication between staff and patients and their carers. Many more people would prefer to die at home than now do so. At the same time there are far too many unwanted, unnecessary and costly end-of-life hospital admissions.

Producing a new strategy for end-of-life care is challenging, because it incorporates primary and secondary healthcare, social care, spiritual care and all possible sensitivities. End-of-life care is an excellent example of how we need to reorganise skills and resources in the NHS so that palliative care teams reach out from the hospital setting into the community, utilising new integrated care pathways that incorporate best-practice models like the Liverpool Care Pathway.⁵ Good communication between the clinician, family, patient and carer underpins successful pathways, and psychological support is another key factor. Open debate, education and increased support from the palliative care team will all be required to change families' perception about where end of life is best managed.

The Royal Marsden hospital has carried out a pilot study that showed a 10% reduction in hospital deaths achieved by instituting a "Hospital2Home" programme.⁶ This begins with a case conference chaired by the patient or their GP and attended by a district nurse, social worker, community palliative care nurse, spiritual adviser and carers. Care needs are discussed, and an action plan agreed which includes advanced care planning and place of death. A responsible professional is allocated to each aspect of the plan. Information recorded in an individual care pathway should provide a contemporaneous document that is shared electronically between all parties. There is lack of a good evidence base

5 Richards, M *The End of Life Care Strategy* (Department of Health, July 2008)

6 Riley, J and Smith, C "Case Conferencing – An Answer to Improving Generalist End of Life Care? The Royal Marsden Experience" (rapid response online) in *BMJ*, 14 October 2008

for such strategies, and clinicians must start pooling data, auditing practice and developing metrics for success or failure, to provide data for research that will shape future practice. Whether preferred place of care and place of death were achieved is one obvious metric.

Conclusion

The current financial climate will exert pressure for change. The question is whether in 10 years' time the NHS will look similar to its current self, each year struggling to make efficiency savings that try to keep a cap on rising costs, perhaps running alongside an expanded private healthcare system catering for those who can afford it, or whether we introduce radical change in the way that we deliver healthcare. The NHS is an expensive resource that has tried to meet the challenge of increased demand from an ageing population by expanding its staff numbers and maintaining them working in long-standing practices. The system sees too many patients in the hospital setting, because of the failure of patients to self-manage their condition and the limited scope of primary care.

Change will involve investment in infrastructure, particularly information technology, but the main change will be in people and how they work together. We want our staff to do things differently and to do different things. Clinical leadership will be essential to champion change and persuade both patients and staff of the benefits. The public will need to be taught how to use the system effectively. Increased funds to improve public health and to increase skills in primary care will be provided by redirecting money now being used in secondary care. The consequences of this must be fewer acute beds. The space created in hospitals could be used to develop new services such as pulmonary rehabilitation, day-case rapid assessment units – which as well as performing investigations to establish a diagnosis could be used to optimise patients' health status pre-operatively – and ward reconfiguration to improve infection control.

There must be clear lines of clinical governance, and the authority for decision making will need to be well defined if the change process is not, as a GP friend of mine described it, to be "like wading through treacle". If successful, the result will be improved care that is readily accessible at reduced cost – true clinical innovation.

Chapter 4

Is pharma innovative enough?

Alison Clough, Commercial and Communications Director at the
Association of the British Pharmaceutical Industry

Is pharma innovative enough?

This is a time of opportunity for everyone concerned with the effective provision and use of medicines within the NHS. To grasp that opportunity, and deliver the value that NHS patients deserve to receive, the pharmaceutical industry is committed to developing stronger relationships and working innovatively with the UK's health service.

But is the pharmaceutical industry innovative enough? It can certainly be said that pharma is renowned as a sector that innovates, that pushes scientific endeavour to new limits, and that invests in new technology and new understanding of diseases: UK pharma companies continue to lead the world in these respects. Pharmaceutical companies invest £4.5 billion in research and development every year in the UK (that's around £12 million every day). This represents a quarter of all research and development across every industry in the UK and is 70 % of UK health research, contrary to the popular myth that most research into new medicines occurs in academia or hospitals. Through the efforts of the pharmaceutical industry, the prospects of patients with numerous conditions, including epilepsy, diabetes and coronary heart disease, have been transformed: for example, the development of statins to treat people with high cholesterol is saving 10,000 lives every year.

Allied to innovation, however, must be an environment and a system that facilitate access to new medicines, maximising the benefits for patients while guaranteeing the highest clinical standards. The Association of the British Pharmaceutical Industry (ABPI) and the pharmaceutical industry share the agenda of the government and the NHS, to work innovatively with stakeholders to improve patient care. This agenda is being energetically pursued in a number of ways.

Firstly, pharma pipelines have, for some years, been aligned to areas of greatest unmet medical need. We are seeing more products emerging today targeting NHS priority areas such as cancer and diseases of the central nervous, cardiovascular and respiratory systems.

The most recent Pharmaceutical Price Regulation Scheme, which began in 2009,¹ introduced the prospect of pro-innovation initiatives that the pharmaceutical industry welcomes. One of these is a single, unified, horizon-scanning database that will allow the NHS to see more easily which new medicines are approaching clinical use, thereby helping pre-launch NHS planning and budgeting. This database is being created now.

¹ Pharmaceutical Price Regulation Scheme 2009 (<http://www.dh.gov.uk/en/Healthcare/Medicinespharmacyandindustry/Pharmaceuticalpriceregulationscheme/index.htm>)

The Pharmaceutical Price Regulation Scheme also articulated how flexible pricing and patient access schemes might facilitate better patient access to more new medicines, within a pricing framework that also reflects value to the NHS. Patient access schemes allow the new medicine time to prove cost-effectiveness, and give patients faster access. Such schemes can be financially based or outcome-based.

Another initiative, as a result of the Office for Life Sciences work in 2009, is the innovation pass, which is to be piloted from April 2010. This will allow a small number of products to gain a "pass" for use on the NHS, prior to undergoing health technology appraisal by the National Institute for Health & Clinical Excellence (NICE) to assess their cost-effectiveness. These products will have received regulatory approval and thus will have met the standards for efficacy and safety but, for good reason, are not able to prove their cost-effectiveness at the time of launch. The ABPI considers the innovation pass to be important in setting a precedent of recognising that not all medicines can achieve a positive NICE appraisal at launch. In the case of some cancer medicines this may be because of only limited data being available at launch, as they might so far have been used only in the most severely affected patients whose costs of healthcare are greatest.

Valuing innovation

We want to work with an NHS that welcomes and champions innovative technology, and which adopts it promptly where it most benefits the patient. The ABPI recognises that many factors are at play in the nexus between the industry and the health sector. Innovation is the lifeblood of our industry, yet the take-up of new medicines in the UK, and the consequent impact on improving patient care, lags behind that of most other European nations. Branded medicine prices in the UK are at the foot of the league table of comparable countries, including much of Europe, and the US. Yet despite these low prices the UK has poorer uptake of innovative medicines. NICE, local prescribing controls and clinical conservatism all play a part in this. In addition, spend on medicines is lower in the UK than in many other countries: the medicines bill accounts for just 12% of the total NHS budget.

There are a number of ways in which access to new medicines could be improved. First, we believe that improvements in patient care would accrue from the Department of Health and the NHS agreeing to a more holistic definition of the value of a medicine: a definition that takes account of all the benefits and potential savings that its appropriate use would create.

For instance, a new medicine might benefit patients by preventing or reducing complications associated with existing treatments. Such wider benefits need to be fully taken into account in government and NICE decisions, if patients are to reap the full value of pharmaceutical innovation. In that regard, we believe that the recent Kennedy report² and the NICE proposals in response are a missed opportunity. The ABPI has communicated this to NICE already, but it is worth emphasising a few of our observations about the inequities of the existing method by which cost-effectiveness of a new medicine is assessed.

First, while cost-effectiveness is, rightly, an important objective for NICE, we believe that the economic modelling needs to be balanced with consistent and transparent consideration of wider benefits, including factors such as unmet need, carer benefits and the extent of innovation. Second, the use of cheap generic medicines as comparators to measure the cost-effectiveness of a new and innovative branded medicine makes it very difficult to demonstrate the new medicine's cost-effectiveness, even where it offers considerable improvements in patient health. This practice is a disincentive to innovate in areas that have not seen any innovation for years.

Likewise, the scale and nature of pharmaceutical innovation is little understood. For every 25,000 compounds tested in the laboratory, only 25 reach clinical trials; of those, just five are eventually approved for use. And there is a tendency to undervalue the small, incremental development steps that constitute most advances in medicine, and which collectively serve to transform treatment, in favour of the big step-change breakthroughs. The failure to recognise and reward incremental innovation potentially endangers improvements in healthcare and the industry's ability to fund each new generation of medicines.

The pharmaceutical industry wants the UK to continue to prosper as a world leader in innovation, and to ensure this remains the case, we want to help combat what has been a sharp fall in the number of patients involved in clinical trials in this country. It is critical that we can attract this kind of research investment to the UK. Through the ABPI, the pharmaceutical industry is working with the government and the NHS to address gaps in school science education, to encourage universities to provide rigorous bioscience degrees, to remove the barriers between private- and public-sector research partnerships, and to incentivise NHS trusts to participate in clinical trials.

Creating the right environment to encourage and incentivise innovation is vital. A stable, flexible and equitable pricing system is another necessity, and progress towards such a system is promised by the latest Pharmaceutical Price Regulation Scheme. The concept of

² Kennedy, I *Appraising the Value of Innovation & Other Benefits: A Short Study for NICE* (July 2009)

flexible pricing recognises that the initial launch indication of a medicine may not fully reflect its longer-term value to patients.

Joint working

Pharmaceutical companies have much more to offer the NHS than simply the expertise to develop new medicines. We also have the management skills and the resources of people and knowledge to forge a greater bond with our partners at the sharp end of delivering healthcare in the UK. This is our objective, and already some ABPI member companies are putting this into practice with certain NHS trusts.

The issues explicit in the QIPP (quality, innovation, productivity and prevention) challenge, which is driving efforts to ensure the continuation of high-quality patient care, are central to making these relationships successful.

The Joint Working initiative between the pharmaceutical industry and the Department of Health has been formalised through the publication of guidance notes for NHS organisations,³ and through the launch in March 2008 of the "Moving Beyond Sponsorship" joint working toolkit.⁴ This online resource contains advice on establishing joint working relationships, how they should be managed and measured, and examples of good joint working practice that already exist; it provides a number of downloadable templates to help people make such projects a success.

It is important to note that the new joint working is quite different from the more traditional practice of sponsorship. We are talking about far more than simply providing funds for a specific programme of improved patient care; joint working as defined in the Department of Health/ABPI joint working toolkit refers to situations where, for the benefit of patients, the NHS and the pharmaceutical organisation, there is pooling of skills, experience and/or resources for the joint development and implementation of patient-centred projects; it demands a shared commitment to successful delivery.

Goals are agreed in advance and a joint working agreement is drawn up. Management arrangements are conducted with participation from both parties in an open and

3 Department of Health *Best Practice Guidance for Joint Working between the NHS & the Pharmaceutical Industry* (February 2008) – "joint working guidance" (http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_082370)

4 Department of Health/Association of the British Pharmaceutical Industry *Moving Beyond Sponsorship: Interactive Toolkit for Joint Working between the NHS & the Pharmaceutical Industry* (March 2008) – "joint working toolkit" (http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_082840)

transparent manner. There must be benefits for patients and there can be benefits for patients and there can be benefits for the NHS and the pharmaceutical companies. This commitment to a shared vision and a more mature relationship between pharmaceutical company and NHS organisation has already proved it can deliver better patient care.

No one is pretending that joint working is easy. The barriers to success are great, and have to be systematically addressed at the outset. They include a backdrop of mutual mistrust and antagonism that must be consigned to history. But the cultural barriers are not the only ones arrayed against successful joint working; there are also those of resource and organisation to overcome. Increased bureaucracy out of proportion to benefit, or an inequitable division of workload, could lead to failure; so also could lack of clarity in defining the scope of responsibility and accountability. It is for exactly this reason that the joint working toolkit has been developed.

Certain safeguards have been built in to ensure probity. The ABPI's own guidance notes on joint working⁵ state that explicit references to a pharmaceutical company's medicine within joint working arrangements are only likely to be acceptable if they are framed in the context of patient care, if the medicine is used in accordance with nationally accepted treatment guidelines, and if there is no inducement to prescribe that product. ABPI member companies are required to comply with the ABPI code of practice for the pharmaceutical industry,⁶ which is designed to ensure a professional and ethical approach to the promotion of medicines in the UK, and their appropriate use in support of the provision of high-quality patient care. (Pharmaceutical companies that are not members of the ABPI are also encouraged to comply with the ABPI code.)

The ABPI is committed to ensuring that the benefits of the new joint working are communicated to all stakeholders. As an industry, we consider this to be a vital strategic aspect of our future relationship with the NHS. The ABPI's NHS partnership programme (previously NHS outreach) was set in motion because of requests from our member companies that we create this platform for closer engagement.

Most importantly, the successes that have already been achieved by ABPI members working with NHS partners must be given the high profile they deserve. Not only will this inspire more NHS personnel to seek these relationships, but it could also clear a pathway to the

⁵ ABPI *Guidance on Joint Working between Pharmaceutical Companies & the NHS for the Benefit of Patients Taking into Consideration the 2008 ABPI Code of Practice for the Pharmaceutical Industry* (http://www.abpi.org.uk/publications/pdfs/ABPI_Code_Guidance_Notes.pdf)

⁶ ABPI Code of Practice for the Pharmaceutical Industry 2008 (<http://www.pmcpa.org.uk>)

national rollout of what are so far only local and regional initiatives. The QIPP programme envisages exactly this kind of extension of good practice.

The quality, innovation, productivity and prevention (QIPP) challenge

Clearly, there are many complex issues involved in NHS-wide implementation of joint working, and the ABPI has therefore selected and presented to the Department of Health a number of tried and tested schemes (rather than radically new and unproven ideas), which have the potential to be up-scaled in this way, as part of the QIPP challenge. Currently, QIPP focuses on three areas of therapeutic need: chronic obstructive pulmonary disease (COPD), dementia and diabetes.

COPD

COPD is a priority area for Salford Primary Care Trust, which has a recorded prevalence of 2% (4,640 diagnosed patients), with actual prevalence estimated to be up to 4.7% (10,904 patients). GlaxoSmithKline (GSK) has partnered with the primary care trust to improve primary care management capabilities and capacity. The objectives of the project are to reduce inappropriate hospital admissions and referrals and reduce inequalities across the primary care trust. This will be achieved by up-skilling clinical staff, moving COPD management to NICE standards, and standardising care across the eight practice-based commissioning clusters (comprising 59 practices).

Variations in care were identified through a health needs analysis, and an integrated strategic approach to address the issues identified was then implemented. Existing services were redesigned to support this approach. This was done in an integrated manner, bringing together expertise from primary and secondary care and the pharmaceutical industry.

Capability was addressed through development and implementation of a best-practice COPD management guideline. This included referral to specialist interventions (consultant-led community clinics, pulmonary rehabilitation and home oxygen). Self-management action plans and a bespoke healthcare professional educational programme were developed jointly by the specialist respiratory nurses, secondary care consultants and GSK's respiratory care associates, following the completion of a health needs assessment.

GSK's POINTS system was deployed in a large number of practices, enabling healthcare professionals to identify and optimise the treatment of at-risk and undiagnosed COPD patients. It also allowed the primary care trust to benchmark its current treatment and management strategies and track progress towards the achievement of NICE

standards. The evolution capacity was increased through deployment of additional nurse resource by the primary care trust and third-party contract nurses by GSK, working together in a collaborative manner to deliver local policies and guidelines.

Over 1,300 at-risk patients were identified for diagnosis and review. The primary care trust was able to develop and implement best-practice guidelines and improve consistency of care. For GSK, the enhanced services grew the market for appropriate COPD medicines prescribing. Evaluation of the project is continuing and analysis of the POINTS database is being undertaken.

A number of other pharmaceutical companies (Pfizer, AstraZeneca, Boehringer Ingelheim and Novartis among them) are also working with local NHS organisations on different aspects of the COPD care pathway. Many other pharmaceutical companies would welcome the opportunity to engage with key stakeholders on diagnosing the issues around the management of COPD patients.

Dementia

Implementation of the national strategy for dementia has been patchy, and the condition is particularly challenging, given that it crosses both health and social care boundaries.

But two pharmaceutical companies – Pfizer and Eisai – have been working together on a number of activities to promote adoption and implementation of the national strategy, and they report some success in a number of local areas, notably in Norwich. This success is potentially scalable across the NHS, but NHS stakeholder (both clinical and managerial) and patient input is essential.

The Pfizer/Eisai programme involves:

- **Raising public awareness of early signs of dementia**
The public are also encouraged to seek help at an earlier stage. Earlier management and treatment of dementia would mean that patients would decline less rapidly; this would deliver subsequent savings in NHS and nursing home costs. Local studies suggest that approximately 10% of people that contact the service are referred for further investigation or assistance.
- **Developing health economic models for local primary care trusts**
The development of such models to aid in planning and service provision allows primary care trusts to look at their current service provision and manage the

changing demand and outcomes for dementia care.

- **Providing training and education for clinicians**

Clinicians are helped to recognise and appropriately refer and manage dementia patients.

Diabetes

Pharmaceutical companies are also working with stakeholder groups on the implementation of the national strategy for diabetes, and the development of a national commissioning set for diabetes services. This would result in improved consistency of diabetes care at a grass-roots level, with increased opportunities to implement best practice across the NHS.

Using its proven expertise in organising educational events, the pharmaceutical industry could play a powerful role in engaging and informing networks and local clinical teams, to ensure that this is achieved. As ever, the biggest challenge will be implementation, and the application of pharmaceutical companies' project management and business skills can help to deliver success.

Conclusion

Our vision for working alongside government and the NHS is an exciting one, and one that is strengthened and articulated through the ABPI's stated imperatives of value, innovation, trust and access. The pharmaceutical industry welcomes the pro-innovation features packaged in the 2009 Pharmaceutical Price Regulation Scheme, and wants to engage with the NHS in new ways, such as joint working projects that deliver value for patients, the NHS and pharmaceutical companies.

Central to our vision is the idea that medicines be used appropriately to maximise the benefits of innovation to the patient, the NHS and the taxpayer. In so doing, the UK will continue to be a world leader in biomedical innovation. The UK pharmaceutical industry will play a full part in transforming this vision into reality.

Chapter 5

Realising the potential of pharmacy

David Pruce, Director of PruceConsulting

Realising the potential of pharmacy

Politicians of every party agree that there is great potential in pharmacy to contribute to the UK's health. In 2008, Dawn Primarolo, then minister of state for public health, said, "I can see that pharmacy has the potential to offer so much more."¹ Meanwhile, Mark Simmonds, shadow health minister, said in May 2009:² "For too long, pharmacy has languished as an underused resource."

Such comments are not new – the potential of pharmacy, particularly community pharmacy, has been recognised for decades. In 1986, the Nuffield Foundation held an inquiry into the future of pharmacy. The report said of community pharmacy: "Their education and training equip pharmacists to play a 'unique and vital role' in provision of health care in the community, but this is not being realised in practice."³

So what is the potential of pharmacy and can it finally be unlocked?

The 2008 white paper *Pharmacy in England: Building on Strengths – Delivering the Future* set out a range of potential roles for community pharmacy, such as:

- becoming "healthy living" centres – promoting health and helping more people to take care of themselves;
- offering NHS treatment for many minor ailments (such as coughs, colds and stomach problems) for people who do not need to go to their local GP;
- providing specific support for people who are starting out on a new course of treatment for long-term conditions such as high blood pressure or high cholesterol; and
- offering screening for those at risk of vascular disease – an area in which there are significant variations in access to services and life expectancy around the country.

This is a broad agenda, ranging from public health to long-term conditions to minor ailments and health screening. It is so wide that it could touch every man, woman and child in the UK, and perhaps this is part of the problem. The sheer scale of the agenda makes it difficult to know where to start and where pharmacy could have the most impact.

1 Department of Health *Pharmacy in England: Building on Strengths – Delivering the Future* (April 2008)

2 http://www.pjonline.com/news/conservatives_seek_to_empower_pharmacy

3 Committee of Inquiry *Pharmacy: A Report to the Nuffield Foundation* (Nuffield Foundation, 1986)

It might be useful to think in terms of the problems that we are trying to solve by using pharmacists in these ways. The issues can largely be split into those directly associated with medicines and their use and wider issues that require input from across health and social care. The medicines-related issues play to the pharmacists' core expertise in the use of medicines, while the wider issues build on the pharmacy's position in the community and the accessibility of pharmacists as healthcare professionals.

There are significant problems associated with the use of medicines. Medicines are estimated to account for between 4% and 6.5% of emergency admissions to hospital.⁴ Reasons put forward for this rate of admission are adverse drug reactions, prescribing errors, sub-optimal prescribing and poor adherence. This makes medicines a major cause of unplanned hospital admission, with the associated costs and effects on patient care. A major study by the General Medical Council builds on the theme of prescribing errors.⁵ This study found a prescribing error rate of 8.9 errors per 100 prescriptions in hospitals. Fortunately, it also reported that most errors were intercepted before they caused harm and that doctors relied heavily on pharmacists and nurses to identify and correct errors.

Prescribing alone does not account for the problems associated with medicines. Even if the prescription is perfect, the medicines may not be taken correctly by the patient. The National Institution for Health & Clinical Excellence (NICE) clinical guideline on medicines adherence⁶ states:

It is thought that between a third and a half of all medicines prescribed for long-term conditions are not taken as recommended. If the prescription is appropriate, then this may represent a loss to patients, the healthcare system and society. The costs are both personal and economic.

The cost of medicines and the amount of medicines wasted is of serious concern, particularly in the current economic climate. The National Audit Office report on prescribing costs in primary care⁷ suggested that GPs could prescribe lower-cost

4 Howard, R, Avery, A and Bissell, P "Causes of Preventable Drug-related Hospital Admissions: A Qualitative Study" in *Quality & Safety in Health Care* no 17 (2008), pp109-116; Pirmohamed, M et al "Adverse Drug Reactions as Cause of Admission to Hospital: Prospective Analysis of 18,820 Patients" in *BMJ* no 329 (2004), pp15-19

5 Dornan, T et al *An In-depth Investigation into Causes of Prescribing Errors by Foundation Trainees in Relation to their Medical Education* (General Medical Council, December 2009) (http://www.gmc-uk.org/FINAL_Report_prevalence_and_causes_of_prescribing_errors.pdf_snapshot.pdf)

6 Guideline CG76 (2009) (<http://www.nice.org.uk/nicemedia/pdf/CG76NICEGuideline.pdf>)

7 Department of Health *Prescribing Costs in Primary Care* (May 2007)

clinically effective medicines without affecting patient care, saving primary care trusts more than £200 million a year, and said that unused or wasted drugs could cost the NHS at least £100 million a year. Many trusts have developed prescribing incentive schemes to help reduce medicines costs. However, a recent judgement by the European Court of Justice has put the legality of these schemes in doubt.⁸

Problems with medicines management in care homes were highlighted by the Commission for Social Care Inspection,⁹ and in the transfer of patients between hospital and primary care by the Care Quality Commission.¹⁰

The desire to make better use of pharmacy does not just come from problems with medicines use. There is a major government agenda to encourage people to care for themselves, particularly for minor ailments. It is estimated that about 57 million GP consultations per year involve minor ailments and each take up to the equivalent of one hour of a GP's time.¹¹ A number of medicines have shifted from being prescription-only to being available for sale from pharmacies, although there have been worrying reports of poor standards of control of these sales in some pharmacies.¹²

In the reports by the General Medical Council, the Care Quality Commission, the Commission for Social Care Inspection and the National Audit Office, pharmacists were seen as a major part of the solution to the issues raised. Pharmacists already play an important role in reducing harm from medicines and in optimising their use. However, there is obviously much that remains to be done to address the problems associated with medicines use in every healthcare setting, from hospitals to primary care to care homes.

Pharmacy could also play a part in addressing wider health issues. These include stopping smoking, obesity management, sexual health, needle and syringe exchange schemes, and health screening. The accessibility of the pharmacy in the community has led to the development of a number of services aimed at improving the health of

8 "Prescribing Incentive Schemes May Be Illegal under EU Law" in *Pharmaceutical Journal* no 284 (2010), p178

9 Commission for Social Care Inspection *Handled with Care? Managing Medication for Residents of Care Homes & Children's Homes – A Follow Up Study* (February 2006)

10 Care Quality Commission *Managing Patients' Medicines after Discharge from Hospital* (October 2009)

11 Joint Proprietary Association of Great Britain/Pharmaceutical Services Negotiating Committee submission to the pharmacy white paper, 2007 (http://www.psn.org.uk/publications_download.php/231/PAGB_and_PSNCPaper_on_minor_ailments.pdf)

12 "Pharmacies Get Test of own Medicine" (<http://www.which.co.uk/news/2008/09/pharmacies-get-test-of-own-medicine-157330>)

the public. It is estimated that 1.6 million visits to pharmacies take place each day, of which 1.2 million are for health-related reasons.¹³ There is good evidence supporting the effectiveness of public health interventions from community pharmacies.¹⁴ These services can be and are offered by other healthcare professionals, but the pharmacy setting is convenient, often with extended opening hours, and is a less formal environment. This enables services to be delivered to people who may not otherwise access them and do not consider themselves to be ill.

What is stopping the potential of pharmacy from being realised?

Innovators in pharmacy are keen to develop new services and to use their skills to improve patient care. The barriers arise when attempts are made to move from pilot to mainstream. The problems for pharmacy arise at a number of different levels: contractual and commissioning; structural issues within pharmacy; and cultural issues.

Contractual and commissioning issues

The new community pharmacy contractual framework in England in 2005 signalled "a move towards reward for quality rather than simply volume of service provided". The aim was to shift from a payment system based on the number of prescriptions dispensed to one that recognised the contribution of pharmacy to improving health. The changes to the community pharmacy contract have largely failed to bring about this shift. The majority of the income of community pharmacies still comes from dispensing, which amounts to more than 90% of turnover for the typical independent pharmacy.¹⁵ The service that was expected to drive the move towards the delivery of a more clinical pharmacy service was the medicines use review. There was a slow uptake of this service by community pharmacies, with numbers only reaching 1.38 million medicines use reviews by 2008/09¹⁶ out of a possible 4.19 million.¹⁷

A national evaluation of the community pharmacy contract pointed to a number of failings, including a lack of implementation and change management

13 Department of Health *Pharmacy in England: Building on Strengths – Delivering the Future* (April 2008)

14 Anderson, C, Blenkinsopp, A and Armstrong, M *The Contribution of Community Pharmacy to Improving the Public's Health: Summary Report of the Literature Review 1990–2007* (March 2009); five earlier reports at PharmacyHealthLink

15 Pharmaceutical Services Negotiating Committee *PSNC's Brief Guide to Community Pharmacy Economics* (2009) (http://www.psn.org.uk/data/files/Funding/psnc_brief_guide_to_pharm_economics.pdf)

16 The maximum number of medicines use reviews that each pharmacy may undertake is set at 400 per year.

17 NHS Information Centre *General Pharmaceutical Services in England 1999–2000 to 2008–09* (November 2009) (http://www.ic.nhs.uk/webfiles/publications/Primary%20Care/Pharmacies/pharmserv9909/General%20Pharmaceutical_Services_in_England_1999_2000_to_2008_09.pdf)

plans.¹⁸ There seemed to have been little thought put into how pharmacy would cope with such a major change or how to integrate the pharmacist's review with the other care the patient receives. Despite this, there is evidence that patients appreciate and follow the advice that they receive from pharmacists.¹⁹

Local commissioning of services is variable across England and Wales. A wide variety of services have been commissioned from pharmacies, including stop-smoking services, supervised administration of methadone, minor ailment schemes, and a variety of patient group direction schemes. There has been little consistency over what is commissioned or the requirements for similar services. This led NHS North West to develop a Harmonisation of Accreditation Group to standardise the future accreditation requirements when commissioning services from pharmacies.²⁰

Pharmacists frequently report frustration about the lack of long-term commitment to locally commissioned services, with yearly changes resulting in pharmacists investing in developing a new service only to see it cut or decommissioned. There is a lack of understanding between commissioners and pharmacy of each other's roles and priorities, which led to the Department of Health issuing a practical guide to support primary care trusts in commissioning pharmaceutical services.

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The All-Party Pharmacy Group in its inquiry into the future of pharmacy recommended: "We wish to see an increase in nationally agreed funding for Advanced and Essential services, and a move away from discretionary funding by PCTs for Enhanced services."²³

18 Blenkinsopp, A et al *National Evaluation of the New Community Pharmacy Contract* (Pharmacy Practice Research Trust, 2009) (http://www.pprt.org.uk/Documents/ResearchFunding/National_evaluation_of_the_new_community_pharmacy_contract.pdf)

19 "Over 90% of Patients Follow MUR Advice, National Audit Finds" in *Pharmaceutical Journal* vol 284 (2010), p178

20 "NHS North West Community Pharmacy Enhanced Services Harmonisation of Accreditation" (<http://www.pcc.nhs.uk/200>)

21 All-Party Pharmacy Group *The Future of Pharmacy – Report of the APPG Inquiry* (June 2007) (http://www.appg.org.uk/documents/ThefutureofPharmacy_004.pdf)

22 Department of Health *World Class Commissioning: Improving Pharmaceutical Services* (March 2009)

23 All-Party Pharmacy Group, op cit

Structural issues

An underlying weakness of community pharmacy is that the majority of community pharmacies have only one pharmacist in the pharmacy at any time. The pharmacist is responsible for dispensing, sales of all medicines and for any additional clinical services such as medicines use reviews or locally commissioned services as well as staff management and other matters. The average pharmacy dispenses 6,400 prescription items each month, with many dispensing a far greater number. The number of prescriptions issued increases at the rate of over 5% each year, equating to an increase of two-thirds over the past 10 years, but there has been little or no change in staffing numbers over the same period.²⁴

The majority of dispensing involves selecting the right pack of medicines and putting the right instructions on it. It is a manual task, crying out for automation. Even simple technology such as barcode scanners cannot be used in dispensing, because there is no standard barcode system used by manufacturers.

It is further complicated by the need to cut up strips of tablets for between a quarter and a third of all prescriptions, because the quantity prescribed does not match the pack size. If 30 tablets are prescribed and the pack contains 28 tablets, the pharmacist has to open up another pack and cut two tablets from it.²⁵

Hospital pharmacists have invested heavily in technology and many have robotic dispensing machines that help them spend less time in the dispensary and more time on the wards working on patient care.

Repeat dispensing and the electronic prescription service were highlighted in the pharmacy white paper as key ways of managing workload for both prescribers and pharmacists. Electronic prescriptions prevent the need to re-key information from a paper prescription, while repeat dispensing would allow pharmacies to better plan and manage their dispensing service. Unfortunately, both these innovations have been painfully slow to be implemented and are running several years behind schedule.

Cultural issues

Dispensing is a task that has moved from the compounding of mixtures requiring considerable professional expertise to the selection and labelling of the correct box

24 NHS Information Centre, *op cit*

25 "Thousands of Pharmacists Join Call for Original Pack Dispensing", news release from the Royal Pharmaceutical Society of Great Britain, 2 February 2010 (<http://www.rpsgb.org/pdfs/pr100202b.pdf>)

of tablets. The complexity of dispensing has significantly decreased, but the number of items dispensed has significantly increased and continues to do so. Each prescription must be checked by the pharmacist to ensure that it is clinically appropriate, and the pharmacist is legally responsible for the accuracy of all prescriptions dispensed.

A simple dispensing error can result in patient harm and a potential criminal prosecution.²⁶ The awareness of possible harm, a perception of overzealous regulation and the risk of legal action makes pharmacists reluctant to delegate responsibility for checking the accuracy of each prescription dispensed. Staffing levels have changed little in pharmacies, although pharmacy technicians are increasingly being used in dispensing. Some of these are trained as accuracy checking technicians, who have been accredited to check the accuracy of dispensing.

Community pharmacists have tended to simply add additional tasks such as medicines use reviews into an already crowded schedule. The workload of community pharmacists has reached a worrying level, with Royal Pharmaceutical Society research reporting that the levels of stress in the profession are "extremely high" and related to "high levels of work overload, and working long hours."²⁷ This was considered so serious that the society issued a council statement requiring pharmacists to take regular rest breaks in the interests of patient safety.²⁸

Community pharmacists work in relative isolation from both their peers and the rest of the health service. The interactions with GPs are mostly through the medium of a prescription – either receiving a prescription from a GP or querying aspects of the prescription with the GP. The relationship between community pharmacists and GPs has not been a high priority for either profession and has often been marred by disputes over dispensing rights. This sense of isolation is also reflected in pharmacists' engagement with local primary care trusts, which varies greatly.

A greater clinical role for pharmacists increases the need for collaboration and good communication between pharmacists and other members of the healthcare team. This is particularly so where pharmacists are becoming prescribers, where it is vital that everyone prescribing for a patient is aware of the actions of other prescribers.

26 "Pharmacists Attack Unfair Law" at BBC Online, 16 June 2009 (<http://news.bbc.co.uk/1/hi/health/8101446.stm>)

27 Open letter from the president of the Royal Pharmaceutical Society, 2009 (<http://www.rpsonline.com/fileproxy/4452>)

28 Royal Pharmaceutical Society of Great Britain *Workplace Rest Breaks* (2009) (<http://www.rpsgb.org/pdfs/workplacrestbreakscounstat.pdf>)

How can the potential of pharmacy be released?

Although steps have been taken to releasing the potential of pharmacy, there remain significant barriers.

General practice has moved away from single-handed practices, and community pharmacy could follow its example bringing together pharmacies to form "superpharmacies" with a number of pharmacists in each pharmacy. This would allow increasing specialisation and bring economies of scale such as through the use of robotic dispensing machines. It could, however, have adverse effects on patient access and be difficult to achieve because of the current models of pharmacy ownership.

A more viable option would be use a hub-and-spoke model of dispensing whereby most dispensing is performed centrally in a "hub" pharmacy and distributed through a number of local "spoke" pharmacies. This enables economies of scale while keeping the local accessibility of community pharmacies. It is easier to see this model working within single companies, although it could be made to work through a co-operative or contracting model.

The solution in the short-to-medium term is to facilitate smarter working. Hospital pharmacy has achieved this through a mixture of technology and better use of support staff. The hospital pharmacist clinically checks the appropriateness of prescriptions and then hands over dispensing to support staff and robotic dispensing machines. Community pharmacy desperately needs to adopt similar solutions. The government could help this by amending legislation to allow pharmacists to dispense only whole packs of medicines, removing the need to cut up packs. Accelerating the introduction of the electronic transfer of prescriptions and repeat dispensing would speed up dispensing and allow for better work planning.

In turn, these moves would facilitate the introduction of improved technology. Technology already exists that would allow pharmacists to authenticate and verify each individual medicine at the point of dispensing through real-time scanning, and is in use in Belgium, Greece and Italy.²⁹ This would give pharmacists the confidence to delegate more dispensing to support staff.

An important aspect of releasing the potential of pharmacy is to give a clear signal to pharmacists, patients, the public and other professions that these services are not optional extras. If a service is optional, the implication is that it is not important

29 "Aegate Steals a March in War against Counterfeit Drugs" in Independent on Sunday, 23 November 2008

and not worth investing in. Many of the locally commissioned services are national priorities, such as stopping smoking. These should be built into the national contract for pharmacy and delivered consistently across the country. Similarly, the contracts for pharmacy and for general practice should be more closely aligned, with clear incentives to work together rather than competing. The All-Party Pharmacy Group advocated a quality and outcomes framework for pharmacy. We should go further than that and include in the relevant quality and outcomes frameworks key elements that can only be achieved through joint working, forcing the two professions to work together.

Local commissioning is important, but it needs to take a more holistic approach, focusing on the overall health needs of the local population. There should be an expectation that all relevant health professionals will contribute to meeting these needs. This is no different from the commissioning of a procedure from secondary care, where it would be inconceivable to exclude the nursing care, physiotherapy, pharmacy, pathology and so forth, from being part of the package. The pharmaceutical care of the patient in primary care has to be built into local commissioning from the start, rather than as an optional extra.

Finally, a change in culture is required in pharmacy. The profession needs to show leadership, state where pharmacy is heading and help pharmacists make the change. The NHS has a critical role in supporting the profession in making this change. A major failure of the introduction of medicines use reviews was to fail to anticipate the change management support required. Change management needs to be taken seriously by both pharmacy and the NHS.

Community pharmacy is a customer-driven profession. If patients, and the public, do not like the service they receive, they can take their custom elsewhere. However, the public can drive change only if they are aware of the services they can expect to receive. The pharmacy white paper included a commitment to deliver a communications strategy to "improve awareness and understanding of the role of pharmacy in providing services". This commitment has not been delivered and needs to be revisited. The public needs to be aware of what it can expect from pharmacy – only then can it use its "purchasing power" to shop around for the best service.

The potential of pharmacy can be released, but it needs the profession and the NHS to work together and a commitment from both sides to deliver the benefits that have been talked about for decades.

Chapter 6

Living well – shifting the public health debate

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Living well – shifting the public health debate

Overview

This paper will set out the challenge for public health systems (which are well beyond the NHS and include all sections of civil society) to do “more with less” in the light of:

- the Marmot review¹ of health inequalities in England, published in February 2010;
- the burgeoning work and evidence (including some tantalising new measures) on the importance of well-being as a core concept for population health; and
- developments in the North West region that build on these two and indicate a route to transforming action.

The core argument is that policy debate, conceptual frameworks, practice, spending priorities, partnership working, research methodologies and modes of public engagement must all shift from the current health/illness spectrum to the promotion of “living well” and the adoption of measures that enable individuals and communities to shift from languishing to flourishing. Even a small change in the shape of this curve could achieve massive benefits – including, we suggest, reductions in the utilisation of health and social care provision in its current pattern and the development of new kinds of arrangements which would add social and public value, particularly in geographical areas where there are entrenched health inequalities and low levels of social capital.

This must also involve a recognition of what needs to happen if the state is to create the enabling conditions for people properly to take care of themselves and others – and to contribute to other dimensions of “living well”, including the development of more convivial and cohesive local communities and moving towards carbon-reducing lifestyles.

Introduction

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 had sustained effects on population health. An earlier contribution to the Smith Institute monograph *Health Futures*² questioned the public health policy focus on inequalities in health outcomes (life expectancy and infant mortality) rather than a broader focus

1 Marmot, M *Fair Society, Healthy Lives – The Marmot Review Final Report* (February 2010)

2 Churchill, N (ed) *Health Futures* (Smith Institute, May 2009) (http://www.smith-institute.org.uk/smith-engine/_filesmgr/File/HealthFutures.pdf)

on the social justice imperatives implied in addressing what the Commission on the Social Determinants of Health terms "the wider, distal determinants of health". Questions were raised about tackling the social gradient, since inequities in health are not confined to the poorest, and about whether the preponderance of targeted interventions in the UK, such as those focused on the Spearhead group of local authorities with the lowest levels of life expectancy, were part of the problem rather than the solution.

A year on, this paper aims to draw on not only the building momentum in the UK concerning health inequalities, partly galvanised by the Marmot review, but also the gathering challenges facing the public sector as a whole, in order to set out a major shift in approach. This shares thinking stimulated by pioneering work in the North West region about how the concept of "living well" can help change assumptions and practice in this area. It represents a further step in making the "third horizon"³ in public health more visible and in offering some conceptual support for a change in mindset that can motivate people engaged in this work.

The challenges

The prosperity and resilience of the UK is closely related to the health and well-being of the people who live in it. This is to some extent self-evident. An educated population, equipped with the tools and conditions to make and grasp opportunities, to care effectively for themselves and others, and to avoid preventable illness and disability, and committed to living purposeful and creative lives, is more likely to contribute to a sustainable society and economy than one that is thwarted, disengaged and debilitated by poor health. However, this is not just assertion. Accumulating evidence demonstrates the vital and complex relationship between the health of the public and the overall well-being of the nation.

Suhrke, McKee et al⁴ and many others, including the 2001 Commission on Macroeconomics & Health – a World Health Organisation initiative – suggest that the evidence points to the need for a new understanding of population health as a key determinant of economic success as much as the other way round. The suggestion is that there is a bi-directional relationship between health and social and economic

³ The third horizon is the long-term successor to "business as usual" or reforms that attempt to "improve" (the first and second horizons). It is the radical innovation that introduces a completely new way of doing things but begins as marginal activity, sometimes perceived as way off-beam or marginal by the mainstream. See: Duggan et al, "Leading Innovation in Public Health" in Churchill, op cit

⁴ Suhrcke, M, McKee, M, Sauto Arce, R, Tsolova, S and Mortensen, J *The Contribution of Health to the Economy in the EU* (Office for Official Publications of the European Communities, 2005)

success overall so that “this mutually reinforcing relationship between health and the economy ... provides a higher return from investing a given amount in both compared with investing the same amount in one or the other”. However, in most high-income countries government and society at large see health status as a cost rather than as an investment in a sustainable future in which the majority can live well.

In the UK, we are at a critical moment in history. While the organised efforts of society and huge scientific and technological advances have ensured that most of us live longer and healthier lives than at any other time, there are forces that threaten to overwhelm and reverse progress.

A new wave of health threats

New threats to health and well-being include rising levels of obesity, poor mental well-being among young people, and the long-term effects of widespread alcohol misuse. Meanwhile, other challenges are emerging that, in our lifetimes, are likely to shake systems to the core. These include:

- the potential impacts on human health of climate change (for example, flooding) and environmental degradation (for example, loss of green space and contact with nature, leading to reduced physical activity and mental ill health);
- the need to respond to the issues posed by an ageing population and the imbalance in opportunities for different generational cohorts; and
- the long-term effects of protracted economic crisis, with widespread unemployment and increasing levels of poverty among key social groups, including children and young people.

Potentially huge benefits are associated with a shift in thinking and planning from the current focus on disease to that of well-being, where health is seen as a positive state rather than simply the absence of illness. It is estimated that even a small shift in the numbers of people who feel they enjoy well-being and so are better able to respond to illness or adversity would achieve massive benefits, including:

- improving the health and well-being of all across the social gradient;
- reducing prevalence of illness;
- more efficient use of current health and social care services; and
- the development of new services and modes of procuring them that would add social and public value.

The evidence for a new approach

There are two main sources of evidence for the benefits that might accrue from such a shift in thinking:

- the Marmot review, and its global forerunner from the World Health Organization, *Closing the Gap in a Generation*;⁵ and
- burgeoning work on the importance of well-being as a core concept for population health.

The Marmot review

The six main recommendations of the Marmot review are:

- giving every child the best start in life – which the review emphasises as its highest-priority recommendation;
- enabling all children, young people and adults to maximise their capabilities and have control over their lives;
- creating fair employment and good work for all;
- ensuring a healthy standard of living for all;
- creating and developing sustainable places and communities; and
- strengthening the role and impact of ill-health prevention.

Professor Marmot commented on the findings of the review:

There will be those who say that our recommendations cannot be afforded, particularly in the current economic climate. We say that it is inaction that cannot be afforded, the economic and more importantly human costs are simply too high.

The health and well-being of today's children, and of those children when they become adults, depend on us having the courage and imagination to do things differently, to put sustainability and well-being before a narrow focus on economic growth and bring about a more equal and fair society.⁶

The evidence of the Marmot review 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 the majority of the population.⁷ For example, rates

⁵ World Health Organization *Closing the Gap in a Generation* (November 2008)

⁶ Executive summary of the Marmot review, p29 (www.ucl.ac.uk/marmotreview)

⁷ Pickett, K and Wilkinson, R *The Spirit Level: Why Greater Equality Makes Societies Stronger* (Allen Lane, 2009)

of mental illness are five times higher across the whole population in the most unequal than in the least unequal societies in their survey. One explanation, they suggest, is that inequality increases stress right across society, not just among the least advantaged.

Wilkinson and Pickett show that the different social problems that stem from income inequality often 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 since 1990; in America it has quadrupled since the late 1970s.

Other international studies suggest that for nations as a whole, reported happiness and well-being is related less to overall GDP than to equivalence of income levels. For instance, where there is high observed inequality of wealth, such as in the UK and the US, both rich and poor are less satisfied with their lives.⁸ Where countries appear to have more similar income levels across social groups, such as in Sweden or Costa Rica, populations tend to report higher levels of life satisfaction irrespective of income.⁹ These measurements are somewhat crude and not easy to interpret, but other evidence also suggests that high levels of inequality are strongly related to poor mental well-being and that people are more likely to report positive mental well-being if their experience is that society is fair.

Other national evidence

- **The 2008 Foresight report on mental capital** describes mental well-being as a dynamic state referring to an individual's ability to "develop their potential, work productively and creatively, build strong and positive relationships with others and contribute to their community".¹⁰ It has also been defined as "a positive sense of well-being and an underlying belief in our own, and others' dignity and worth".¹¹ The New Economics Foundation says that "well-being is more than happiness and satisfaction. It includes developing as a person, being

8 See: Friedli, L *Mental Health, Resilience & Inequalities* (WHO Regional Office for Europe, March 2009) (www.mentalhealth.org.uk/publications/mental-health-resilience-and-inequalities-report); Wilkinson and Pickett, op cit

9 Abdallah, S, Thompson, S, Michaelson, J, Marks, N and Steuer, N *The UnHappy Planet Index 2.0 – Why Good Lives Don't Have to Cost the Earth* (New Economics Foundation, 2009) (<http://www.happyplanetindex.org/>)

10 Foresight *Mental Capital through Life: Future Challenges* (2008); Foresight *Well-being & Work: Future Challenges* (2008) (www.foresight.gov.uk/OurWork/ActiveProjects/Mental%20Capital/ProjectOutputs.asp)

11 Health Education Authority *Mental Health Promotion: A Quality Framework* (1997)

fulfilled and contributing to society".¹² Friedli reported in 2009 on the strong relationship between inequalities and mental well-being.¹³

- **The Department of Health's New Horizons**¹⁴ replaces the 1999 National Service Framework for Mental Health. In contrast to the old framework, which focused on service improvement for mental health services, the new policy embraces the wider health, social and economic benefits of promoting good mental health for everyone (such as improved educational attainment, reduced antisocial behaviour, fewer days off work and improved health), summing this up in an evidence-based model that emphasises the broader social determinants of health, such as employment, education, housing, community cohesion, and makes links to physical health and well-being.¹⁵
- **Lord Ara Darzi's 2007 report**¹⁶ emphasises the necessity of improving the mental health of the population, making promotion of good mental health one of six goals for the local NHS, which is tasked with commissioning services that promote well-being in partnership with the local authority. The National Institute for Health & Clinical Excellence (NICE) has produced a number of reports on promoting well-being¹⁷ and various guidance on living well in relation to physical activity¹⁸ and public involvement.¹⁹
- **The Local Well-being Project by the Young Foundation**, a social innovation centre involved in practical research, is one of the first policy trials to target improving community well-being by working directly with three local authorities,

12 New Economics Foundation *A Well-being Manifesto for a Flourishing Society* (2004)

13 Friedli, op cit

14 Department of Health *New Horizons: Towards a Shared Vision for Mental Health – Consultation* (July 2009) (www.dh.gov.uk/en/healthcare/mental+health/newhorizons/index.htm)

15 Department of Health *Flourishing People, Connected Communities A Framework for Developing Well-being* (June 2009)

16 Darzi, *A High Quality Care for All – NHS Next Stage Review Final Report* (Department of Health, June 2008) (www.ournhs.nhs.uk)

17 NICE *Public Health Interventions to Promote Positive Mental Health & Prevent Mental Health Disorders among Adults: Evidence Briefing* (2007) (<http://www.nice.org.uk/niceMedia/pdf/mental%20health%20EB%20FINAL%2018.01.07.pdf>); NICE *Promoting Children's Social & Emotional Well-being in Primary Education*, NICE guidance PH12 (2008) (<http://guidance.nice.org.uk/PH12>); NICE *Promoting Young People's Social & Emotional Well-being in Secondary Education*, NICE guidance PH 20 (2009) (<http://guidance.nice.org.uk/PH20>)

18 NICE guidance on physical activity – various papers, 2006-09 (<http://www.nice.org.uk/guidance/index.js?jsessionid=96536422DE09D1D9672D.0?d=16544-s=3&textonly=false&t=16544-o=2&tstatus=3&t=16544-p=1&action=byType&ttype=4/>)

19 An assessment of community engagement and community development approaches including the collaborative methodology and community champions (<http://guidance.nice.org.uk/PH9>)

experts on well-being, and the Improvement & Development Agency (IDeA).²⁰ The project includes practical initiatives to promote well-being, an apprenticeship scheme to develop "soft skills" and employability among young people, a school-based resilience programme and a peer volunteer programme to build older people's resilience to mental health problems.

- **A 2007 study of deprived constituencies in Britain** concluded that there is no single "protective factor" for resilience.²¹ The main ingredients for resilience are a combination of progressive policies and practices and the community's ability to draw effectively upon its own resources. A number of social and cultural factors may be protective, including the political, economic, ethnic and religious characteristics of the local population. More resilient communities are better equipped to deal with the health effects of economic decline and are better protected in economic recession.

'Business as usual' is not an option

In the face of this vast and growing body of evidence, it is clear that we will continue to be let down by traditional ways of thinking about the public's health and how to improve it. At the heart of these traditional ways of thinking and doing is the focus on illness rather than health, on negatives rather than positives, on services that "do to" people rather than work with people to create health-enabling conditions and environments.

Professional practice in the public services is geared to reacting to problems rather than preventing them in the first place. "For every problem", remarked one experienced commentator, "the service provider's answer is 'more of me'."²²

Despite these efforts and real increases in funding for the NHS and other public services – and indeed, some limited successes in certain areas – the health and well-being of many communities has not improved at all. There is evidence that the gap is widening and, while there has been an increase in longevity overall, our efforts have not tackled the groundswell of chronic disease that most of us experience, sometimes in multiple ways, as we grow older and which means that our added years

20 <http://www.youngfoundation.org.uk/our-work/local-innovation/strands/well-being/well-being>

21 Tunstall, H et al "Is Economic Adversity Always a Killer? Disadvantaged Areas with Relatively Low Mortality Rates" in *Journal of Epidemiology & Community Health* no 61 (2007), pp337-343 (While this study did not include Lambeth, its findings are relevant.)

22 Naomi Eisenstadt "Developing a Mental Well Being Strategy for Lambeth", address to an open space in Lambeth in 2009

of life are not lived well. These lost years of illness and disability are not an inevitable consequence of ageing, and many more of us could with the right support live our longer lives more fully and vibrantly, continuing to make useful and valid contributions to our communities and consuming fewer NHS and other public services.

Increasingly, organisations in the public sector – particularly in the health service and local government – are recognising that even when money on reactive services is spent well, the need tends to recur year after year. They are finding it makes sense, therefore, to shift effort and resource towards building an environment and a society that prevents such problems in the first place. This approach is strongly supported by research evidence and examples of good practice from around the world. Our systems are reaching the limits of their health-giving power.

Even if we wanted to carry on with "business as usual", running to catch up, this option will soon not be available. Looming financial austerity will end our ability to respond to increasing health and social need by providing more and more public services. The big challenge facing us now is how to achieve more health and well-being for less investment. As Charles Leadbetter recently pointed out,²³ "we need radical and innovative social innovation if we are to transform this situation".

A plethora of recent policy papers and informed commentaries point to the need to shift the focus. This must go far beyond the development of new techniques to "make people eat their greens". Rather it is about helping individuals – and communities – to help themselves. We ignore the assets in our communities at our peril. Professor John McKnight has said:

... local assets are the primary building blocks of sustainable community development. Building on the skills of local residents, the power of local associations, and the supportive functions of local institutions, asset-based community development draws upon existing community strengths to build stronger, more sustainable communities for the future.²⁴

We already have evidence that there is untapped social capital potential in the UK population. More than 40% of people in the UK volunteer each year, and Mulgan et al have informed us that "hyper-local" citizens are much more likely to respond to the

23 Leadbetter, C "Innovation- Harnessing the Power of Local Communities" in Health Services Journal, 10 March 2010

24 John L McKnight "The Recovery of a Space for Citizens", distinguished public policy lecture at the Institute for Policy Research in 2003

local application of national campaigns or small-scale local work, over involvement opportunities at a borough level.²⁵

A new mindset: 'living well'

In this context, nothing less than a new paradigm is required to frame national policy in all sectors. In the North West, a growing body of academic, theoretical and practical work suggests that the concept of "living well" provides a framework for the approach that is needed. Superficially simple, "living well" is a complex and multidimensional concept. It addresses the ways in which individuals experience their quality of life personally, embracing both the emotional and functional aspects of human life.

It also addresses the ways in which people live, work and interact with others in a range of social settings. Moreover, it recognises and endorses the critical importance of individual and community resilience. Living well involves the capabilities for responding effectively to risks and coping with the inevitable adversities that are part and parcel of our individual and collective lives – "bouncing back", learning and adapting. Beyond all this, living well touches upon a range of ethical and philosophical issues about the key focus and drivers of policy and the nature of governance, particularly the nature of the interaction between government and state institutions at all levels and citizens.

Living well therefore has implications for what happens at many different levels. Individuals, policy makers and the structures of civil society all have a part to play in enabling it. It is far more than a set of lifestyle choices or individual behaviours but, of course, includes these. Living well requires a powerful connection with policies and practices that hold a proper balance between the needs of a prosperous economy, social justice and the need to live within sustainable environmental limits. Fundamentally, living well is about the primary human need to live a purposeful life with sound relationships within cohesive and supportive communities.

Thinking about living well is a more positive approach to improving health than focusing purely on the illnesses people have and what they die from. Using this as the primary measure of individual and community health will require all agencies, including the NHS, to radically rethink the way they "do health". This change will take time, and there may be a turbulent transition from traditional ways – but the need for the change is clear and action must not be delayed.

25 Halpern, D, Bates, C, Mulgan, G and Aldridge, A, with Beales, G and Heathfield, A Personal Responsibility & Changing Behaviour: The State of Knowledge & its Implications for Public Policy (Prime Minister's Strategy Unit, February 2004)

Making it happen – North West pioneers

There is no single "intervention" or evidence-based programme to support living well. The concept involves local government and health bodies especially playing a clear leadership role, while also power sharing with local people to define the ways in which living well might occur, identifying and supporting the local assets that may support it and removing obstacles to achieving it for as many people as possible. These may vary for different local communities. A number of potentially transformative initiatives now in train in the North West point the way forward. These include:

Better decision making: Investment for Health

The Investment for Health (i4h) programme, supported by a cross-sector steering group, has developed a framework to help decision makers create more health and well-being from their decisions. Focused on organisations outside the NHS, initially across the public sector and voluntary, community and faith organisations, the framework offers practical tools to develop and assess the goal of "sweating assets" to achieve more health and well-being alongside the organisation's core goals. The programme also tracks examples of i4h in action on the ground.

Examples include MerseyLearn, an employee skills development initiative established by a partnership of Merseyside organisations and trades unions,²⁶ which has created real benefits for employees' well-being, accelerated opportunities for promotion and so increased income. Another example is the adoption of regional healthy catering guidelines by the DW stadium in Wigan, which has brought it additional business and so strengthened local employment.²⁷ Yet another example is provided by the Merseyside Fire & Rescue Service, which in its annual report for 2009 stated that:

... improving health is intrinsic to all aspects of the service's community fire safety approach. We let each district decide how they can best help their community. In St Helens the fire station has also become a health centre, run in partnership with the local PCT, where people come in for advice. In Wallasey, the station is also an anti social behaviour centre. Most of our stations also open their gyms to the general public too, so people can come and get fit for free.²⁸

26 <http://www.wea.org.uk/conference2007/pdfs/MerseyLearn%20pp.pdf>

27 www.i4hnw.wordpress.com

28 www.merseyfire.gov.uk

Better use of public resources: social value framework

The North West Social Value Framework links to the i4h programme and provides a mechanism for considering how well scarce resources are allocated and used, and how their collective use delivers measurable and improved outcomes.²⁹ The framework reflects a balanced approach in assessing outcomes, taking into account the wider benefits to the patient, the community and the public – that is, the collective gain to the community from commissioning or procurement over and above the direct purchase of goods and services. In a pressured financial climate, it is more important than ever that both commissioners and providers account for value, reflecting a better shift of resources to the right people, in the right place, at the right time.

The North West has been leading this work in the NHS and with partners to create a national framework, but has also been piloting ways to achieve social value across the region. Examples include: a local procurement project in Blackburn with Darwen; in Manchester the primary care trust is keen to review current third-sector and mental health services and the contract review process to affect transformational change in care delivery, while the council is looking at the extension of its investment in the community programme in supporting local apprenticeship opportunities; Salford has a diverse cross-sector project team concentrating on the health equality agenda and the primary care trust there is using social value as part of its business case framework for a well-being service.

Better opportunities to work with the public: Our Life

Our Life is the North West's campaign for well-being and health and marks a radical departure from typical approaches to health promotion. It is a membership social enterprise established in 2009 by and for organisations in the North West committed to achieving social change and reducing health inequalities. Membership is open to individuals as well as to organisations from the public, voluntary and private sectors.

Our Life's remit is to engage the public in the debate about health inequalities and barriers to good health, and to mobilise people and organisations around solutions. The focus is on campaigning and advocacy for those solutions that require business change or new government policy to implement.

To date, Our Life has worked extensively on public engagement around alcohol, and in particular driving public support for changes to how alcohol is priced and marketed. The issue of inequality is more complex, and Our Life has been tasked in 2010 with developing a greater understanding of how the public views inequality

29 http://www.northwest.nhs.uk/whatwedo/socialvalueproject/social_value_project.html

the appropriate language, approaches and tools to actively engage the public in developing and delivering solutions to reduce inequality. Our Life will work to ensure this understanding is widely shared and utilised across the region by all organisations working to create a more equal society.³⁰

At the beginning of 2010, Liverpool became the first local authority in the country to host a Year of Health and Well-being as a key partnership intervention aimed at promoting healthier lifestyles.³¹

Better contribution from the private sector: developing health and well-being industries

Health and well-being are key drivers of economic growth and are expected to exert a stronger influence in the future. This provides an economic opportunity, although without strategic recognition of this trend there is a risk that economic development policy will fail to maximise the potential benefits of the health and well-being industries. At the same time, since many of the trends driving economic opportunities, such as self-management, are dictated by individual consumer choices, there is the potential to open up wider health inequalities, driven by barriers such as imperfect information, low income and low aspirations.

Research to explore potential was carried out for Our Life, the Department of Health North West, the strategic health authority and the Northwest Regional Development Agency (NWDA) jointly. This research mapped the dimensions of this highly diverse economic cluster of often disparate and contrasting industries, linked together by consumers' and wider society's demand for improved health and well-being. As a dynamic cross-section of economic activity across a wide range of existing and clearly defined sectors, understanding the interaction between health, well-being and economic activity now allows synergies to be identified and policy options considered, such as extending the use of ICT for public health and developing a local healthy food initiative with producers in Lancashire.

Better measurement: the North West well-being survey

NHS North West undertook research in 2009 into the mental well-being of the North West population, providing a unique and important new baseline and greater understanding of the factors contributing to people's well-being and the inequalities across our population.³² Some 18,500 residents of the North West provided

30 www.ourlife.org.uk

31 <http://www.2010healthandwell-being.org.uk/>

32 <http://www.eph.org/a/3899>

information to the survey. The findings revealed a clear link between general health and mental well-being; for example:

- those with relatively high mental well-being were three-and-a-half times more likely than those with relatively low mental well-being to say they were in very good health; while
- those with low mental well-being were nearly five times more likely to say that their health was very bad or bad than those with high mental well-being.

The importance of these findings for promoting the concept of living well is that it is clear that how people feel about their lives has a direct relationship to how they feel about their health. This appears to be illustrated by data from Knowsley on Merseyside, an area that, despite equivalent levels of deprivation and low scores on standard measures, is nonetheless making steady progress on closing the health inequalities gap at a time when many localities in the North West and throughout England are struggling. The key difference appears to be the as yet little defined or understood concept of communal or collective well-being. This raises important questions for research methodologies as well as policy and practice and has particular implications for attempts at resilience building. One possible suggestion is that a sense of shared adversity and a strong local identity helps people to cope. This appears to require committed and responsive local leadership, working to a mutual agenda across all sectors.

Scaling up the transformation

The challenge now is to build upon these and other developments in order to achieve a transformation in the direction of living well at the required scale. The Living Well Framework for the North West will be published for consultation in June 2010. In aiming towards large-scale change in the direction of living well, the region as a whole is helped by a unique context and in particular the strategic opportunities provided by the development of England's first single regional strategy, which will guide regional planning across the spatial, economic, social and environmental sectors in the next 20 years.³³ The single regional strategy offers the potential for developing and embedding an approach to regional development that may achieve an optimum balance between the need for individuals and communities to live healthy, productive and meaningful lives and the needs of industry, the broader regional economy and the environment. Only time will tell if this aspiration is achievable.

³³ <http://www.nwregionalstrategy.com/>

Example of local research on living well: Knowsley on Merseyside

The strongly positive experience in Knowsley, in particular of meeting inequalities targets on life expectancy when many other areas are falling short, is striking and raises a number of questions about how to research "living well". The North West well-being survey results (adjusted for age, sex, and deprivation index) show that, compared with the rest of the region, Knowsley respondents: have low scores for well-being using the standard WEMWBS instrument; are relatively income-poor; are generally less likely to have healthy lifestyles in relation to smoking and exercise, although they are less likely to be harmful drinkers; are much more likely to be unemployed or to be in a household whose head is unemployed, and are much the likeliest to be long-term unemployed; and are the least likely to join sports clubs, religious groups or educational groups.

So individual well-being and behaviours are, if anything, consistently worse than elsewhere. Yet Knowsley reports far the strongest indicators of area well-being, with:

- the highest likelihood of feeling you belong in your immediate locality;
- the second highest (after Cumbria) satisfaction with the local area as a place to live;
- the highest assessment of being safe in your own home at night;
- the highest assessment of being safe outdoors in the day (though a low assessment of being safe outdoors at night);
- the highest likelihood of talking regularly to neighbours;
- the high likelihood of being able to find help in a crisis;
- the high likelihood of finding help if ill; and
- the highest level of agreement that you can influence decisions in the local area.

While we cannot simply assume from these results that one positive local feature (improved mortality and health outcomes) and another (high area well-being) are causally linked, nonetheless important questions are raised. In so far as something is working in Knowsley, it does appear to be positively associated with perceptions of neighbourhood support and of local public agencies and local partners.

This context provides fertile ground for addressing the broad social determinants of health and well-being and for implementing the recommendations of the national strategic review of health inequalities led by Professor Sir Michael Marmot.³⁴ It is, moreover, resonant with a growing evidence base that sets out the business case for investing in health and well-being for a range of agencies with responsibilities that extend beyond the NHS.³⁵

The Living Well Framework for the North West will include six key strategic intentions that have been chosen to express what the future will “feel” and look like in order for people to live well.

Figure 1: North West Living Well Framework – strategic intentions



These strategic intentions were developed from a large event in October 2009 that drew 180 people from across the region in all sectors and at all levels into an “open space” discussion, where they set the agenda themselves in responding to the question: “From social injustice to health, wealth and well-being for all in the North West: how can we work together to make this a reality within a generation?”

34 <http://www.ucl.ac.uk/gheg/marmotreview>

35 <http://www.idea.gov.uk/idk/aio/16326177>

The framework as a whole reflects the aspiration of the regional strategy to "release the potential of our people and tackle poverty by ... tackling the serious challenges raised by social exclusion, deprivation, ill health and inequality".³⁶

How will we know if we're making progress?

In establishing living well as a key focus for the work of public agencies, we need to challenge our own and others' entrenched ways of thinking – and these include ways of counting. The key argument for the status quo may be caricatured (though not grossly so) as: "This is important because I count it. That can't be important because you don't/can't count it."

Counting what really matters: 'living well' metrics

At the February 2010 conference associated with the development of the North West Living Well Framework, Camilla Batmanghelidjh of Kids Company commented that "invisible people need no funding". The visibility of the health gap and the social gradient of inequality are key to keeping the spotlight on efforts to change them as well as to measure progress.

Accordingly, a range of measures have been developed in the region, to sit alongside existing standardised measurements of well-being. The key dimensions of these measurements include:

- **Assets and deficits**

Most indicator sets currently utilise metrics of deficits – the prevalence or incidence of undesirable or hazardous states in the population. Assessment of living well will require indicators of assets: the prevalence or incidence of desirable or health-supporting states in the population. In some circumstances the same data source may be expressed either as an asset or as a deficit; hence the proportion of smokers in the total population is a deficit indicator, while the proportion of total ever-smokers who have successfully quit is an asset indicator.

- **Backwards and forwards**

Some indicators – such as life expectancy – tend to look backwards to the outcomes of past health states, whereas others – such as childhood obesity – allow a forward look towards future differential risks and opportunities.

36 Part One summary of the 2010 regional strategy (www.nwregionalstrategy.com)

- **Vigilance and performance**

Some indicators monitor performance towards specific defined policy objectives – such as reduction in early mortality from cardiovascular diseases. This allows us to tell how successful our actions have been in delivering the results intended. Other indicators may be deliberately less selective, such as all-cause mortality. These may allow us to be vigilant in relation to the possibility that circumstances may have arisen generating priorities for action not envisaged in defined plans. They create the flexibility we need to work with the complexity of the determinants of living well.

- **Individual, social and reciprocal**

A number of metrics of well-being concentrate on reported individual mental and physical states and feelings, such as the Warwick-Edinburgh Mental Well-Being Scale (WEMWBS). But, as we are learning from work in Knowsley, for example, overall well-being will also relate to social states – such as reported degrees of satisfaction at living in a local area, or assessment of night-time safety, or being in a relationship – and also to reciprocal states, such as the regularity of contact with neighbours, being employed or doing volunteering.

Ideally, an indicator set should provide a degree of assessment in respect of all the above dimensions; on the other hand, multiple new measures and data collection requirements would not help hard-pressed systems. So selected metrics are needed that function satisfactorily in several dimensions.

The Living Well Framework proposes a “top 10” of indicators, as follows:

Deficit indicators:

- disability-free life expectancy for men (or healthy life expectancy);
- disability-free life expectancy women (or healthy life expectancy);
- adult smoking prevalence and alcohol consumption;
- child obesity in year six.

Asset indicators:

- percentage redundant in past year who found a new job;
- percentage reporting coping on current income/confident in ability to receive financial help in a crisis;
- percentage reporting recommended levels of recreational exercise;

- percentage reporting participation in local groups and/or frequency of meeting people outside own household;
- percentage reporting positive mental well-being (WEMWBS or equivalent measure of life satisfaction);
- percentage reporting positive evaluation of functioning in the local area (for example, the ability to influence local decisions, a sense of belonging in the locality, feeling safe at home at night).

Complex systems can get in the way of good responses to complex problems

Effective support for living well means finding ways of collaborating across boundaries. This is a real challenge. It is easy to trip over the professional, managerial and sectoral dividing lines that characterise the complex systems in place for public agencies in the North West, as elsewhere. There is a clear need to identify and develop the new skills and relationships needed to work with partners across all communities and sectors.

Take, for example, the intention of the NHS to find new ways of working with people in relation to tobacco, alcohol, exercise and diet. These, after all, are related to key elements of individual and community well-being. However, the focus in the future will be on the social factors underpinning the choices people make and on supporting them to find solutions, not just providing descriptions of the problems or offering one ready-made solution or service. For example, with smoking, people across the social gradient want to quit, but the lower-income groups have less success. The approach to building success not failure requires cross-system work:

The focus will be on encouraging healthier behaviour rather than on clamping down on unhealthy choices. We will always prefer policies to make the healthier choice the easier choice, rather than policies that attempt to remove unhealthy choices altogether.³⁷

Alongside enabling positive individual and community achievements, the assets and resources of individuals, communities and organisations to help achieve positive outcomes must be understood and maximised. "Hyper-local" approaches are needed that do not rely on people identifying across a whole borough or locality but simply with their street, school or social grouping.³⁸

³⁷ Reeves, R *A Liberal Dose? Health & Wellbeing – the Role of the State* (Department of Health, February 2010), p31

³⁸ Savage, V, with O'Sullivan, C, Mulgan, G and Ali, R *Public Services & Civil Society Working Together: An Initial Think Piece* (Young Foundation, November 2009), p13

Conclusion

Using the concept of living well as a lens helps explain the obstacles to removing entrenched inequalities; it makes a clear link between mental and physical healthiness; it offers important connecting ideas to support local partnership working and community development. Importantly, the notion of living well applies across the social gradient and reflects current debates about income inequality and future economic direction: What is sustainable economic activity? Is growth alone the answer? What will improve the quality of life of the population? Taking a "living well" approach to improving the public's health therefore confronts some of the hardest public policy challenges we face – but offers the potential to engage people more fully than ever before. This may have important social and political implications in addition to the more utilitarian objectives of "getting more for less".

Chapter 7

Healthcare beyond the NHS

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Asthma UK

Healthcare beyond the NHS

A number of well-documented factors will affect the ability of the NHS to meet rising patient expectations. There will be an even greater emphasis on the need for other sectors of society to share the burden of healthcare. Confronting this challenge should not be thought of purely in terms of helping people when they're ill; instead a greater effort is needed to focus on addressing illness prevention in new settings and in new ways.

In fairness to the government, the arguments for illness prevention, greater personal responsibility and a holistic approach to tackling the big health issues have been taken on board. Innumerable well-meaning initiatives, from Healthy Schools to Dame Carol Black's *Working for a Healthier Tomorrow*,¹ have driven home the benefits that can accrue, and the emphasis is now very much on implementation.

This chapter will examine the role other parts of society can play in improving the health of the nation and reducing the pressure on the NHS. How should employers embrace the new health agenda? How far should we expect them to take on not only effective health promotion at work but also more nuanced issues, and how should small and medium-sized enterprises be assisted to avoid falling through the cracks? There is potential for new health inequalities to emerge, as comparatively under-resourced small companies suffer a knowledge deficit.

I will then look at how schools are developing their statutory duty to support the health of pupils, focusing on how long-term conditions are managed in the school setting. There are pockets of good practice in this field, but too many schools are following risk-averse strategies, to the detriment of their pupils. There is a role for Ofsted to develop more meaningful measures of well-being as well as greater clarity around medicines use in schools. Asthma, as a major long-term condition among children, is a useful example of how good practice can be developed at relatively little cost.

Finally, I will briefly examine how the NHS will need to engage patients more actively and the role that patient organisations have in delivering this agenda. I will examine some of the new trends that are worth watching and discuss how the NHS can

¹ Black, C *Working for a Healthier Tomorrow* (Department of Health/Department for Work & Pensions, March 2008)

exploit the expertise of patient groups in helping to deliver more personalised healthcare. For all three areas, there is a role for government to play in creating a more collaborative public policy environment.

Background

There are over 15 million people in England with a long-term condition such as asthma or diabetes, with that figure set to rise by 3 million by 2025, as our population gets older. At present such conditions account for more than 50% of all GP appointments, 65% of all outpatient appointments and over 70% of all inpatient bed days.² Many of these people live with more than one condition. Taken in the context of the financial squeeze, whereby the NHS will need to deliver annual efficiency savings of between £15 billion and £20 billion by 2013/14, the need to prioritise long-term conditions is paramount.

To underscore this, the last Budget before the general election identified £2.7 billion of savings in "transforming the lives of people with long-term conditions, through best practice in care planning and case management, empowering patients to self-care, reducing emergency admissions levels to be on a par with the best levels internationally and providing more efficient, integrated community services". A further £1.5 billion has been targeted through "more effective commissioning by reducing unnecessary referrals and prescriptions".³

the NHS over the next 10 years, stressing the need to offer care closer to home. Lord Darzi's final report focused on high-quality care for patients and members of the public through improving health as well as treating sickness and giving patients more rights and control over their own healthcare. It also targeted quality at the heart of the NHS.

Effective commissioning will be central in driving down costs in the NHS, and if commissioners are to meet the quality and productivity challenge then a "transformational change" in how services are managed and provided for people with long-term conditions will be an essential part of that process. Under the current financial constraints this is a change that is one of necessity not one of choice – even more so given that the Department of Health allocates 80% of health spending to primary care trusts precisely to meet the health needs of their respective populations.

² Department of Health *Improving the Health & Well-being of People with Long-term Conditions – World-class Services for People with Long-term Conditions* (January 2010)

³ http://www.dh.gov.uk/en/MediaCentre/Pressreleasesarchive/DH_114554

The recently published *Improving the Health & Well-being of People with Long-term Conditions – World-class Services for People with Long-term Conditions* presents commissioners with a guide to how this agenda can be met, together with a vision for what constitutes a good service for people who live with a long-term condition. Innovative solutions are the order of the day. For example, telecare is already playing an important role in transforming social care services and relieving the pressure on the NHS, giving patients greater independence and helping to improve their quality of life. Although recognition and adoption of new technologies is nothing new, this has to become the norm rather than the exception.

Healthy employers

The argument for "healthy work, productive workplaces" is proven. With over 172 million days lost due to sickness absence, about 34 million of these due to work-related illness,⁴ it is not hard to see why. Providing effective health promotion in the workplace can lead to reduced absenteeism and increased productivity. Large employers in particular have embraced the agenda, aided by government initiatives. The pharmaceutical company Astra Zeneca, for example, introduced a range of health and well-being initiatives that resulted in cost savings of between £500,000 and £700,000 through improved productivity after counselling, as well as an £80,000 saving on health insurance for psychological illness – not to mention an enhanced image as an employer.⁵ However, some have argued that the tax system needs to better incentivise employers.⁶

Subsidised gym membership, healthy canteen options and health information leaflets, while useful, will not achieve the desired improvements in health outcomes. A concerted effort is needed to address what Professor Sir Michael Marmot in his recent review of health inequalities calls the "status syndrome" – workers in lower-status jobs who suffer worse health and lower life expectancy than workers in higher-status jobs.⁷ In this instance, effective health promotion, as described above, is only part of the answer.

The Work Foundation's *Healthy Work, Productive Workplaces*⁸ report, drawing heavily on Marmot's *The Status Syndrome*,⁹ states that employees will experience worse

4 Department for Work & Pensions and CBI (2007 statistics quoted)

5 Business in the Community Healthy People = Healthy Profits (March 2009)

6 Reform *Fit for Recovery* (March 2009)

7 See, for example: Vahtera, J, Virtanen, P, Kivimaki, M and Pentti, J "Workplace as an Origin of Health Inequalities" in *Journal of Epidemiology & Community Health* no 53 (1999), pp399-407

8 The Work Foundation *Healthy Work, Productive Workplaces* (December 2005)

9 Marmot, M *The Status Syndrome: How Social Standing Affects Our Health and Longevity* (Holt, Henry & Co, 2004)

health if they feel job insecurity, their work is boring and repetitive, they have little autonomy and they are not confident they will be fairly treated by their employer. The report highlights the importance of social networks in giving employees a "voice" that can tackle the "status syndrome". Clearly, there is a benefit in looking at ways to minimise the impact of social and economic disadvantage on people's health and well-being.

Business in the Community, a business-led coalition, suggests that there are various ways in which companies can tackle health inequalities, particularly through their supply chains and by investing in the community. It says that, at community level, a failure to invest in tackling health inequalities can result in rising benefit costs and polarised communities, and has developed a number of campaigns through which to engage business, including Business Action on Health, which aims to highlight the business benefits of better health at work and to make reporting on workplace health issues commonplace in UK boardrooms.

Healthy schools

Since September 2005, Ofsted expects schools to demonstrate how they are contributing to the five national outcomes for children as set out in the Every Child Matters framework, one of which is to "be healthy". The National Healthy Schools Programme has the stated aim of ensuring that health education becomes an integral part of the school curriculum and that the wider community is actively engaged in the process. To date, the programme has achieved near universal participation, with more than three-quarters of schools having achieved full "healthy school" status, ahead of the government's target.

The minimum nutritional standards for school food seek to ensure that schoolchildren are eating more fruit and less salt and sugar, in a bid to tackle the crisis in children's diets – the National Diet and Nutrition Survey found that 86% consume too much sugar, 72% consume too much salt and 96% do not get enough fruit and vegetables.¹⁰ The package consists of new kitchens in schools, cookery courses for children during secondary education, and subsidised healthy ingredients. The key question is whether schools and local authorities are keeping to and creating the right environment for the new rules to embed and whether the government has set aside enough resources to maintain improvements in school food well into the future.

¹⁰ http://www.statistics.gov.uk/ssd/surveys/national_diet_nutrition_survey_children.asp

These initiatives demonstrate the efforts (and progress) made by the government in tackling the major issues facing children's health. An equally sustained effort is required in the management of long-term conditions in schools. To illustrate the challenge, Asthma UK last year published *Missing Out* on how children's school and life opportunities are affected by their asthma. A survey of teachers was also commissioned which identified differences in levels of confidence between senior leaders and class leaders and between secondary and primary teachers. A substantial minority (20%) of teachers said they were not confident they knew what to do in the event of a child in their class suffering an asthma attack.¹¹

As well as a full review of the guidance on managing medicines in schools, other more practical measures can be taken, including the new school report cards (which Ofsted will produce to provide information about schools for parents) to provide a section on health support in each school, to improve standards in this area. Children with long-term conditions should be recognised as a vulnerable group with specific needs, to be treated appropriately and sensitively, and appropriate support and training should be co-ordinated and paid for by local education authorities. The Training & Development Agency for Schools would need to be brought into the process, not only to provide adequate resources for newly qualified teachers but also to address the need for better training for all school staff, in order to empower them to better understand medical conditions and learn how to fully include pupils in lessons and activities.

Schools should have a policy in place setting out how they plan to meet the support needs of children with long-term conditions, including measures on medicines management. At present, too many teachers do not know what to do when a child encounters difficulties in managing their condition or has an emergency episode. An Asthma UK survey found only 58% of children with asthma or their parents are confident that their class teacher knows what to do in the event of an asthma attack.¹²

There should also be access to a school nurse in every school. School nurses are well placed to play a key role in children's health and well-being. They bridge the gap between school and health services, advise about the most prevalent medical conditions, and can help schools to implement policies for those conditions. Finally, school inspection frameworks should measure the performance of schools in supporting and including children with health conditions.

11 Asthma UK *Missing Out* (May 2009) (<http://www.asthma.org.uk/document.rm?id=749>)

12 Asthma UK's National Asthma Panel 2008

Patient organisations and patient engagement

Lord Darzi's Next Stage Review pinpoints quality as the overriding priority. Based on the adage that if you cannot measure something then you cannot improve it, quality will now be an integral part of the NHS agenda over the next decade. A key element of the quality agenda is patient experience, but how will this be measured? Patient groups have a role to play here. Their long history of patient advocacy and championing their respective causes should offer insight into what patients want.

At best, there is some way to go before patient participation is fully embedded within the decision-making process – a survey of primary care trusts by the Picker Institute in 2009 indicated how far.¹³ Although the report acknowledged “the beginnings of a cultural shift”, there was a worrying admission that trusts could not show how patient and public engagement was able to influence the commissioning process.

They are still failing to adequately engage patients in priority settings. In an earlier survey, the Picker Institute¹⁴ identified eight aspects of healthcare that patients consider most important, including fast access to reliable health advice, effective treatment delivered by trusted professionals, involvement in decisions and respect for preferences, clear, comprehensible information, and support for self-care. The survey concludes that, above all, patients value the relationships they have with the staff who are taking care of them, saying: “Good communications and effective clinical care delivered by well-trained professionals are the keys to a high quality patient experience.”

Current advice to commissioners is to engage patients through the National Association for Patient Participation (NAPP), local involvement networks (LINKs) and the Patient Advice & Liaison Service (PALS). But for some time there has been a feeling within patient charities that commissioners are failing to consult with them on a regular basis, and that where there is engagement it has not emerged out of any systematic involvement process. Patient groups at both a national and a local level have a huge bank of knowledge and experience of the patient journey. They know and understand what represents good services for patients and where blockages in the system exist; and, crucially, they are trusted by their constituencies. This is in part a result of the democratic structures that patient groups have carefully crafted over the years. The British Lung Foundation has around 250 local groups nationwide that provide support and information for patients. These groups are actively engaged with

13 Picker Institute Europe *Patient & Public Engagement: The Early Impact of World Class Commissioning* (June 2009)

14 Coulter, A “What Do Patients and the Public Want from Primary Care?” in *BMJ* no 331 (2005), pp1,199-1,201

GP practices and primary care trusts to offer support and advice and to influence the decision makers.

What role can patient charities play in the "transformational change" agenda? A more collegial relationship between the NHS and patient charities would be welcome; a starting point would be for local NHS services to recognise the strengths that patient groups possess and the expertise they have to offer. Nationally, the Department of Health has become more willing to adopt this approach and has identified four areas for initial work in developing the quality and productivity challenge: heart disease, cancer, COPD/asthma and diabetes.

The department has also enlisted the support of charities in furthering work to meet other parts of the challenge: for example, information prescriptions and the Information Standard, which was created in an attempt to control the vast amount of unregulated health advice available online. Although well meaning, however, in some ways these Department of Health initiatives have become over-burdensome and inaccessible. At a national level, patient groups can provide useful feedback on such initiatives and can play an important role in disseminating the good practice that will be crucial in helping to meet the quality targets.

Conclusion

"More of the same" is no longer an option if other parts of society are to share the burden of illness prevention and healthcare delivery in strenuous financial times.

Policy makers have acknowledged the most pressing issues for the NHS today, but they need to confront the more esoteric challenges facing healthcare delivery in the next decade and beyond. Employers have made positive strides in providing advice and information in the workplace, but business networks between larger companies and small and medium-sized enterprises so that good practice can be disseminated would be another positive step. In addition, employers need to move beyond mere health promotion if meaningful progress on health inequalities is to be achieved.

Schools need the support of local authorities and other agencies to understand complex conditions that can drain the confidence of pupils and have a long-term effect on their development. Ofsted has a natural role to play in delivering lasting change on this front.

The NHS and, more specifically, commissioners can work more closely with patients and patient groups to help them understand more effectively the needs of their local population, particularly in developing the strategies required to access hard-to-reach communities.

Chapter 8

Engaging the public in change

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Engaging the public in change

The financial pressures now facing the NHS are unprecedented. This is at a time when social trends suggest the public are becoming more demanding, less trusting, and more willing to organise in protest – look at recent Twitter and Facebook campaigns. Yet, against this backdrop, the NHS is being asked to cut about a fifth of its budget over the next five years. As the Independent Reconfiguration Panel notes, “Rapid and large scale change to deliver services for patients more efficiently and effectively will be required to meet the challenge ... Service reconfiguration will have an important role to play”.¹ And given the scale of those financial challenges, one aspect of service reconfiguration that the NHS will inevitably want to examine will involve the closure of wards – and even hospitals. As one respondent noted in a recent Policy Exchange report, “There are big buckets of savings to be had, we just don't address them.”²

The argument about hospital reconfigurations is not just economic. Darzi's Next Stage Review,³ for example, argued for “an NHS that has quality of care at its heart”. One of the mechanisms advocated for delivering this was to centralise the specialist services, while moving routine care as close to the patient as possible. Clearly, this has implications for the capacity needed at a typical district general hospital: if its specialist services are being pulled into centres of excellence, and its routine services will be delivered via GP polyclinics, then how many beds does it still need?

Nevertheless, despite potential economic and clinical benefits, the prospect of closing or downgrading the local hospital is still one that has the power to get the public marching on the streets. And the public anger is clearly real. In areas where they have gone down the reconfiguration route, there are primary care trust leaders who can recount stories of hostile, and sometimes abusive, public consultation meetings. There are anecdotes of officers' cars being vandalised, and of protesters turning up at meetings with a coffin (for the hospital? for the NHS? for the trust chief executive?). And the local NHS leaders who front these public consultations will be aware of the hostility they face: as one primary care trust chief executive told us, “You've got to be brave – because it's not comfortable. They don't trust you, and it gets personal.”

The public reaction to reconfiguration proposals can also be widespread. For instance, when one primary care trust consulted the public on its proposals to rationalise secondary care, it received 36,000 responses. Against 700,000 residents living in the

1 Independent Review Panel *Learning from Reviews* (2nd edition) (December 2009)

2 Policy Exchange *Controlling Public Spending: The NHS in a Period of Tight Funding* (January 2010)

3 Darzi, *A High Quality Care for All – NHS Next Stage Review Final Report* (Department of Health, June 2008)

trust area, this equated to some 5% of the population. These reactions are often picked up – and perhaps stoked up – by the local press and politicians. Local proposals to downgrade or close a hospital can be accompanied by a lot of noise.

Furthermore, this public anger is not the only problem arising from closing local hospital services. It is an issue that also brings with it a real risk of *reputational* damage for the NHS as a whole. For instance, Ipsos MORI survey data has shown that the prospect of hospital closures prompts distinct pessimism about the future of the local NHS. Furthermore, it consistently features among the top reasons given for local residents' belief that NHS services will get worse over the next few years. In a survey we conducted for one strategic health authority, for example, 22% of people felt health services would get worse in their area over the next few years – and when we asked why they felt that, the top reason – mentioned by 17% of them – was the closure of local hospitals and accident and emergency departments.

Now, 17% of 22% is a relatively small proportion of the population blaming hospital closures for the NHS getting worse. But if the current economic climate pushes hospital and ward closures up the NHS agenda, it is easy to envisage this view spreading across the population more widely.

Understanding public anger about hospital closures

The NHS is clearly caught in something of a cleft stick. The financial arguments and potential clinical benefits from reconfiguring services mean it has to be free to consider ward and hospital closures. Yet the public backlash and potential reputational damage is, clearly, something it will want to avoid. The question therefore becomes one of what the NHS can do to help *manage* this public reaction. But in order to do this, it is important first to understand the reaction: what does this public anger *mean*? The research we have conducted at Ipsos MORI over the last few years provides some useful insights into this – so it is worth attempting to unpick why the public react as they do. Below, we consider five undercurrents that appear to play important roles in shaping public anger about hospital reconfigurations.

1. Public expectations of the NHS

There is a huge amount of fondness for the 60-year-old institution of the NHS – and public satisfaction has never been higher than at present. However, the expectations that come with that present the NHS with something of a challenge.

This can most clearly be seen in what might be regarded as a “psychological contract” with the NHS: our data shows that 82% believe the NHS will be there for them when they need

need it. Related to this, a recurring theme in our qualitative work is that people feel they have paid into it, so it should be there *in return* when they need it. Furthermore, for many, these expectations appear unbounded: around a third strongly disagree that there should be limits on what is spent on the NHS, and 72% expect the NHS to provide drugs *no matter what they cost*.

And even in these times of economic uncertainty, people do not appear ready to cut the NHS any slack: around three-quarters believe the current financial challenges should be met through efficiencies without damaging public services; and around 80% think the NHS should be protected from any cuts. So even now, people expect that psychological contract to be honoured.

So when a hospital is downgraded or closed, people are reacting not just to that proposal; it also infringes some fundamental beliefs about how the NHS should operate. If you believe that the NHS should do whatever is needed, regardless of cost, without cutting services, then proposals to close a hospital will be seen as a breach of faith.

2. What hospitals mean to the public

It also appears there is a something of a particular sensitivity around closure of hospitals and wards as distinct from other NHS services. In the strategic health authority study noted above, we reported that among the 22% of people who thought the NHS was in decline, the main reason they cited for this was closures of hospitals and accident and emergency departments. In the same study, around a third of people thought the NHS was getting better – and the main reason they felt this was that new hospitals were being built or extended. In other words, what is happening to local hospitals appears for many to define what they think is happening to the local NHS as a whole.

The reasons for equating the local NHS with local hospitals are probably varied. Hospitals are probably one of the clearest symbols of the NHS: they are solid and tangible, and most people probably have a fairly clear – if broad-brush – understanding of how they operate and what they are meant to do. Many hospitals also have a long history in the area they serve, and are often seen as belonging to the local community. You cannot point at a community service in the same way – they are less of a clear entity around which public reaction can coalesce.

The other issue that is likely to come into play is that people probably regard hospitals as “healthcare of last resort”: if the NHS cannot fix you through its other services,

you will get referred to hospital. It is where you go if you *really* need the NHS. If this service is perceived as being taken away, it will inevitably create anxiety – which will readily translate to public anger.

3. What health means to the public

It is also useful to consider the setting for this debate – few subjects raise emotions to a greater extent than health and the system that cares for and protects our health. When discussing a hospital closure, it is not just a public service that we are talking about – it is the “healthcare of last resort”. Health, by its very nature, is an emotive subject and it is difficult to engage in complex debate when the issue is such a primal one.

Consider the example of a primary care trust that proposed to withdraw a particular service from two of its hospitals in order to protect and improve that service at the third of its three hospitals. The plan would result in a more resilient specialist team at that centre, stronger development of clinical expertise, more targeted investment, greater patient safety, and ultimately services that were more cost-effective and more sustainable. Across the primary care trust area as a whole, patients would receive a better, safer service.

Yet the public reaction was one of fury: at hospitals downgraded, services closed, patients having to travel further, with a belief that it was just about cutting costs. At face value, when dealing with the raw emotion of health, a simple binary argument was all that held sway – people could not equate downgrading sites with improving service quality. It just did not make sense.

4. Clash with the NHS narrative

We also know that the public find hospital and ward closures particularly hard to understand against the backdrop of investment that has gone into the NHS over the last decade or so. If the money going into the NHS has tripled, then how can you justify closing a hospital?

It would appear that this public reaction is based on an assumption that the best way for the NHS to spend its money is on hospitals – which in turn is based on the mindset, described above, that hospitals are the most important part of the NHS. It is clear from this that the NHS still has a job to do in articulating to the public why spending in other areas should take priority.

Interestingly, one chief executive we spoke to in a recent study felt the financial downturn should make it easier for primary care trusts to engage the public around hospital closures. That said, his view that “for those starting now, it should be a joy” is perhaps somewhat optimistic!

5. Starting the engagement on the wrong foot

The four strands outlined above all revolve around public perceptions of how the NHS should be run, and how the money should be spent. Much of the public anger around reconfiguration arises from the NHS doing something different with its resources compared with what the public feel it *should* be doing.

This final strand is somewhat different: it relates to how the NHS has sometimes approached the public engagement process. In a number of cases we have touched on in our research, the reconfiguration decisions appear to have been presented to the public as a *fait accompli* from the outset – and this seems particularly potent in stirring up an adverse reaction.

Now, there may well be cases where there is only one option for change, in which case the NHS needs to articulate clearly why this is the case. However, even if it *appears* to be the case that there is only one option for change, this may not be a helpful starting point for engaging the public. As one primary care trust chief executive suggested to us: don't start from the solution; a more effective way forward is to engage the public and other stakeholders in the problems and constraints that the trust faces, then work with those stakeholders to find the best way forward. While this will still involve some tough discussions and decisions, our research suggests this is a valuable way to manage down the levels of public anger.

Finally, it is worth just illustrating how potent it can be to get the starting point for this dialogue wrong. For one study, we interviewed the leader of the campaign to save the local hospital. He felt that the reconfiguration plans had originally been presented as a done deal – and noted the key role this had played in how the local consultation rolled out: "It was a good thing – as it got us riled enough to get the campaign group going," he said. Clearly, then, it is in the interest of local NHS leaders to think about how they manage the reconfiguration debate: get it wrong, and you can stoke up the public backlash.

Implications

So, how should NHS leaders manage this public reaction? The above analysis highlights a number of implications relating to communication. In addition, it is important for local leaders to understand precisely who is angry, and also to think more creatively about how they might engage them. These three areas are discussed more fully below.

1. Communications

Clearly, if you are planning to close a local hospital service, you should expect a hostile reaction. This in large part will arise from public perceptions and expectations about how NHS funds should be spent – and it can be exacerbated if you get your messaging wrong.

However, the above analysis provides some useful messages on how local NHS leaders can best engage their local populations to minimise the level of public anger. In particular, there are some important implications for the communications strategy needed to support hospital closure:

Firstly, the public do not grasp the scale of the challenges facing the NHS in the light of the current financial downturn. Without understanding this, it will be difficult for them to accept there is a case for change. This is exacerbated given that the NHS narrative from both main parties is about protecting budgets and services. Nevertheless, local NHS leaders need to articulate the severity of the financial situation as a platform for discussing the need to review hospital services.

Furthermore, the public will often react on a simplistic and emotional level when presented with a perceived threat to their health services. There is a need for a stronger narrative about the clinical benefits of reconfiguration: it is a redirection of resources to where they can be used more effectively. This needs to be a central part of the communications around any reconfiguration process – but even more important is the need for simplicity in this argument, particularly about what is being *gained*.

Linked to this, there needs to be some stronger messaging to highlight the wide range of services that are not hospital based – and to highlight why investing in these rather than hospital services is useful. Essentially, the long-term communications aim for the NHS should be to challenge the perspective that means the public regard hospitals as the barometer by which they judge the NHS. This will provide an invaluable backdrop when it comes to engaging the public on specific proposals to reconfigure hospital services.

Finally, it appears that how you open the dialogue with the public will have a real bearing on how the public reaction plays out. Starting from the *solution* risks causing an adverse public reaction. In contrast, there seem to be benefits in engaging stakeholders on what the *problem* is, and the *constraints* the local NHS has to work within – allowing the NHS and its stakeholders to co-create the most effective way forward.

2. *Who is actually angry?*

To an embattled local leader, it can seem that their whole population is up in arms. Open consultations tend to hear particularly from those who are concerned about the proposals being made – and the stream of critical feedback can make it feel like everyone locally is unhappy.

But that is not necessarily the case. A representative survey of local residents will often show a much lower level of anger. In one consultation that we conducted on the relocation of local walk-in services, the self-selecting sample responding to the open consultation expressed strong opposition to the plans. But in our survey, where the sample was recruited to reflect and represent the local population, we found that opinion was much more evenly divided. Furthermore, a properly conducted survey can be far more revealing about where the public concerns are concentrated: for instance, in this example, opposition was concentrated largely among older residents and women, while other sections of the population were far less concerned.

Clearly, it is important for local NHS leaders to be sensitive to the concerns and anger that are felt by the local population. But equally, it is important they do not over-generalise the reactions they are hearing through the consultation process: if local leaders want to run an effective engagement and communications process, they need to understand precisely who is angry and why.

3. *Thinking about how to engage the public*

Faced with angry, inflexible protest groups, it can feel that there is little point in trying to engage the public constructively. However, the findings from our research challenge this in a number of ways.

The first point is that while consultation about a specific service reconfiguration can generate a lot of heat and noise, the public do appear to accept the principles behind reconfiguration. For instance, in Consulting the Capital, Healthcare for London's consultation following *A Framework for Action*, over three-quarters of respondents (77%) said they agreed that ambulances should take patients directly to specialist centres, even if there was another hospital closer to them. And in another, more rural strategic health authority, four in five people who had not previously heard of the local reconfiguration plans agreed that, in principle, they would be happy to travel further to obtain the best possible outcome for their treatment. And a similar proportion agreed that centralisation would improve the skills of specialist care staff. The public at large are not dead set against the principles behind many hospital reconfigurations, despite their emotive reactions to specific cases.

Secondly, as hospital reconfigurations become more commonplace, the NHS may need to look to new and more innovative ways to engage local opinion. For instance, one of the case study primary care trusts in a recent Ipsos MORI study had been very proactive in getting its messages into the local press – buying editorial space, constantly arguing the benefits of change, and getting positive news stories into the local press coverage. In another example, the trust had given the local campaign groups half the seats on its reconfiguration planning group, and after agreeing confidentiality ground rules, shared all the relevant in-house information relevant to the reconfiguration plans. The fact that the primary care trust and campaign groups were then releasing joint press releases was a key factor in bringing down the temperature of the local media coverage.

Finally, there is a clear need to keep making the arguments to the public. As noted above, the public are not intrinsically against the principles that underlie many reconfigurations – though they may need to have the case made to them. And where public doubts remain, the arguments need to be convincing. For example, many people just do not believe that care provided in the community or in their homes can be of the same standard as that they would receive in hospital. Is there data that clearly makes the case?

It is also worth asking whether the NHS is always assertive enough at advocating the case for change. In our recent study talking to local NHS leaders about reconfigurations, one strand of feeling was that the NHS sometimes needed to do more – for instance, that it did not fight enough to get good stories into the press. As one local NHS leader noted, "We've got to be convinced of our argument and make that argument to the public, or we don't deserve to be successful. In general, we're quite poor at that in the NHS." While this was not a universal finding – indeed, there were examples of very active advocacy and press management – it came up enough in our research to suggest that, in some contexts at least, NHS leaders could be doing more.

Conclusion

Proposed hospital closures do, clearly, appear to serve as something of a lightning conductor for public anger. What is also clear is that the anger is about more than the hospital closure itself – although it is often not as widely felt across the community as a whole as the consultation meetings would suggest.

What also appears to be the case is that the NHS has some influence over how that public reaction develops. By engaging early, by arguing the case and presenting the

evidence, and also by entering into a real dialogue about how the NHS can meet the challenges it faces, it can help diffuse the local reaction – and help build a local coalition through which the NHS can work out how best to survive the financial wave that is about to hit it.

Chapter 9

Changing behaviour to improve population health

Professor Theresa Marteau, Professor of Health Psychology at King's College London and Director of the Centre for the Study of Incentives in Health

Changing behaviour to improve population health

Most people value their health yet persist in behaviour that undermines it: the majority in the UK are overweight or obese; few eat the recommended amount of fruit and vegetables a day; more than one in five smoke, and increasing numbers drink at a level likely to harm health. Informing people of the risks to their health from engaging in these and other behaviours has little effect. Designing policies based on an understanding of the actual drivers of human behaviour, not what we would like them to be, holds more promise in changing behaviour to improve population health.

Understanding behaviour

Recent evidence from neuroscience, psychology and behaviour economics supports a model of behaviour that reflects the workings of two systems: a reflective, goal-directed system in which behaviour is driven by values and goals, and an automatic, impulsive system, in which non-conscious processes of learned associations give rise to behaviour that is cued by context.¹

Goal-directed behaviour requires cognitive capacity or thinking space. By contrast, impulsive, automatic behaviour is cued by the immediate social and physical environment, reflects feelings, and requires little or no cognitive capacity. The reflective system allows our limited cognitive capacity to be used in completing complex and valued tasks such as planning a holiday or writing a paper, with routine and less valued tasks, such as travelling to work or buying lunch, regulated by the automatic system. It is estimated that around 45% of our behaviour is habitual: repeated at similar times and in the same location each day.²

The two systems interact to influence behaviour either synergistically or antagonistically. Many of the behaviours that adversely affect our health reflect the operation of the impulsive and reflective systems working antagonistically. Most people intend to change their behaviour to become healthier but most fail, with intentions failing to explain most of our health-related behaviour.³ Thus, a sofa becomes the resting point for an evening despite a strong intention to walk after

1 Strack, F, Deutsch, R "Reflective and Impulsive Determinants of Social Behaviour" in *Personality & Social Psychology Review* no 4 (2004), pp108-131

2 Neal, DT et al "Habits - A Repeat Performance" in *Current Directions in Psychological Science* no 15 (2006), pp198-202

3 Webb, TL and Sheeran, P "Does Changing Behavioural Intentions Engender Behaviour Change? A Meta-analysis of the Experimental Evidence" in *Psychological Bulletin* no 132 (2006), pp249-268

work each day; a proffered chocolate biscuit is eaten despite a strong intention to lose weight; regret is expressed following an evening that included unprotected sex; and a third pint of beer is drunk despite an intention to go home to finish an essay.

These gaps between our intentions and our behaviour, sometimes more aptly described as gaping chasms, reflect the power of immediate pleasures over more distant ones, reinforced by environments that cue the former rather than the latter, as well as a general preference for smaller, immediate gains or pleasures over larger, more distant ones.⁴ Unfortunately for those charged with improving population health, much behaviour that increases the risk of disease provides certain immediate enjoyment, while change provides only uncertain and far distant health gains. Such an understanding, though, provides a basis for designing more effective policies that aim to change the behaviour of populations.⁵

Understanding the social patterning of behaviour

Some of the difference in life expectancy and health between the rich and the poor can be explained by differences in behaviour, particularly smoking but also diet and physical activity (see figure 1). Smoking is more common in those who are poorest: 17% of men in professional occupations smoke, compared with 31% of those in manual occupations. Smoking in pregnancy is four times more common among the poorest women than among the richest, a behaviour that contributes to lower life expectancy not only in women but also in their babies.

Fruit and vegetable consumption is also socially patterned, with those who are richest consuming more than the poorest. Weight is socially patterned among women but not among men. Reflecting this, poorer women undertake less physical activity and consume more calories than those who are richer. Finally, alcohol consumption, while greater in those who are least socially deprived, has greater adverse health effects on low-income heavy drinkers,⁶ reflecting different patterns of consumption and poorer underlying health.

Many of these social patterns are likely to be mediated by the two systems outlined above – the reflective, goal-directed system and the automatic, impulsive system – reflecting experiences of different social and physical environments. A child's primary social environment of the family is core to the development of skills needed to control behaviour

4 Berns, GS et al "Intertemporal Choice: Toward an Integrative Framework" in *Trends in Cognitive Sciences* no 11 (2007), pp482–488

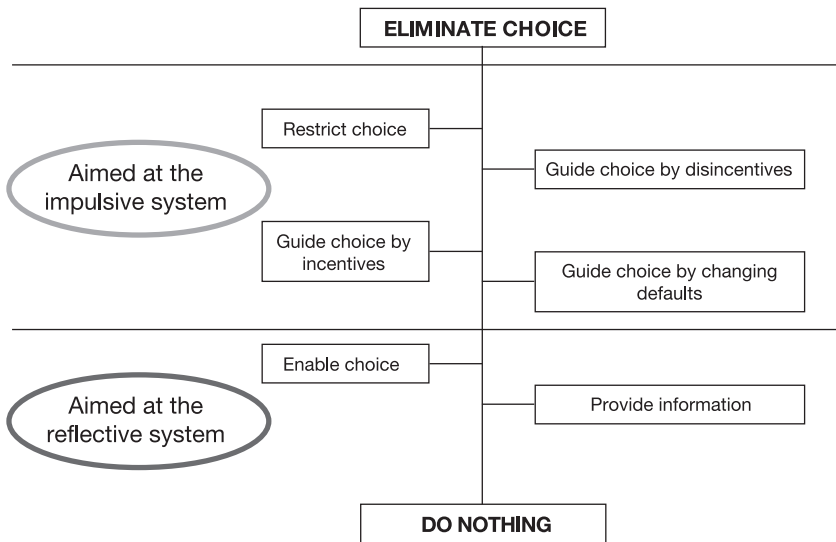
5 Dolan, P et al *Going with the Grain: Influencing Behaviour through Public Policy*, discussion document (Institute for Government, 2010); Parliamentary Office of Science & Technology *Delaying Gratification*, POSTnote 328 (2009); Grist, M *Changing The Subject: How New Ways of Thinking about Human Behaviour Might Change Politics* (RSA, 2009)

6 Office for National Statistics "Professionals Drink More than Manual Workers", news release (January 2010)

to achieve goals. Such skills arise from confident, skilful parenting characterised by "tough love", which is undermined by poverty and parental low educational achievement.⁷ Such a parenting style probably explains the lower rate of discounting the future in those who are not deprived⁸ as well as greater perceived control over their own behaviour,⁹ with a resulting greater motivation and ability to act today for future health gains.

In addition to a lower chance of developing robust self-regulatory skills, those who are more socially deprived have been exposed to more stressful social environments which have effects on brain activity that enhance impulsivity,¹⁰ as well as living in places where there are many more cues to unhealthy behaviour, such as a higher

Figure 1: State options for changing behaviours



Source: After *Public Health: Ethical Issues* (Nuffield Council on Bioethics, 2007)

7 Lexmond, J and Reeves, R *Building Character* (Demos, November 2009)

8 Shamosh, NA and Gray, JR "Delay Discounting and Intelligence: A Meta-analysis" in *Intelligence* no 36 (2007), pp289-305

9 Adler, NE and Snibbe, AC "The Role of Psychosocial Processes in Explaining the Gradient between Socioeconomic Status and Health" in *Current Directions in Psychological Science* no 12 (2003), pp119-23

10 Matthews, KA et al "Does Socioeconomic Status Relate to Central Serotonergic Responsivity in Healthy Adults?" in *Psychosomatic Medicine* no 62 (2000), pp231-237

Table 1: Social patterning of health-related behaviours in the UK (%)

	Men			Women		
	<i>Managerial/ professional</i>	<i>Intermediate</i>	<i>Routine and manual</i>	<i>Managerial/ professional</i>	<i>Intermediate</i>	<i>Routine and manual</i>
Smoking	17	21	31	14	21	29
Physical activity	32	35	43	34	25	24
Diet (5+ fruit/day)	28	24	18	35	25	21
Alcohol (5+ days/week)	25	23	15	15	12	8

Sources: Office for National Statistics (2008 data on smoking; 2006 data on alcohol); Department of Health (data on physical activity); Joint Health Surveys Unit (2003) and Health Survey for England (2001) (data on diet)

density of fast-food outlets¹¹ and more people engaging in unhealthy behaviours, including smoking. The increased exposure to other smokers, as well as higher levels of stress in disadvantaged groups, may explain at least in part why, despite being as likely to try to stop smoking, socially deprived smokers are less likely to succeed in quitting.¹²

In summary, human behaviour reflects both goal-directed and automatic processes, with the latter playing a larger role. It is therefore unsurprising that simple information about the risks to people's health, aimed at influencing goal-directed systems, is generally an ineffective way of changing behaviour.¹³ It can, however, be useful in altering attitudes to make acceptable the implementation of more effective interventions by the state or others in authority. Smarter policies will be those that capitalise on this understanding of human behaviour, working either to strengthen our ability to regulate our behaviour in "toxic" environments or to alter environments so that they cue healthier behaviours.

11 Cummins, S, McKay, L and Macintyre, S "McDonald's Restaurants and Neighbourhood Deprivation in Scotland and England" in *American Journal of Preventative Medicine* no 29 (2005), pp308-310; Macdonald, L, Cummins, S and Macintyre, S "Neighbourhood Fast Food Environment and Area Deprivation – Substitution or Concentration?" in *Appetite* no 49 (2007), pp251-254

12 Kotz, D and West, R "Explaining the Social Gradient in Smoking Cessation: It's not in the Trying, but in the Succeeding" in *Tobacco Control* no 18 (2009), pp43-46

13 WHO Regional Committee for Europe *Behaviour Change Strategies & Health: The Role of Health Systems* (World Health Organization, 2008)

Promising approaches

The state has several options for intervening to change behaviour (see figure 1). These vary in both effectiveness and acceptability. Information is generally the most acceptable intervention, compatible with libertarianism, with its emphasis upon providing information as a basis for autonomous decisions. This, however, has little effect on behaviour. Paradoxically, autonomy is sometimes fostered by more rather than less state intervention.¹⁴ This idea has been popularised in *Nudge*, which describes what Thaler and Sunstein have termed “libertarian paternalism”—libertarian in that people remain free to select unhealthy options but paternalistic in that governments play an active role in framing options. Debate on this is likely to develop over the coming decade as governments consider the failure of recent policies based on information in the context of alcohol and food, to the neglect of the powerful influence of environments largely shaped by commercial interests.¹⁵

Looking back over the past decade, there are two notable success stories in changing behaviour to improve population health: reduced rates of smoking, from 27% to 21%; and lower salt intake, from a weekly average of 13g to 8g. Achieving the former involved a range of interventions. Some were aimed at enhancing self-regulatory systems through, for example, the offer and provision of stop-smoking services. Others were aimed at altering the environment, for example by restricting smoking. Salt reductions were achieved largely by environmental change, through an agreement between the Food Standards Agency and the food industry to reduce the salt content of food in a way that did not generate competitive disadvantages.

Promising interventions over the next decade are those aimed at increasing self-regulatory skills as well as at altering environments to make healthy behaviour more likely, outlined below.

Enhancing self-regulatory skills

Self-regulation of behaviour involves a complex set of skills including goal setting, self-monitoring and adjustment of behaviour or immediate environments to achieve goals.¹⁶ Feedback to enhance self-monitoring skills appears promising as a way of strengthening self-regulatory skills.

14 Camerer, C, Issacharoff, S, Loewenstein, G, O'Donoghue, T and Rabin, M “Regulation for Conservatives: Behavioral Economics and the Case for ‘Asymmetric Paternalism’” in *University of Pennsylvania Law Review* no 151 (2003), pp1,211-1,254; Thaler, R and Sunstein, C *Nudge: Improving Decisions about Health, Wealth & Happiness* (Yale University Press, 2008)

15 Mulgan, G *Influencing Public Behaviour to Improve Health & Wellbeing* (Demos, February 2010); Reeves, R A *Liberal Dose? Health & Wellbeing – the Role of the State* (Department of Health, February 2010)

16 Carver, CS and Scheier, MF “Themes and Issues in the Self-regulation of Behavior” in Wyer, RS (Jr) (ed) *Perspectives on Behavioral Self-regulation: Advances in Social Cognition* (Lawrence Erlbaum Associates, 1999)

Feedback can provide information on the gap between an existing state and one to which an individual aspires. Bathroom scales are used by many for such a purpose. Feedback that allows self-monitoring such as this, when combined with other self-regulatory techniques such as goal setting, distinguishes more from less effective interventions aimed at increasing physical activity and healthy eating.¹⁷ Computer-based technologies in the form of text messages to mobile phones and internet-based interventions particularly lend themselves to strengthening self-regulation by prompting target behaviours and encouraging self-monitoring.¹⁸

Feedback can also be used to encourage the setting of new goals. This can be done by providing information on how an individual is doing relative to others perceived as similar. For example, Goldstein et al found that hotel guests were most likely to reuse towels when told that other guests in the same room had done so. Descriptive norms – information on what others are doing – can, however, cause those with desirable behaviour to behave less desirably, corresponding to the descriptive norm. Adding an injunctive norm – information that others approve of the socially desirable behaviour – reduces this effect.

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17 Michie, S et al "Effective Techniques in Healthy Eating and Physical Activity Interventions: A Meta-regression" in *Health Psychology* no 28 (2009), pp690-701

18 Patrick, K, Raab, F et al "A Text Message-based Intervention for Weight Loss: Randomized Controlled Trial" in *Journal of Medical Internet Research* (2009), 11(1):e1; Murray, DM et al "Interactive Health Communication Applications for People with Chronic Diseases" in *Cochrane Database of Systematic Reviews* (2005), CD004272; Wantland, DJ et al "The Effectiveness of Web-based vs Non Web-based Interventions: A Meta-analysis of Behavioural Change Outcomes" in *Journal of Medical Internet Research* (2004), 6:e40; Bennett, CG and Glasgow, RE "The Delivery of Public Health Interventions via the Internet: Actualising their Potential" in *Annual Review of Public Health* no 30 (2009), pp273-293

19 Goldstein, NJ, Cialdini, RB and Griskevicius, V "A Room with a Viewpoint: Using Social Norms to Motivate Environmental Conservation in Hotels" in *Journal of Consumer Research* (October 2008)

20 Schultz, PW, Nolan, JM, Cialdini, RB, Goldstein, NJ and Griskevicius, V "The Constructive, Destructive, and Reconstructive Power of Social Norms" in *Psychological Science* no 18 (2007), pp429-434

Such interventions, while seeming to promise significant behaviour change for little input, have yet to be shown to have an impact on behaviours more resistant to sustained change, including physical activity, diet, smoking and alcohol consumption. In the context of increasing physical activity, for example, interventions might build on the power of social norms by feeding back levels of physical activity at individual or group levels (such as in a street or housing estate), revealing an individual's or group's performance against similar others. As suggested by the recent meta-analysis in this area, such techniques are likely to be effective in combination with techniques designed to enhance or instill other self-regulatory skills.²¹

Offering financial incentives

Financial incentives and disincentives aimed at whole populations inform the fiscal policies of all governments. Increasing the cost of tobacco and alcohol decreases how much is bought and, in turn, consumed. Similar effects are predicted with food pricing, although the extent to which this is feasible, acceptable and effective in practice is currently the subject of debate.²² Personal financial incentives, by contrast, are aimed at individuals and contingent upon behaviour change. These are increasingly being used in high-income countries to motivate individuals to change their behaviour as part of schemes aimed at reducing obesity, smoking and other addictive behaviours.²³

Evidence for the effectiveness of financial incentives is greatest for drug misuse programmes²⁴ and non-habitual behaviours involving the use of health services, including attending clinic appointments and undergoing vaccinations, effects seen largely in low-income groups.²⁵ The greatest interest in their use lies, however, in their potential to achieve sustained weight loss and smoking cessation.

A meta-analysis of nine weight loss trials with follow-up of a year or more showed no improvement from the use of incentives on weight loss or maintenance at 12 or 18 months.²⁶ The authors did, however, note a weak trend in favour of incentives

21 Michie et al, op cit

22 Brownell, KD and Frieden, TR "Ounces of Prevention – the Public Policy Case for Taxes on Sugared Beverages" in *New England Journal of Medicine* no 360 (2009), pp1,805-1,808

23 Marteau, T et al "Using Financial Incentives to Achieve Healthy Behaviour" in *BMJ* no 338 (2009), pp983-985

24 Lussier, JP, Heil, SH, Mongeon, JA, Badger, GJ and Higgins, ST "A Meta-analysis of Voucher-based Reinforcement Therapy for Substance Use Disorders" in *Addiction* no 101 (2006), pp192-203

25 Kane, RL et al "A Structured Review of the Effect of Economic Incentives on Consumers' Preventive Behaviour" in *American Journal of Preventive Medicine* no 27 (2004), pp327-351

26 Paul-Ebhohimhen, V and Avenell, A "Systematic Review of the Use of Financial Incentives in Treatments for Obesity and Overweight" in *Obesity Reviews* no 9 (2008), p355-367

being more effective when they comprised more than 1.2% of individuals' incomes. Several internet-based companies offer individuals the opportunity to pledge money with the chance to win back more than they pledge.²⁷ While grand claims are being made for the effectiveness of these schemes, confirmation from formal evaluation is needed.

The evidence from 17 smoking cessation trials in a recent Cochrane review showed no higher quit rates at six months when incentives were used.²⁸ The authors noted, however, that most offered only small incentives. A recent trial, the largest to date, offered up to \$750 (£510; €560) to employees of a large organisation.²⁹ The incentives were incremental and tied to the completion of a smoking cessation programme, as well as to abstinence at six and 12 months, with the largest sum deliverable for 12 months' abstinence (\$400). This is the first trial to show that personal financial incentives can lead to higher sustained quitting for at least 12 months. While promising, it requires replication. There is also some evidence that incentives can work for pregnant smokers, although these promising findings require replication in UK samples with more reliable measures of smoking cessation.³⁰

Offering an immediate and certain incentive to change health-related behaviours seems an effective way of overcoming the often very low value accorded to an uncertain future health gain. The incentive schemes currently being used in smoking cessation and weight loss programmes are best characterised as providing rewards in the near future, but rarely are they immediate. Typical incentive programmes in smoking cessation, for example, offer rewards for validated smoking cessation at weekly intervals in the initial stages of quitting,³¹ although the most effective programmes have offered incentives either daily in the first week,³² or on just two occasions in the first six months.³³ They may therefore work by strengthening the

27 fatbet.com; makemoneylosingweight.com; weightwins.com

28 Cahill, K and Perera, R "Competitions and Incentives for Smoking Cessation" in *Cochrane Database Systematic Reviews* no 4 (2008), CD004986

29 Volpp, KG et al "A Randomized, Controlled Trial of Financial Incentives for Smoking Cessation" in *New England Journal of Medicine* no 360 (2009), pp699-709

30 Bauld, L and Coleman, T *The Effectiveness of Smoking Cessation Interventions during Pregnancy: A Briefing Paper* (UK Centre for Tobacco Control Studies, 2010)

31 Ballard, P and Radley, A "Give It Up for Baby: A Smoking Cessation Intervention for Pregnant Women in Scotland" in *Cases in Public Health* no 3 (2009), pp148-160

32 Heil, SH et al "Effects of Voucher-based incentives on Abstinence from Cigarette Smoking and Fetal Growth among Pregnant Women" in *Addiction* no 103 (2004), pp1,009-1,018; Higgins, ST et al "A Pilot Study on Voucher-based Incentives to Promote Abstinence from Cigarette Smoking during Pregnancy and Postpartum" in *Nicotine & Tobacco Research* no 6 (2008), pp1,015-1,020

33 Volpp et al, op cit

self-regulation of behaviour through prioritising limited cognitive capacity to achieve the change. Alternatively, or additionally, financial incentives may work through the automatic system by linking a positively evaluated stimulus (money) with a previously negatively evaluated behaviour such as quitting smoking.

In summary, the emerging evidence suggests that incentives can change behaviour, but the conditions under which change is achieved and sustained, for whom, and the psychological mechanisms involved, all require elucidation. Unlike many other behaviour change interventions, the use of financial incentives raises a particular set of concerns for policy makers and the public that would need to be addressed before effective schemes were to be introduced. These include their potential to result in "gaming" whereby people engage in harmful behaviours so they can qualify for incentive schemes, and the crowding out of individual and collective motivation to change behaviour in the future.³⁴ Their use also generates a sense of unfairness whereby money is offered to those perceived as *behaving badly*.

Changing environments

The power of subtle environmental changes to influence our behaviour is illustrated in an experiment conducted in the US comparing the impact of information about the nutritional content of food with the impact of where on the menu the items are described.³⁵ While the former had no impact on choices, the latter did: items presented at the start of the menu were more likely to be selected than those presented elsewhere. In addition to the layout of menus, the layout of a supermarket and a cafeteria can each influence what we buy and eat, independent of our intentions. Our physical environment also influences how active we are, with the effects of the positioning of stairs in buildings and the layout of towns and cities being well described.³⁶

Altering environments has the potential to affect the behaviour of many, across all social groups, at relatively low cost. This explains why such interventions have been the focus of much recent positive speculation for their potential to improve population health.³⁷ The environment here can be broadly conceptualised to include fixed aspects of the context in which behaviour occurs, including the built

34 Frey, B and Jegen, R "Motivation Crowding Theory" in *Journal of Economic Surveys* no 15 (2001), pp590-611

35 Downs, JS et al "The Psychology of Food Consumption: Strategies for Promoting Healthier Food Choices" in *American Economic Review: Papers & Proceedings* no 99 (2009), pp1-10

36 Saelens, BE et al "Environmental Correlates of Walking and Cycling: Findings from the Transportation, Urban Design, and Planning Literatures" in *Annals of Behavioral Medicine* no 25 (2003), pp80-91

37 Thaler et al, op cit; *A Healthier Nation*, Conservatives policy green paper no 12 (2010)

environment (such as the layout of towns), as well as the default presented when more than one option is possible (for instance, opt-out schemes for pensions, or the layout of menus). Uncertainty remains, however, about their effectiveness, including the scale of the impact we might expect from such changes. While there are several compelling examples of behaviour change following relatively modest changes to, for example, the layout of canteens, these effects are not always found.³⁸ Synthesis of existing studies would be timely to estimate the impact of these interventions, including their ability to reduce the social patterning of behaviours that influence health outcomes.

Even if effective, it is unclear how feasible it will be to alter environments that have the potential to make the most difference, given that many are under commercial control. While some companies can profit from interventions that achieve healthier behaviours, other companies will make financial losses. The alcohol industry in the UK has worked alongside government in promoting "responsible drinking". A recent government report has, however, questioned the sincerity of such a partnership, given that achieving responsible drinking in the population would be likely to result in a minimum 40% loss of sales to the industry.³⁹ Such a tension may go some way towards explaining why strategies with a high impact on reducing harm (including raising prices and restricting availability) have not been adopted, while the largely ineffective policies supported by the alcohol industry, including public education campaigns and voluntary advertising restrictions, have. Finally, the acceptability of altering environments requires consideration.⁴⁰ Discussions should, however, have as their starting point the observation that many environments are already structured to shape our behaviour, of which many may be unaware.

The challenge

In the UK we spend less than 4% of our health budget on prevention⁴¹ and less than 1% of our health-related research budgets on developing and evaluating behaviour change interventions to prevent disease.⁴² This stands in stark contrast to the scale of the prevention task. Shifting the balance of budgets even slightly from treatment to prevention seems critical.⁴³ Smarter spending has to be accompanied by rigorous evaluations that include what has been termed the application of a health

38 Hawkes, C "Financial Incentives and Disincentives" in *Which? Food & Nutrition Policy* (July 2009)

39 House of Commons Health Committee *Alcohol*, first report of session 2009-10, vol 1 (January 2010)

40 Reeves, op cit

41 Health England *Prevention & Preventative Spending*, report no 2 (2009)

42 UK Clinical Research Collaboration *UK Health Research Analysis* (2006)

43 NICE *Using NICE Guidance to Cut Costs in the Downturn* (December 2009) (<http://www.nice.org.uk/aboutnice/whatwedo/niceandthenhs/UsingNICEGuidanceToCutCostsInTheDownturn.jsp>)

inequalities filter, to determine the extent to which any intervention not only changes behaviour but also shifts the social patterning of such behaviour.⁴⁴

Looking to improve health outcomes beyond the next decade, there is a clear case for large investments to be made now in innovative, intensive early intervention programmes that teach vulnerable parents techniques to foster self-regulatory skills in children from the earliest age.⁴⁵

Whatever the size of the health budget, investing in interventions rooted in an understanding of human behaviour for what it is (often automatic, driven by feelings and cued by social and physical environments) and not for what we would like it to be (a consequence of considered thought, uninfluenced by a wider world) holds most promise for improving population health through behaviour change over the next decade.

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44 Marmot, M *Fair Society, Healthy Lives – The Marmot Review Final Report* (February 2010)

45 Children's Zone Harlem (<http://www.hcz.org/>); Family Nurse Partnership (http://www.cabinetoffice.gov.uk/social_exclusion_task_force/family_nurse_partnership.aspx)

Chapter 10

Ensuring the public interest

Andrew Dillon, Chief Executive of the National Institute for Health & Clinical Excellence

Ensuring the public interest

What is the 'public interest'?

People have an interesting attitude towards the way the NHS uses its money. In surveys we have conducted, in which we focus on the work done by the National Institute for Health & Clinical Excellence (NICE), it is clear that the people who pay for the NHS expect the money they put into it to be used as efficiently as possible. It is also likely that most people (although we have not asked them this) would want the NHS to make sure that its money is used fairly (although what people might actually mean by that is likely to vary widely). At the same time, a substantial majority do not think that money should be a factor in decisions taken about what treatments should be made available. This translates, crudely, into a view that if it works, it should be made available, regardless of its cost. This very human contradiction is not really surprising; most of us, however aware we are of the arguments in favour of evidence-based practice and the need to secure value for money, instinctively take a more personal view of what should be done for us, when it's us or someone close to us who needs care.

So what is the "public interest" in the NHS and the way it uses its resources? There is probably an interesting philosophical answer, but at a practical level I think it can be defined as follows. First, the public expects the NHS to do its job well. By that, I mean that people working in the NHS are expected to do the right thing for their patients and clients. Second, it is expected to apply its resources in ways that get the most out of them. I mean this not in the strict utilitarian sense of maximising health gain, but in the sense of a more subtle, compassionate approach, combining the strengths and minimises the weaknesses of the utilitarian and egalitarian approaches to distributive justice in healthcare. As the NICE approach to the use of social value judgements puts it:

This compromise is not a synthesis of the conflicting demands of utilitarianism and egalitarianism but a procedural device that allows the resolution of divergent values in order to provide "accountability for reasonableness".¹

This "reasonableness" in the operation of the NHS is the third element of the "public interest" in the NHS. It speaks to the notion of fair play in the British culture and is an acknowledgement of the degree of trust that the British public places in the government's stewardship of public services, which has its roots in the social reforms of the post-war government.

¹ NICE *Social Value Judgements: Principles for the Development of NICE Guidance* (July 2008)

How do we help?

NICE, through the guidance we produce, is at the front line in helping the NHS meet these expectations. Established in 1999, our purpose today is to improve the quality and productivity of clinical practice, public health and social care. We do this by:

- horizon scanning for new health technologies and practices;
- developing a range of guidance (evaluation of health technologies, clinical guidelines, public health guidance, and safety and efficacy reviews of new interventional procedures), as well as developing quality standards, clinical indicators for the GP contract, and producing resource impact assessments, commissioning guides, audit criteria, educational modules and other materials that help people use our advice; and
- making evidence-based information, including the British National Formulary, clinical knowledge summaries for primary care, and electronic journals and books widely available to all those working in health and social care, through our new web portal, NHS Evidence.

How we make judgements about value

In making our recommendations, we compare the health impact and costs of new interventions and forms of practice with those of the care already provided by the NHS, using cost-utility analysis. In cost-utility analysis, the impacts of different treatments are compared on a common measuring instrument, the quality-adjusted life year (the QALY), which expresses the impact in terms of both the quality and length of life. The independent advisory committees appointed by NICE to make decisions consider the results of the cost-utility analysis alongside submissions from stakeholders, clinical and public health evidence, and testimony from patients, the public and professionals.

Managed entry of new medicines

The price paid by the NHS for new drugs is modulated through the UK's voluntary Pharmaceutical Price Regulation Scheme. The scheme exists to ensure that the interests of patients, the NHS, industry and the taxpayer are promoted for each other's mutual benefit.

The 2009 revised scheme encompasses a much broader agenda than previous schemes and includes two new elements aimed at better reflecting the value of medicines in their price. The first – flexible pricing – allows a company to increase or decrease its original list price in light of new evidence or a different indication being developed. The second – patient access schemes – will facilitate earlier patient

access for medicines that are not in the first instance found to be cost-effective and clinically effective by NICE, within a framework that preserves the independence of NICE. Recent schemes include that for Velcade (bortezomib) for relapsed multiple myeloma, whereby the NHS is reimbursed for patients who make less than a partial response treatment (using serum M protein as the measure), and for Sutent (sunitinib) for advanced and/or metastatic renal cancer, where the company has agreed to pay for the first cycle of treatment. In the first example, the scheme was the critical factor in enabling a positive recommendation. In the latter, it made an important contribution.

Perspective on costs and benefits

When we undertake cost-utility analysis, the perspective we take into account is the direct health effects for patients and, where relevant, for other individuals, such as carers. For costs, we use those incurred by the NHS and personal social services, provided in the UK by local government.

However, there are circumstances in which a substantial proportion of the costs (or cost savings) are expected to be incurred outside the NHS and personal social services, or which are associated with significant non-resource effects other than health. In a number of exceptional circumstances, we can consider a wider perspective for costs and benefits.

Cost-effectiveness threshold range

Because the NHS has a fixed budget, any money spent on a new intervention is not available to spend on other things, so it has an opportunity cost. Therefore a new intervention or form of practice should, as a minimum, have the equivalent benefits (in QALY terms) as the things that are going to be given up. It could then be considered an efficient (cost-effective) use of NHS resources.

Obviously, we cannot measure the cost-effectiveness of every alternative use of the same money. Therefore assumptions have to be made, one of which is the cut-off point, or cost per QALY threshold, at which something is deemed to be cost-effective or not. When NICE began appraising health technologies, it was not given a threshold by the Department of Health. The committees were allowed to use their judgement in order to establish a broad level, or range, within which interventions would normally be regarded as cost-effective.

In the event, the committees' decisions to recommend the use of a treatment generally fell below £30,000 per QALY. This experience was subsequently translated into a decision framework, which guides the committees to routinely approve

treatments falling below £20,000 per QALY, and normally approve when they fall between £20,000 and £30,000. Above this level, committees would only rarely be expected to approve the use, but they can do so (and have done so) in circumstances that justify what generally involves a high cost per QALY.

It is variously argued that the range is too high, displacing more cost-effective interventions locally, or too low, preventing novel interventions from being available. We are bringing stakeholders together in 2009 to play out the arguments on both sides with a view to identifying an approach to setting the threshold range which will carry the support of the majority of our stakeholders.

Life-extending, end-of-life treatments

As outlined above, innovation tends to come at a price, compared with existing treatment. This is particularly the case when the resulting licence targets a small number of patients and therefore the potential market is small. This can inevitably result in the economic analysis indicating that an intervention is not cost-effective compared with existing care according to NICE's established criteria.

The debate has been particularly acute when this involves innovative treatments that may extend life in circumstances where an individual has a shortened life expectancy due to, for example, a terminal disease. The challenge to NICE has been that our current methods do not fully take into account the value such individuals and their families place on extensions to life beyond that which existing NHS treatments can provide them.

In January 2009, we provided our advisory committees with supplementary methodological advice.² The advice applies only to a tightly described set of circumstances, in order to maintain the general approach to securing an equitable application of the fixed resources available to the NHS.

Valuing innovation

The extent to which the healthcare system, including NICE, takes account of and values innovation is a matter of considerable interest and concern to the healthcare industries. The argument that innovative technologies both bring immediate benefits to patients and provide companies with platforms for further, potentially more significant development, is argued strongly by companies whose products are appraised by NICE.

² NICE *Appraising Life Extending, End of Life Treatments: Supplementary Advice to the Appraisal Committees* (January 2009)

In order to investigate the issues further we asked Professor Sir Ian Kennedy, emeritus professor of health law, ethics and policy at University College London, to lead a study into the issue. He delivered a report to us,³ in July 2009, with a set of recommendations on how we might better engage with stakeholders to understand and take account of the value of new interventions. We have responded to that with some changes to our processes and methods, which we think will further improve our approach in these respects.⁴

How does all this help the NHS – and the people who rely on it for their care?

Evidence-based practice improves outcomes for patients and helps ensure that resources are used efficiently. By producing guidance once, at a national level, the NHS avoids the costs and adverse consequences (including decision making of variable quality, so-called postcode prescribing and variation in service provision) that multiple decision points would inevitably produce. The NHS and the people who use advice from NICE therefore have a single point of reference, reinforcing the principle of equal access to care and the notion of a national service.

Our guidance informs the relationships that exist between commissioners and providers, and between the NHS and the people it serves. Our guidance, and the tools available to support its use, guide the service specifications that form the basis of the contracts between commissioners and provider organisations. Other information specifically targeted at commissioners is also available through NHS Evidence. Both providers and primary care trusts can use our guidance, including the new quality standards, as a means of describing the local NHS "offer" and informing patients and the public about the quality of care available and how this changes over time.

NICE guidance covers billions of pounds of clinical and public health practice. Our recommendations optimise the use of this money, ensuring that people, equipment and cash are directed to practice which we can be confident represents value for money as well as getting the best outcomes for patients. NICE is the most powerful and credible source of advice available for delivering high-quality, productive services.

NHS Evidence was established within NICE in 2009 to provide a single portal for evidence-based information in health and social care. Its location within NICE enabled it to build on the institute's credibility and expertise in the synthesis and

3 Kennedy, I *Appraising the Value of Innovation & Other Benefits: A Short Study for NICE* (July 2009)

4 NICE *Response to Sir Ian Kennedy* (March 2010)

assessment of research evidence, and to make information readily available across health and social care. In addition to acting as an electronic portal, the service supports central procurement for key resources, identifies and accredits key sources of information, and sorts, sifts and prioritises information for users.

Also very much part of ensuring the public interest is the role we play in UK plc by enabling the healthcare industries to engage more effectively with the NHS. The government regards the life sciences industries as one of the engines of recovery for the economy, and its blueprint for them, published in January 2010, sets a number of key roles for NICE. These can be summarised as:

- enhancing collaboration (for example, our new medtech evaluation pathway and our scientific advice service);
- improving uptake (including through more appraisals, medtech advice, and measuring uptake); and
- building a sustainable life sciences skill base (stimulating and commissioning secondary research and health economics).

NICE has also enhanced the global reputation of the NHS. Although it is criticised, particularly by some in the US, it is admired for its principled approach to guiding the NHS and for the objectivity of its methods and rigour of its processes. Without NICE, the UK would lose this intangible benefit and its global lead in the use of evidence to inform practice.

What would the NHS do without NICE?

Put at its simplest, the benefits described above would disappear. The NHS would return to a position in which evidence-based policy and practice, where it existed at all, would be inconsistent and of variable quality. Postcode prescribing would return, and the variations in service provision would have no defensible justification. This, in turn, would undermine public confidence in the NHS.

As the service enters a period of minimal growth, ensuring that money is used as effectively as possible will be even more important than it has been in recent years. Without NICE, the NHS would lack a systematic approach to establishing the value of new treatments and practice. There is the even greater risk that money would be wasted as a result. It is likely that, without the central NICE guidance development function, local organisations would return to developing their own “advice”, leading to duplication of effort, increased development costs and variable decision making.

Without NICE, with the mounting pressure for consistency in the availability of new, often high-profile treatments, ministers would come under increasing pressure to intervene. If they did so, they would be challenged to demonstrate that the bases of their decisions were objective and verifiable (that is, based on the evidence). The prospect of judicial challenge would be real and constant.

The opportunity the NHS has, with the advent of NICE clinical standards (to be published as a series, beginning with four pilots topics, in April 2010), to provide the basis for a consistent approach to measuring the quality of care would disappear. The challenge faced by the Care Quality Commission in assessing the NHS would become more difficult. Without these standards and the other guidance that NICE produces, the Care Quality Commission and anyone else looking to assess the quality of care provided by the NHS would need either to seek other less reliable sources on which to base their assessments or to develop their own.

Without NHS Evidence, outcomes for patients would inevitably suffer, as staff across health and social care turned to less reliable sources of advice or simply ignored evidence-based practice altogether and rely on local opinion and ambition. Adoption of effective new treatments would be slower, and might be blocked completely in some areas, either on cost grounds or simply through lack of knowledge. Without NHS Evidence, significant staff time would be wasted in identifying relevant evidence from a wide range of different resources, and procurement of journals and books would be inefficient and more costly.

Patient and public involvement is essential in securing the public interest

By working with patients, carers, patient organisations, service users and the public, NICE is much more likely to secure the public interest in its work by producing guidance that addresses the concerns of patients and carers, reflects their views and meets their healthcare needs. Giving a voice to the user interest is thus not just a matter of principle, but also vital in assuring the quality and relevance of our products.

Patient and public involvement in NICE's work takes several forms, but falls into two main categories: involvement in guidance development; and involvement in what might be called the development of NICE "policy".

There are opportunities for involvement at various stages in the development of guidance. Patients, patient organisations and the public can comment on the scope and various drafts of the guidance, submit evidence, and join committees and

working groups. The degree or depth of involvement varies. For example:

- National patient and user organisations can register their interest in topics in NICE's work programme. Registration means that an organisation can influence the way the institute interprets evidence and enables it to suggest potential members of committees and working groups.
- Individuals can apply for membership of advisory committees and working groups. We publicise vacancies through national patient and carer organisations, the NICE website, and sometimes the national press. They can also participate in other ways. For example, the groups producing NICE guidance sometimes need to collect information on patients' and the public's views and experiences, using focus groups, workshops and surveys.

Increasingly, patient organisations are helping us by disseminating guidance to individual patients and carers and encouraging the NHS to implement the guidance as quickly as possible.

The Citizens Council

Involvement at a policy level also takes several forms, but probably the most innovative of these involvement mechanisms is NICE's Citizens Council. How did this come about?

As NICE began its work, two things became immediately apparent. First, public involvement in our work was going to have to go well beyond the occasional consultative exercise and, second, we would have to be able to explain the basis of our decisions. Genuine involvement is underpinned by sensitive process design and support, in our case, provided by our patient and public involvement programme. Explaining why we are making a particular recommendation, however, requires us to show how we have interpreted the evidence and, importantly, how we have made the scientific and social value judgements that inevitably influence the outcome.

The nature of the scientific value judgements that need to be made will be familiar to anyone undertaking research. They involve, for example, deciding on the relevance of studies and the quality and generalisability of clinical trials. However, social value judgements are also applied. They relate to society, rather than science. They take account of the ethical principles, preferences, culture and aspirations that influence the nature of the services provided.

The kind of social value judgements that our advisory committees come across include matters such as whether our assessment of the cost-effectiveness of interventions for babies and young children should be more generous than for middle-aged or old people. Another would be whether the NHS should be prepared to pay premium prices for drugs for very rare conditions.

As a general proposition, it might be reasonable to assume that the public would be prepared to accept that scientific value judgements should be made by those with the competence to do so, provided always that it is done transparently. Such experts do not, however, have any special legitimacy in making the necessary social value judgements. Those judgements need to reflect the values held by those who pay for and use the services concerned.

Having reached this conclusion, we needed to decide how best to elicit those views. We looked at different mechanisms, including opinions polls and surveys, and focus groups, both of which offer a sense of the public's views and reactions to particular issues. However, we were particularly interested in citizens juries. We liked them particularly because of their deliberative approach and the ability to hear and cross-examine witnesses.

So we set up our Citizens Council in 2002 as a deliberative forum, with a membership of 30 people. The membership changes by a third annually, thus preventing the council from being "captured" by NICE or developing an unrepresentative approach to its work. In addition, the meeting is facilitated by an independent organisation. When we advertised for members we received 35,000 expressions of interest. If ever one needed an indication of the extent to which the public is interested in how its institutions work on its behalf, this would seem a pretty good example. Some 4,500 people actually made an application to join the council. The people who were appointed reflected the demographic structure of the population of England and Wales with respect to gender, age, ethnic background, socioeconomic status and disability. Their ages ranged from 18 to 76 years and included a cab driver, a scaffolder, a single parent and a retired airline pilot.

The Citizens Council has now produced around a dozen reports. As an example, for the second of these reports we asked the council to consider whether there were any "circumstances in which the age of a person should be taken into account when NICE is making a decision about how treatments should be used in the NHS". The council's view was that, first, health should not be valued more highly in some age groups than in others. In other words, one year of life is of the same value whether a person

is three years old or 83 years old. Second, individuals' roles at different ages should not influence considerations of cost-effectiveness, so people with young children, say, and people with special professional responsibilities should not be given priority.

Third, where age is an indicator of risk or benefit, for example in the targeting of people over 65 for influenza immunisation, it should be taken into account. Incidentally, this latter recommendation, when it was included in our guidance on social value judgements, was widely misinterpreted. It was suggested that NICE regards life in old age as less important than earlier life. This simply is not true, and nothing in what we have written or the decisions we have made supports the accusation.

We have been careful to inform the council's work with expert witnesses and also with commissioned research. For example, when we looked at the age question, we asked the National Children's Bureau to try to establish the views of children and young people. They worked with groups of children in a range of settings, including after-school groups and in classrooms. What was interesting was that children generally supported the view that no one age group should have preferential treatment over another.

More recently, the council has considered the circumstances in which it would be reasonable to introduce mandatory public health measures. In considering who has responsibility for the public's health, individuals or the state, the council took the view that where possible people should have freedom of choice and be responsible for their own health. The state should attempt to educate people to adopt a healthier lifestyle and try to persuade them to access the help they need voluntarily. But ultimately, and if necessary, we should adopt mandatory measures. Freedom of choice is overridden by the responsibility not to cause harm to others, and where others are being harmed by a particular activity the state has a right to intervene.

Conclusion: the NICE 'offer'

Our core expertise covers a range of functions relating to the development and provision of evidence-based information and guidance across health and social care:

- analysis and synthesis of research evidence into recommendations for routine clinical and public health practice;
- health economics and cost impact assessment;
- active stakeholder engagement to develop and support the use of our guidance;
- setting standards, indicators and audit criteria for measuring processes and outcomes;

- assessing and accrediting the quality of externally generated guidance and evidence-based products; and
- information technology expertise in searching and retrieving information, including leading on standard metadata and taxonomy requirements.

As the NHS emerges from a period of rapid expansion into one in which improvements will still be expected but with little or no real-terms growth, the suite of advice that NICE offers will be an essential resource. NICE guidance helps NHS practitioners and organisations to direct their resources to practices that will deliver good outcomes for patients, avoiding interventions and approaches to care that have little or no value. Our guidance helps to identify the circumstances in which patients should be referred for further investigation and treatment, and our new quality standards (which will be published from summer 2010) will enable NHS boards as well as individual health professionals to assess whether what they are providing really is the best the NHS can offer.