Delivering a new health agenda

NHS: new health services
Managing the budget
Healthy competition

With Simon Burns MP, Rt Hon Stephen Dorrell MP, Dr Phillip Lee MP, Rt Hon Lord Warner of Brockley, Cynthia Bower, Steve Bundred, Sophia Christie, Adrian Fawcett, Dr Nicolaus Henke, Sam Lister, Andrew Manning, Professor Alan Maynard, Mark Pearson and Roger Taylor
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# Programme

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<td>08.30 – 09.00</td>
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| 09.00 – 09.20 | Welcome and introduction             | Andrew Haldenby, Director, Reform  
Andrew Manning, Chief Executive, Bevan Brittan |
| 09.20 – 10.15 | NHS: new health services               | There is a growing recognition that some services will need to change from their current form. Hospitals, in particular, are increasingly unable to meet the needs of a modern healthcare system. This session will discuss how the reconfiguration of services can reduce costs and improve the quality of care. This session will also discuss what can be done to ensure greater integration of care and maximise clinical leadership.  
A panel debate chaired by Dr Patrick Nolan, Chief Economist, Reform  
Dr Phillip Lee MP, Member of Parliament for Bracknell  
Sophia Christie, Chief Executive, Birmingham East and North Primary Care Trust  
Cynthia Bower, Chief Executive, Care Quality Commission  
Sam Lister, Health Editor, *The Times* |
| 10.15 – 10.45 | Keynote speech by Simon Burns MP     | A keynote speech by Simon Burns MP, Minister of State for Health, on the new health agenda. |
| 10.45 – 11.15 | Coffee                               |                                                                              |
| 11.15 – 12.10 | Managing the budget                  | The NHS needs to deliver value for money. Patient expectations, more expensive treatments and an ageing population will put the budget under pressure. Controlling costs will be vital. This session will discuss what can be done to make savings and how better commissioning, management and innovation can reduce waste without undermining the quality of care.  
A panel debate chaired by Andrew Haldenby, Director, Reform  
Rt Hon Stephen Dorrell MP, Chair, House of Commons Health Select Committee  
Roger Taylor, Director of Public Affairs, Dr Foster Intelligence  
Dr Nicolaus Henke, Director and Head of Healthcare Practice, McKinsey & Co  
Professor Alan Maynard, Professor of Health Policy, University of York |
| 12.10 – 13.05 | Healthy competition                 | Healthy competition can drive innovation on the front line of health services and lead to better health outcomes. However, competition is held back by barriers to entry and it is uncertain how proposed commissioning arrangements will encourage competition. This session will discuss possible benefits from expanding patient choice and encouraging the emergence of new business models for healthcare, and the barriers to these changes taking place.  
A panel debate chaired by Nick Seddon, Deputy Director, Reform  
Rt Hon Lord Warner of Brockley, Former Health Minister 2003 to 2006  
Adrian Fawcett, Chief Executive Officer, General Healthcare Group  
Mark Pearson, Head of Health Division, Organisation for Economic Co-operation and Development  
Steve Bundred, Chair, Monitor |
| 13.05 – 13.10 | Closing remarks                      | Reform will sum up and close the conference                                   |
| 13.10 – 13.40 | Lunch                                |                                                                              |
Healthcare is an expensive business and is set to become even more so. Derek Wanless’s projections demonstrated that health costs will increase to £137 billion, or 10.6 per cent of GDP, in 2017. The challenge for health reform is not only to save money in the next few years, but to make the health service affordable for the 21st century.

Over the last decade the approach has been to avoid dealing with challenges by throwing more money at the NHS. As is well known the budget for the NHS doubled in real terms between 1999 and 2009 and accounted for 40 per cent of the total increase in spending in public services between 1997 and 2007. Yet rather than delivering proportionate improvements in health outcomes, too much of this increase in spending was simply eaten up by higher wage bills and over-investment in hospital buildings.

The parlous state of the public finances means that this approach of “spending not reform” cannot be sustained. This is a serious constraint – as the rising cost of treatments, growing patient expectations and an ageing population will put pressure on the health budget and mean that the service needs to make savings of £15 billion to £20 billion over the course of this Parliament.

Achieving efficiencies on this scale from a total annual budget of £105 billion should be possible. Indeed, the size of the NHS budget means that no other departmental budget can offer the same scope for savings. There are, however, good and bad ways of saving money. Simply trimming budgets would lead to the disruption of services, more ad hoc rationing of care, rising waiting times and breakdown of specialist care. Top-down exercises to drive innovation and service redesign lead to local people feeling disenfranchised from the management of local health services. To address waste in the system and ensure that the NHS delivers value for money a new approach is needed.

The Government has set out a plan to radically reorganise the NHS. Current administrative structures will be torn down and GPs will be put in charge of around £80 billion of the budget. The jury is out on whether this will shake up the NHS so it better suits patients or whether this will be another radical “redisorganisation”, to use Alan Maynard’s coinage, without long-term progress. What is clear, however, is that, given the poor state of the public and NHS finances, this is a high risk gamble.

What is also clear is that, by choosing to reorganise the service rather than grasp the nettle on how health services are financed, the Coalition has missed the real opportunity for NHS reform. An honest debate is needed on how health services are funded. Other international countries have faced the need to consider the greater use of co-payments and user charges, to define a core set of services that the public system provides and to encourage the greater role of insurance. It is time to catch up with these international debates.
NHS: new health services

The National Health Service is the sacred cow of British politics. Party leaders proclaim their lifelong love of it and MPs vow to fight for their local hospitals, but few dare spell out the difficult realities it faces – not least, unprecedented pressure on funding in the next few years.

Nothing in politics is harder than closing a hospital. Yet redesigning services is the right thing to do. It is the right thing to do in the face of the funding pressures and, more importantly, it is the right thing for the health of the population.

The key challenge of a modern healthcare system is to improve the quality of life for people with long term conditions. This means the NHS needs new innovative ways to deliver treatment. Advances in clinical skill and new treatments have enabled more patients to be treated at home and outside hospitals. However the NHS continues to focus its resources on hospital care.

Clinicians and NHS managers have tried to introduce new ways to provide care for patients and integrate services but too often blind opposition to change has bedevilled this modernisation. Changes to services will be most effective if they are local initiatives carried out by locally accountable managers, but Ministers and MPs often find the short term political gain from blocking closures too hard to resist. Let us hope that in the new Parliament, instead of protests blocking change, we see local people marching to reform their local hospitals and shift more care into the home.
With the rising costs of an ageing and increasingly obese population, the continual demand for better health services and the increasing costs of new medical technologies and drugs, it is no surprise to those of us who work on the “front line” of healthcare that the manner in which we deliver and receive healthcare requires much debate and consequent reform. To my mind, the way in which we configure healthcare services in this country must be based upon true clinical need and the best clinical outcomes. My decade long professional experience of the NHS in the Thames Valley has proved to me that the structure of healthcare services can impact negatively upon both morbidity and mortality statistics. Drawing upon this local experience, I will suggest that a future with fewer, better located, acute hospital sites and more community-based clinics could lead to better health outcomes for all.

It is, however, not just about the supply of healthcare. The realities of the political cycle have led to the implementation of policies by previous governments to attract “positive” media coverage, often with little regard to any actual benefits to this country’s long-term healthcare provision. Clearly, it is politically easier to address perceived supply problems than deal with the population’s ever increasing demands. I would argue that unless policies address this inexorable increase in the demand for services, the future of the NHS in its present state remains bleak. It is my belief that an honest and open discussion about where the responsibilities for both an individual’s health and local healthcare provision should lie is long overdue in this country.

Dr Phillip Lee MP, Member of Parliament for Bracknell

Sophia Christie

The challenge for the NHS

The first decade of the 21st century has been characterised by the realisation of the digital opportunity. Like many other fields, medicine has been revolutionised by modern technology. Medical imaging and minimal interventions have emerged as an alternative to major surgery, while new pharmaceuticals have allowed greater management of disease. The increasing role of genetics has not only allowed greater understanding of family risk, but also targeted interventions in the treatment of cancer. Public expectations have more than kept pace with these changes, with baby boomers reaching an age where they become common recipients of health services. Significant improvements in access have fed the belief that local and immediate is always best, while the constant reporting of petri dish findings as “golden bullets” have driven the perception that every death is a service failure as opposed to a natural event.

These major developments have largely been adopted within a structure which has stayed remarkably static since 1948 when the nationalisation of hospitals placed them at the core of the NHS. New policiesj have locked us into a largely 19th century model of care.

Hospitals originally emerged as a response to a situation of few doctors and huge demand, where illness tended to be infectious and acute and with limited treatments available other than rest under observation. They also provided a useful concentration of patients as a basis for teaching and research. However, we now manage most illness through pharmaceuticals, with the potential for chemotherapy and other sophisticated treatments to be delivered outside hospital. Access to diagnostic and interventional technology means that even invasive procedures can be carried out with minimal collateral damage and risk of infection and early rehabilitation. For example, the George Eliot hospital now safely undertakes 24-hour hip replacement, to the significant benefit of elderly recipients at particular risk of infection, pressure ulcers and confusion from a prolonged stay in hospital. Hospitals remain a key element of the system, but within an increasingly sophisticated network of care, which no longer sees the “bed” as a technology in its own right.

The nature of the “problem” facing the NHS has shifted from acute intervention in infectious disease to the long-term management of chronic conditions. The greatest potential benefit is increasingly to be realised through prevention and delay of the onset of disease, rather than radical new treatments in acute phases. Much of the government activity of the last term was focused on addressing years of under-investment through improvement within the traditional model of delivery. Access, payment by results and infection control was all about improvements to institutions within the current model (at considerable expense). Relatively little attention and less money was given to personalising care around the patient by making best use of telephone, email, community support and crucially challenging poor practice in addition to incentivising the good. In his recent book The Innovator’s Prescription, Clayton Christensen notes that it is rarely those who have dominated a mature market who successfully deliver innovation, as their business model will be predicated on traditional delivery. If we are to realise significant productivity gains, which will realise the promise of better quality services, we shall need new business models and new forms of delivery.

In the 21st century, in constrained economic circumstances, we may want to start with thinking about the home as the hub of healthcare, the patient as most likely to be elderly, with multiple conditions, and a user of a range of public services, and our core response to the broader population being the application of marketing and nudge psychology, to support wise choices both in staying well and in seeking help when ill. This implies a very different infrastructure for both delivery and the pattern of investment, and an ongoing attempt to develop this without fundamental review of the distribution of the essential acute infrastructure will just increase costs and promote unresponsive, unfair care.

Sophia Christie, Chief Executive, Birmingham East and North Primary Care Trust
Cynthia Bower
Integrated care – challenges and opportunities

Care Quality Commission is the regulator of England’s healthcare and social care services. It is our job to make sure they meet essential standards of quality and safety, and give people a positive experience. As the first regulator to look across the NHS, social care and the private and voluntary sectors, we can give a complete picture of care in England.

So how important is integrated care? A Nuffield Trust study from 2005-08 showed that 90 per cent of people who used social care also received secondary healthcare over a three-year period. The Government expects that 1.7 million more adults will need care and support within 20 years. Growing demand and shrinking resources mean there is a real need for more, and better, joined up care to deliver good quality and safe outcomes for patients.

At the heart of better care is effective service configuration and hospitals play a vital role in the care pathway. So many points of the hospital journey have an impact – admission, length of stay, discharge, information sharing with other parts of the system, and links with local social care services. When these are poorly managed they can have a major cost, both personal and financial.

Many leaders in health and social care services are aware of this. Real change has taken place in policy and in practice to try to improve integration. In the most recent CQC State of Care report, we found that 148,000 people in England had access to services that helped them avoid emergency hospital admissions, compared to 80,000 five years ago. Delayed discharges from hospital fell from 3,600 a week in 2003-04 to 2,200 a week in 2008-09.

This is steady progress, and it is the right direction of travel in terms of outcomes and cost. CQC’s analysis suggests that reducing emergency stays for people aged over 75 in line with the best performing hospitals would result in 8 million fewer days in hospital per year. This would provide a saving of £2 billion a year.

 Joined up care is a challenge for both sectors, but the benefits to the care services and people who rely on them could be significant. It needs dedicated teamwork across agencies and disciplines. It takes innovative thinking, a willingness to develop new ways of working, strong leadership and commitment. Services need to be configured in a way that leads to the best care outcomes, and not in a way that protects budgets in existing silos. In the current economic climate, this will be no mean feat.

Cynthia Bower, Chief Executive, Care Quality Commission

Sam Lister
A radical blueprint

As a message of intent, last week’s NHS White Paper looked every bit the work of a Health Secretary-in-waiting. Six years sitting on the shadow frontbench, watching a succession of Labour ministers pass in and out of Richmond House, has given Andrew Lansley the time to build a strong, coherent vision for the health service. It has made for a mission statement packed with innovative initiatives - from the NHS Commissioning Board and GP consortia to the Public Health Service and more formal local authority involvement - and laced with the new Government’s watchwords of reducing costs and improving quality.

Few would deny that the NHS, for all its productive reforms in the New Labour years, has become a behemoth that happily consumes every taxpayer pound pushed its way. Efficiency and accountability have fallen by the wayside; and levers are needed urgently to drive better value for money. The Lansley vision, in its simplest form, has a more efficient NHS with GPs holding most of the purse-strings, using their front line knowledge to commission the most effective forms of care. His flabby fall-guys are the service managers, who will be subject to cost-saving cuts that will chop down the complex Primary Care Trust and Strategic Health Authority hierarchies.

The extent of the reorganisation will be enormous - far greater than anyone would have thought from the Conservative or Liberal Democrat manifestos and campaign speeches a few months back. Bland statements of a more personal NHS and improved integration between primary care and hospitals have been translated into a radical blueprint that brings a more open market for healthcare providers and “quality standards” and outcome assessments that make the patient less passive recipient and more arbiter and architect of care.

The energy is refreshing - coming after a period of stagnation for health policies - and some of the restructuring may work. The problem is that such sweeping change cannot avoid being costly, and will require several years of rigorous Westminster policing, starkly at odds with the Lansley mission to devolve NHS power.

It also offers a model of reconfiguration that tiptoes around the elephant in the room. Bringing personalised care ever closer to people could make some hospital departments, and even entire hospitals, an unnecessary indulgence - offering services that do not cater for enough patients to make them economically viable, or safe. The idea of merging costly, semi-redundant District General Hospitals is far too emotive to be included in the Lansley script. It is, however, a reconfiguration endpoint that cannot be avoided.

Sam Lister, Health Editor, The Times
Bevan Brittan is delighted to be hosting this critical and timely event in the week following the Coalition Government’s publication of a blueprint for the future of the NHS in the White Paper *Equity and excellence: liberating the NHS*.

The changes proposed in the White Paper go further than any other reform since the inception of the NHS. At the heart of the proposals lies a fundamental realignment of relationships throughout the health service; placing much greater emphasis on individual patients to exercise greater involvement and control over their care. Alongside this significant empowerment for patients there is a wide range of issues affecting clinicians; most notably for GPs with their role in GP commissioning and more widely on employee engagement at its highest level through to employee controlled social enterprises. This is intended to drive a continuing revolution in quality of services.

To further support that revolution a complex range of new relationships will be required between independently commissioning GP practices, NHS Trusts (Acute and Mental Health) and a range of public and private sector stakeholders in the NHS. At the heart of these relationships lies a statutory and contractual framework within which the NHS operates – changing these frameworks and the legal parameters on which they are based is one of the many immediate challenges required to deliver the reform.

At the most simple level, the immediate legal issues include GP contracts, contracts between healthcare providers (GPs, Acutes, Mental Health Trusts, and Local Authorities) and GP accountability. But at a more complex level, legal questions that must be addressed concern the future ownership and replenishment of the significant NHS asset base, to new relationships with social care providers and local authorities and the challenge of achieving major change and reducing costs simultaneously.

We look forward to participating in the ongoing discussion about implementation of the Coalition Government’s vision for the NHS and Bevan Brittan, with a range of other key advisors to the NHS, will continue to act as critical friends in identifying and resolving the many issues of detail still outstanding.

*Stephen Hughes, Partner, Head of Health, Bevan Brittan*

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**Fewer hospitals, more competition**

“The taboo has been broken. There is now debate about closing hospitals as an essential step towards improving UK healthcare.”

Richard Vize, Health Service Journal

“Today the centre-right think-tank Reform attempts to puncture the prevailing complacency with a radical programme of cuts to shift more NHS care into the community, obtain more bang and save extra bucks.”

Jeremy Laurence, The Independent

“Could a quarter of hospital beds be abolished? A new report says ‘yes’.”

Stephen Pollard, Daily Express
Managing the budget

The state of the public finances is perhaps best summed up by the words of Liam Byrne in his letter to his successor at the Treasury: “Dear Chief Secretary, I’m afraid to tell you that there’s no money left.” The Government has committed to accelerating the elimination of the deficit, with an emphasis more on reduced spending than tax rises. Oddly, though, it has promised to increase spending on the NHS.

It is perverse to commit to protecting an area of public spending where so much waste has been identified. Real terms health spending has doubled since 1999, yet over the same period, according to the Office for National Statistics, productivity fell by 0.3 per cent on average each year.

What is needed is structural reform – not just of the delivery, but also the purchasing.

This is about putting money – and power – in patients’ hands. The best way to do this is to increase private contributions to health costs, in line with other developed countries. As the OECD recently found, countries with private insurance models score better than the UK on both quality and equality.

As demand rises in the future, the challenge will be to meet consumers’ demands without increasing the burden on the state. Sadly, ringfencing public spending on the NHS is not the solution. It is a Pyrrhic victory that will do nothing to save the NHS; instead, the NHS, which the Government has worked so hard to neutralise, will be the great flashpoint of this Parliament.
Delivering a new health agenda / Reform

Thomas Cawston
Paying for tomorrow’s health system

Probably the biggest mistake that the Coalition has made has been to ring-fence the health budget. Health is not only the largest departmental budget but has also been the main beneficiary of the increase in spending over the last decade. Real terms health spending has doubled since 1999, reaching around £105 billion in 2009. Over the same period productivity fell each year by 0.3 per cent on average. Despite this the Coalition has refused to reduce the NHS budget, which means that other departments have been asked to find savings of up to 40 per cent.

But even protecting health from the spending cuts that are needed to restore the public finances will not satisfy the NHS’s insatiable appetite for taxpayers’ money. The ever increasing cost of new treatments and the rising demand for healthcare fuelled by patient expectations and an ageing population will mean the NHS could face a funding gap of as much as £41 billion by 2017.

For many, this funding gap means the NHS budget should be sacrosanct. But whether the budget is cut or not, the NHS will need to deliver value for money on an unprecedented scale. If the budget is ring-fenced, the NHS will need to deliver annual efficiency savings of at least 3 per cent to fund rising demand. This is not impossible. Over the last decade the NHS has over-invested in the wrong buildings and over-invested in the wrong staff. Too much care is still delivered in hospitals and more than half the NHS budget is spent on staff.

Roger Taylor
Health and technology

The NHS is embarking on the toughest financial squeeze in its history. To implement the necessary changes it is relying on a commissioning system which almost all commentators agree lacks the skills necessary for the task.

There is much debate over the relative merits of different structures for deciding how budgets are spent but no real evidence that one approach works better than another. Overall, attempts to get more for less out of healthcare systems have a very chequered history - spending on commissioning often costs as much as it saves.

If we look beyond the issue of organisational structure however, there is strong evidence that particular strategies can drive up quality and get more for every pound spent. We know that defining standards and auditing their implementation can be a very effective way to get more for less. We also know that comparative outcomes data helps to raise quality. In England, we have seen top down targets achieve great success in addressing issues of major public concern such as long waiting times and infection rates. These approaches are all about better use of information – measuring performance and setting standards. But they have been applied consistently to relatively few areas of healthcare. Disagreements about access to data, reliability of information and approaches to measurement have hindered the broader application of these approaches. And while it needs to be acknowledged that the NHS’s history with information technology is, if anything,
Managing the budget: five themes

Dr Nicolaus Henke

For political leaders, health ministers, finance ministers, or, indeed, Prime Ministers or Presidents, healthcare is a juggling act. The challenge is to boost economic competitiveness and maintain a grip on fiscal expenditure, whilst trying to achieve superior health outcomes and access for patients. When it comes to healthcare, the public are fickle consumers – they rarely give credit for improvement but rapidly articulate dissatisfaction. The challenge is here to stay. Healthcare is, perhaps, the greatest success story of the last century: in the developed world, life expectancy has doubled, and quality of life has been vastly improved. As a sector, healthcare has continuously expanded its share of national wealth: in OECD countries for each of the last 60 years health spending has grown by GDP growth plus 2 percentage points. Why? Technology, ageing, and poor lifestyle choices (drinking, smoking, obesity) are part of the answer – but the most significant factor has been rising expectations. In short, as societies become wealthier, they devote more resources to healthcare.

If the next century looks like the last, then more than half of GDP would be dedicated to health by the year 2100, and the United States (the outlier in terms of rapid spending growth) would see 98 per cent of GDP absorbed by the healthcare sector. This is clearly as absurd as it is impossible. So, what needs to change? The only solution will be dramatic productivity growth in health systems. Health systems face a fundamental choice: double or triple productivity, or ration access to care.

Here are five themes for maintaining the budget:

• **Maintain strong accountability.** As a general rule, systems with cash-limited budgets (e.g., Scandinavia, Australia, Canada, Spain) spend less than comparable systems which define the benefit bundle without constraining expenditure (e.g., Germany, Switzerland, US). The fundamental difference is the power to say “no” to an intervention so that financial control is maintained. GP commissioning could be a particularly successful example of this for well documented reasons.

• **Harness incentives and information.** While various closed systems, such as Kaiser Permanente, have achieved a lot through combining powerful and real time patient information with appropriate incentives, most open regional or national systems struggle with encouraging patients to use information and become “fully engaged”. An interesting exception is Singapore, which spends less than 4 per cent of GDP for European level outcomes - which through co-payments incents patients to use services responsibly. Another example is Valencia, where 21 sub-regions serve a population of five million in a free choice model.

• **Seize the opportunity of payment shifts.** Many systems which have experienced challenging budget periods have used shifts of payment system to apply quite significant improvements to productivity. For example, various states in Australia reduced hospital tariffs between 1 per cent and 10 per cent upon the introduction of Diagnosis Related Groups. There are various changes in allocation and pricing regime in store in England, and all may have potential in this area.

• **Drive provider productivity.** Of the levers above help to constrain the overall budget growth and reduce demand, but driving provider productivity remains key. At the McKinsey Hospital Institute we observe that provider organisations show inexplicable variance across multiple metrics – including annual productivity growth. The question is how to make the rest as good as the best.

• **Let innovation flourish.** This is a time to embrace disruptive change, to sacrifice dogma, and be as bold as we are open to new approaches. Our recent research in partnership with the World Economic Forum has shown that step-change improvements in productivity are possible – delivering high quality maternity care for one-sixth the cost, for example – and that those who succeed share a set of common practices. Many models and solutions exist – the challenge is for health systems to allow these models to enter and to flourish.

Dr Nicolaus Henke, Director and Head of Healthcare Practice, McKinsey & Co

Delivering a new health agenda / Reform

Professor Alan Maynard

Doctors are the problem! Doctors are the solution!

Despite large differences in culture, politics and the structure of public and private healthcare systems, their problems are similar: much of healthcare lacks an evidence base of clinical let alone cost effectiveness; there are large variations in clinical practice and “what works” is often not delivered to patients; medical errors are excessive; and there are no measures of success or whether healthcare makes “patients better”. These ubiquitous problems have been well evidenced for decades and ignored by policy makers, public and private. For instance the 1845 Lunacy Act sought to get hospitals to measure whether patients were “dead, recovered, relieved or unrelieved” and Semmelweis was advocating rigorous hand hygiene in hospitals in 1848. Sadly healthcare today has not implemented the policies of 150 years ago!

Why is this? Professions were described as a “conspiracy against the laity” by George Bernard Shaw and Milton Friedman in *Capitalism and Freedom* concluded that “occupational licensure” has reduced both the quality and quantity of healthcare. In principle the objective of medieval guilds and professions was to provide consumer protection. In practice they inhibit it.

A patient entering a hospital might expect benchmarking of potential errors such as wrong drug/wrong dose, wrong site surgery, pressure sores, central line infections in intensive care, catheter induced urinary tract infections.
infections, patient falls and other “adverse events.” In practice, benchmarking is often absent as is managing these rates down to protect the patients.

A patient might also expect that their surgeons were part of national audits and efforts by peers to identify outliers and continually improve practice. Often audits are voluntary and incomplete. Patient protection is absent and this is compounded by the failure of Colleges and the General Medical Council to oblige practitioners to benchmark and audit as a condition of re-accreditation.

Whether or not government reorganises the structure of the NHS, the challenge is to ensure that “physicians heal themselves” by acting in a transparent and accountable fashion. The techniques of production engineering (e.g., “Six Sigma”) need to be used to ensure continuous quality improvement by applying existing activity data (i.e., hospital episode statistics) and emerging patient level cost data and patient reported outcomes information (PROMs).

Doctors determine how resources are allocated and it is they who should be obliged to manage each other efficiently and thereby protect patient and taxpayers’ interests.

Professor Nick Bosanquet, Professor of Health Economics, Imperial College and Consultant Director, Reform

GP commissioning: realism on implementation

GP commissioning is a good aim with great longer term promise but could be ruined by the manner of implementation. To succeed it needs a realistic implementation plan – which will need the whole five years of the Coalition.

At present the start of GP commissioning will coincide with the epicentre of the financial hurricane of 2011. The immediate impact will be greatest on NHS Trusts - the Operating Framework will shift deficits from Primary Care Trusts to NHS Trusts. By November 2011 it is highly likely that between 35 and 40 NHS Trusts will find that they do not have funding to cover their pay bills for the rest of the year. They will then put great pressure on commissioners for an emergency bailout. The NHS has to have the capability to manage the cost increases which are heading its way.

In practical terms, there is no way that 500 GP commissioning groups can have accurate budgets by April 2012. Each group would have around 60 GPs covering a population of 100,000 patients with a budget of £115 million. In practice the funding would have to be distributed by a formula, given the lack of any accurate local information about spending for local populations. For 2011-13 there would be great insecurity about the possible appearance of deficits. Nor are the new groups equipped to drive forward initiatives to find £15 billion to £20 billion of essential savings.

A more realistic approach would be to abolish Strategic Health Authorities but keep Primary Care Trusts to manage the introduction of GP commissioning. The presence of the Strategic Health Authorities blurs responsibility and the Government is right to abolish them. Some leading Primary Care Trusts should be given responsibility for developing balance sheets for business units – and informatics for increasing GP and patient choice. They should also mentor the groups – we need to find a new generation of GPs leaders. The fund holders are long gone. After some years Primary Care Trusts could be reduced in role and number – back to the 60 unitary authorities of the first Kenneth Robinson Green Paper of 1967: but now is not the time for another top down reorganisation cut off from the realities on the ground.

GP commissioning could work but at present it is an aspiration. The Coalition has five years to develop a workable system for local responsibility.

Professor Nick Bosanquet, Professor of Health Policy, University of York
The UK’s No. 1 independent healthcare provider

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million
patient visits per year

General Healthcare Group (GHG) focuses on clinical excellence, quality of service and efficiency, and has a deserved reputation in the independent healthcare sector for consistent achievement of these values. For more information about GHG, please visit www.generalhealthcare.co.uk
As Albert Einstein wrote “if you always do what you always did, you’ll always get what you always got.” This is true of healthcare. New ways of delivering and funding health services are needed if the UK is to improve value for money of health services and do the right thing for patients.

Some people mistakenly see innovation as being just about science. However, as well as the science behind new treatments and technologies, innovation requires changes in ways in which services are funded and delivered. This innovation in business models occurs when, for example, providers enter markets and discover new ways of delivering services that are closer to the home, more convenient for patients, deliver better clinical outcomes and cost less.

Research shows that competition, especially from the threat of new entrants, can be a key factor in encouraging more innovative health systems. This is why, if done in the right way, greater competition can lead to improvements in clinical quality, such as faster reductions in mortality from acute myocardial infarction, a more business-like culture and higher levels of patient satisfaction.

However, competition is not a silver bullet. If the policy context is not right then competition can fail to deliver desired outcomes. Healthy competition requires a stable investment environment, government treating different providers fairly (rather than emphasising preferred providers), few barriers to entry to the market (such as differences in pension provisions) and patients to have the information on which to base effective choices.
Delivering a new health agenda / Reform

Rt Hon Lord Warner of Brockley
More choice needs more competition

Over the past decade a stuttering approach to NHS reform has been adopted with bursts of activity on competition and choice followed by lengthy lulls. Not surprisingly many in the NHS are confused and some take great comfort from the lulls.

Most PCT commissioners are still weak controllers of money and demand, with 47 per cent rated “fair” or “weak” by the Care Quality Commission for financial management in 2009-10. Acute hospitals are allowed to overtrade and create supplier-induced demand. They have scooped up too much of the huge increase in investment in the NHS under Labour. Access to services has been improved, waiting times reduced and many lives saved from killer diseases. But most of these improvements have been produced by centrally-driven targets rather than by competition, choice and commissioning.

The shift of services from acute hospitals to the community proposed in the 2006 White Paper Our health, Our care, Our say has not been delivered. Too many acute hospitals are unsustainable in their present form and some would fall over financially if services were indeed relocated. Nearly 50 per cent of Acute Trusts have not achieved Foundation Trust status seven years after the legislation was passed. About 40 NHS Trusts still have historic deficits, some very large. Community health services are still attached to the far too many Primary Care Trust commissioners so there is no proper purchaser/provider split. There are few performance metrics for these Primary Care Trust service provider arms which makes market-testing more difficult; but the information that is available suggests they have scope for approaching 20 per cent efficiency savings. There is now a danger that weak community service providers and failing acute hospitals will seek to save themselves by vertical integration, thereby reducing competition further.

NHS regulation has improved and exposed shortcomings in NHS Trusts but there is no effective economic regulator who can drive competition, particularly where there is persistent failure. Those who overspend have been bailed out repeatedly and given many chances to improve. There is a reluctance, across the political spectrum, to grasp the nettle of service reconfiguration when changing circumstances make a hospital unsustainable in its present form in case politicians get “Kidderministered.” The scope for competition was diminished by a political intervention in 2009 to say that the NHS was the preferred service provider, which hardly encouraged new providers to come forward.

The default setting of the NHS is local public monopoly with little challenge until the four to five years at the end of the Blair government. As the NHS moves from feast to famine the competition engines need a further revving up. This is particularly the case in failing specialist hospital services, community health services, NHS pathology and primary care in deprived areas. To do this requires replacing most existing PCT commissioners with a more robust system involving effective GPs, a more commercially-aware contracting process and a few larger agencies all overseen by a regulatory framework to prevent abuse. There is a growing appetite for more competition in the NHS as in other public services. But can it do the degree of innovation and increased demand is such that even before the election it had been warned of a need to deliver savings of £15 billion to £20 billion. Now it is being told that even that might not be enough. At the same time, the OECD reported earlier this month that our health outcomes, including in areas such as avoidable deaths, lag behind those of other western economies.

So the challenge to deliver more with less is as real in the NHS as in other public services. And there is increasing discussion among policymakers about the role that competition could or should play in meeting this challenge.

In other sectors, competition has helped deliver benefits in terms of responsiveness, cost-reduction, quality and innovation. But can it do the same in healthcare?

Two studies published in June provide evidence that it can. LSE researchers looked at elective hip replacements and found that hospitals exposed to competition after a wave of market-based reforms took steps to shorten the time patients were in the hospital prior to their surgery. This resulted in a decrease in the overall length of stay without compromising patient outcomes. And a study led by Carol Propper of Imperial College London and the University of Bristol showed that greater competition results in better management, which in turn leads to improved clinical outcomes such as better survival rates from emergency heart attack admissions.

Although successive governments have introduced market-based reforms since the early 1990s, competition in the healthcare market in England is still a relatively new concept and does not work as effectively as it could. Barriers to market entry and exit, difficulties in adjusting supply to match demand, and an inability of providers to respond to fluctuating demand by amending prices, all raise questions about how far these reforms can go.

The answer is “a lot further than they have gone so far.” The Coalition Government believes the issues, real though they are, can be addressed and is rightly committed to a more patient-focused, outcome-driven healthcare system, characterised by greater devolution and more diversity of providers.

Of course, competition alone cannot deliver everything that the public and the taxpayer demand of the healthcare system. But we should not ignore the potential of competition to drive innovation, quality and efficiency.

Steve Bundred, Chair, Monitor
Mark Pearson
Healthy dose of competition

No-one who has spent much time looking at health services can be in any doubt that they are riddled with inefficiency. Services are over-used, under-used and misused all the time. It seems a matter of common-sense that a healthy dose of competition could do wonders to sort out the more extreme cases of inefficiency. But health systems have a habit of kicking apparently sensible reformers in the teeth, with common-sense leading to perverse outcomes. International evidence is that realising benefits from competition in health systems is immensely complicated.

In most markets we would assume that price competition would be a main driver of efficiency. But in the vast majority of OECD countries, healthcare services are free of charge for patients or have uniform prices (and copayments) set at the national level. Only a few countries allow physicians and hospitals to charge patients prices above reimbursement levels and “statutory copayments.” and most often only in some circumstances (e.g., Australia, France and Ireland).

Competition could be on the basis of quality, rather than price. Giving users of health services the freedom to choose providers would lead them to choose the best providers, even if they have no financial incentive. This sort of choice was common in most insurance based health systems, but countries have often not provided the information necessary for it to influence quality. Only five (of 31) OECD countries indicate that information on quality is made available for physician services, while seventeen report information on quality for hospitals (on process, outcomes and/or patient experience). However, information on quality is seldom used by consumers. Patients value choice very much, but most often choose to be treated by local providers and seldom use information on quality. Worse, extended user choice of providers and high density of physicians favours induced demand, leading to physicians becoming more responsive to medically unjustified demands from patients (who can shop around until they find the provider responding to their wishes). Perhaps it is not surprising to find health insurance companies trying to steer patient choice, providing patients with incentives to register with a primary doctor acting as a gate-keeper (e.g., in Belgium, France, Germany, and Switzerland).

None of this means that the common-sense view of health services is wrong; rather it tells us not to apply competition indiscriminately, nor to expect it to achieve miracles. Using payment systems to encourage efficiency; being open to private (both for-profit and otherwise) providers; developing information on quality: none of these will dramatically transform the fiscal landscape and free up vast amounts of resources. But they do have the potential to improve the quality, flexibility, and satisfaction that patients will get from the health system.

Mark Pearson, Head of Health Division, Organisation for Economic Co-operation and Development

Adrian Fawcett
Time for an intelligent partnership

At General Healthcare Group (GHG), we believe that key to improving healthcare in the UK is not only about empowering people to take more control of their medical decisions, but also incentivising them to do so. This can be achieved through not only better education and awareness of the many care pathways available in the private sector but also by offering tax breaks and co-pay for those who choose to utilise these options. By encouraging those who are financially able to do so to use private hospital facilities and services, we will help to effectively relieve some of the great burden on NHS resources, freeing up more time and capacity for those who are in most need of publicly-funded care.

The healthcare debate has historically positioned the private healthcare sector as a “fail safe” – for example, in helping the NHS reduce waiting lists. But, now the time is right for the private healthcare sector to have a proper seat at the planning table – we have expertise and capacity that can make a real difference in delivering timely healthcare in a clean, efficient manner which benefits everyone.

GHG is looking for an “intelligent partnership” between the NHS and the independent sector. The creation of a more predictable environment for the independent sector will lead to increased investment, innovation, efficiency and most importantly improved outcomes for all patients – whether treated in the private sector or the NHS.

GHG is also seeking a level playing field which requires all providers to meet the same level of compliance and adhere to the same level of scrutiny and regulation.

In the next few months, GHG will come forward with solutions to enhance the sector and to ensure that independent healthcare makes a significant contribution to the health of the nation.

Ultimately, GHG is judged on the quality of our services and the quality of our patient outcomes. It is these simple tenets that in the end will shape GHG’s continuing success and partnership with the NHS.

Adrian Fawcett, Chief Executive Officer, General Healthcare Group
Ten Years Younger

Practice based commissioning (PBC) was last year characterised as “a corpse not for resuscitating” by the English National Clinical Director for Primary Care, Dr David Colin-Thomé. Now one year on we have a patient who is going to be resuscitated but hopefully will look like the result of a Ten Years Younger makeover.

The NHS budget will be squeezed, requiring efficient ways to limit costs but still deliver high quality care. It is generally accepted that some secondary care functions could be delivered in primary care at reduced cost. Patients also favour more localised care.

It is for these reasons that PBC in the form of GP commissioning is worth resuscitating and maybe given a full makeover.

Why did earlier efforts for PBC fail? GPs had scant incentives for the time required to devote to the project. Primary Care Trusts were unwilling to allow GPs the freedom to innovate as they feared a loss of financial control due to the lack of accountability of PBC groups. The data available was poor, which makes commissioning decisions difficult. Added to this there was a conflict of interest for GPs who could be both providers and commissioners. To top this, the last Labour Government and GPs did not have the best of relationships. It is little wonder initiatives have failed and the “corpse” was moribund.

The new Coalition Government has rightly recognised that GPs are well placed to be in the driving seat of reforms and patients, given the right information, can direct their care to suit them. There are of course inherent risks in the idea. The inexperience of GPs as commissioners, the potential for conflict between local clinicians and the reluctance of some to take part in what will be a compulsory scheme are some major issues. How to deal with failed GP consortia and risk-reward dynamics will also need to be worked out.

However, this is a potentially exciting change for the NHS provided GPs are prepared to grasp the opportunity. In my view there needs to be a fundamental change in the role of GPs who should no longer be seeing patients with mild self-limiting illness, in order to release time to manage complex illness and develop their commissioning role. Perhaps at last with the new changes this can happen.

For patients this too represents a valuable opportunity, but they too must change by taking more responsibility for their healthcare. Empowerment and education through better information is a vital part of this process.

I am hopeful with the right care the “corpse” can not only be rehabilitated but can look ten years younger.

Dr Paul Charlson, GP and Chair, Conservative Medical Society
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In 2009 we stepped up our activities, gaining significant media coverage and making an impact with leading politicians. In 2010 our programme has continued to focus on public policy solutions to the deepening fiscal crisis and reform of public services to achieve value for money and better outcomes.

Anna Calvert, Communications and Events Manager, Reform

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Jeremy Laurence, The Independent, 17 March 2010

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