

• Our Future Health Secured?

A REVIEW OF NHS FUNDING AND PERFORMANCE



Summary

A major review to examine health care funding needs over the next two decades, led by Sir Derek Wanless, was published by the Treasury in April 2002. *Securing our Future Health: Taking a Long Term View* was commissioned by Gordon Brown, the then Chancellor of the Exchequer, to help close unacceptable gaps in performance both within the United Kingdom and between the United Kingdom and other developed countries. It was the first time such long-term funding projections had been undertaken.

The review outlined three possible spending ‘scenarios’ for health care up to 2022/3 – *solid progress*, *slow uptake* and *fully engaged* – each reflecting different assumptions about the effectiveness of NHS performance and the health status of the population. For example, *solid progress* was a scenario of steady and significant improvement, with public health targets met, performance gaps closed and life expectancy continuing to grow fairly rapidly.

Fully engaged, the most ambitious and resource-efficient scenario, showed NHS spending rising from an estimated £68 billion in 2002/3 to £154 billion (at 2002/3 prices) by 2022/3, representing real growth of 126 per cent; *slow uptake*, the least satisfactory and most expensive scenario, had spending rising to £184 billion – real growth of 171 per cent; while *solid progress*, a scenario of steady improvement, projected a rise to £161 billion – real growth of 137 per cent.

The 2002 review made it clear that spending the recommended amounts would not succeed in transforming the health service unless it was accompanied by radical reform to tackle such underlying problems as excessive waiting times, poor access to services, poor quality of care and poor outcomes. And, while it did not go into detail about the policies the government should pursue to keep spending and performance in line with its assumptions, it did set out in broad terms how health care policy should be developed and included a number of more specific recommendations for policy-makers.

The review’s final recommendation was that a further review of future resource requirements should be carried out again, about five years later – that is, in 2007. However, this is one recommendation the government has yet to take forward. Earlier this year the King’s Fund asked Sir Derek to lead a team to go some way towards addressing this omission by undertaking a retrospective review of NHS spending five years on from his original report. It builds on the major work the King’s Fund commissioned from Sir Derek on the future funding of social care for older people in England in 2006. However, it is not a full-scale, forward-looking review of future funding as was recommended in the 2002 review, and as this report argues there is still a need for such a review. Rather, this latest contribution attempts to provide answers to some pressing questions:

- did health care resources increase in line with the recommendations of the 2002 review, and what are the prospects for funding up to 2022/3?

- where did the extra money go and what has it achieved in terms of resource inputs (labour and capital), outputs (activity) and, most crucially, outcomes (health benefits and productivity)?
- have the additional resources been used effectively, and if not why not? Have the policy decisions taken since 2002 produced health systems that put the United Kingdom on track for an optimistic future?
- what lessons can be learned to inform similar reviews in future?

The review is divided into two main sections.

Part 1 provides an analysis of NHS funding and its impacts since 2002 and is followed by an assessment of current government health policy and recommendations for the future. It also includes a summary of the findings of the 2002 review and a subsequent publication focusing on the public health aspects of the review's recommendations, *Securing Good Health for the Whole Population: Final Report* (Wanless 2004).

Part 2 presents detailed evidence about what has been spent on the NHS since 2002 and what it has achieved in terms of resources, services, productivity and, crucially, health benefits.

Key findings

The following sections summarise the key findings of individual chapters in Part 2 of the review.

FUNDING: WHAT WAS SPENT

The five years since 2002 have witnessed unprecedented levels of government investment in the NHS – there has been average annual real term growth of 7.4 per cent over the five years to 2007/8. Over that period, real spending on the NHS has risen by nearly 50 per cent – a total cash increase of £43.2 billion – while the proportion of the United Kingdom's gross domestic product (GDP) devoted to health care spending has grown to 9–10 per cent, within striking distance of the European Union average. Chapter 5 of this review examines actual spending in the light of this promise and the funding recommendations of the 2002 review, then goes on to consider funding prospects up to 2022/3.

Total UK and private NHS funding in 2007/8 stands at around £113.5 billion, which takes the UK close to the estimated average EU health care spending in 2007/8. Higher-than-anticipated level of GDP makes the total spend about 0.3 per cent lower as a proportion of GDP than had been assumed. Although the total spend is £2.4 billion higher than assumed by the 2002 review, it is broadly in line with the Wanless recommendations, covering even the most expensive scenario. However, it is important to note that funding in the first five years was the same across all three scenarios, with projected UK spending expected to diverge across the three paths from 2008 onwards.

If, as is widely assumed, NHS funding growth slows to its long-term average of around 3 per cent by the end of the next comprehensive spending review period (2010/11), funding would fall short of the fully engaged spending path by around £7.2 billion, the solid progress path by £9.2 billion and the slow uptake path by £15.2 billion (all at 2002/3 prices). This represents shortfalls of 6 per cent, 7.6 per cent and 12 per cent respectively.

Funding: an overall assessment

Additional UK NHS funding since 2002/3 broadly matched the recommendations of the 2002 review for the first five years of its spending trajectories, taking total health care spend to within striking distance of average European Union spending as a proportion of GDP. Such a rate of increase cannot be sustained indefinitely, but spending would have to increase by at least 4.4 per cent a year in real terms if the NHS were to follow the 2002 review's most optimistic scenario and by more than that in the other scenarios. If funding growth in the health service slows to its long-term average of around 3 per cent by 2010/11, the NHS would fall short of the slow uptake, solid progress and fully engaged spending paths. This would place the United Kingdom near the bottom of future estimates of the average total EU health care spend as a proportion of GDP.

INPUT COSTS: WHY THEY ROSE

NHS funding rose by more than £43 billion in the five years after 2002. Pay and price inflation accounted for £18.9 billion (43 per cent) of the extra investment. Chapter 6 looks at how new employment contracts introduced for virtually all the 1.3 million staff employed by the NHS has contributed to this inflation and considers the impact of the contracts on productivity and other benefits.

The main source of these higher costs has been pay increases arising from three new contracts introduced in the last four years – Agenda for Change (covering all nurses and non-clinical staff) and new contracts for hospital doctors and general practitioners. Consultant pay under their new contract has risen by around 25 per cent, while the new GP contract has boosted average net income by 23 per cent. The cumulative additional cost of Agenda for Change from 2005/6 to 2007/8 has been around £1.8 billion.

Although there is some tentative evidence that these new contracts may have reduced three-month vacancy rates and may be starting to improve productivity among consultants and nurses, there is very little robust evidence so far to demonstrate significant benefits arising from the new pay deals.

Input costs: an overall assessment

Overall, actual increases in input costs in the NHS have broadly matched assumptions made by the 2002 review, with actual pay inflation slightly higher than assumed but non-pay inflation slightly lower. Pay and contract modernisation for all NHS staff groups over the past five years have contributed to higher input costs, with benefits yet to be fully realised. This places the NHS between the slow uptake and solid progress spending paths in terms of input costs.

RESOURCES: INVESTMENT IN STAFF, PREMISES AND EQUIPMENT

The 2002 review echoed and, in some instances, exceeded the commitments of the government's 10-year NHS Plan of 2000 to invest substantially in additional staff, premises, hospital beds, equipment and IT systems. Chapter 7 evaluates progress towards meeting these commitments.

NHS Plan commitments to employ 7,500 more consultants, 2,000 more GPs, 20,000 more nurses and 6,500 more therapists (allied health professionals) by 2006 have been more than achieved, with targets exceeded by 16 per cent, 166 per cent, 272 per cent and 102

per cent respectively. However, the projections of the 2002 review suggest that even *more* staff, particularly in terms of full-time equivalent doctors, will be needed to cope with the predicted increasing demand for care by as early as 2008.

The government seems on track to deliver the NHS Plan targets of building 100 new hospitals and modernising more than 3,000 GP premises. However, it seems unlikely that the 2002 review's more ambitious aspirations to replace one-third of the hospital and community estate by 2022/3 and upgrade the entire primary care estate by 2010/1 will be met. Disappointingly, backlog maintenance increased by a fifth between 2000 and 2005 rather than declining by the one-quarter assumed at the time of the review.

As a result of investment in scanning equipment, around three-quarters of MRI scanners, CT scanners and linear accelerators now in use in the NHS are new, while targets for increased numbers of procedures have been exceeded.

The National Programme for IT (NPFIT) in the NHS is responsible for implementing an integrated care records service, an electronic prescribing system, an electronic appointment booking system and the underpinning IT infrastructure by 2014. The 2002 review identified better use of ICT as key to potential productivity improvements and health gains and recommended a doubling of ICT spend by 2003/4, peaking at around £2.7 billion in 2007/8 in the solid progress and fully engaged scenarios.

Given the well-documented delays that have beset the programme, it is not surprising that actual spending on ICT in England has followed neither the solid progress nor the fully engaged spending trajectories. Actual spending fell short of these projections by around £0.7 billion in 2003/4. Overall, it is estimated to have increased from £1 billion in 2002/3 to £2.3 billion in 2005/6. However, planned spending of just under £2.9 billion in 2006/7 would overshoot both those spending trajectories and so come closer to that assumed in the solid progress scenario.

The fact that actual spending fell short of these projections by around £0.7 billion in 2003/4 reflects the well-documented problems and delays that have beset the NPFIT and have the potential seriously to undermine the productivity gains envisaged by the 2002 review.

Resources: An overall assessment

Additional funding for the NHS over the past five years has enabled the service to invest in substantially increased resources – particularly labour. Staff numbers are at their highest for many years and have exceeded commitments made in the NHS Plan and adopted by the 2002 review. However, the 2002 review estimated that further increases in the number of doctors will be needed before the end of this decade to address anticipated extra demand. There has been substantial replacement and upgrading of buildings but no progress on reducing the maintenance backlog and some way to go on upgrading primary care premises and providing single rooms in hospitals.

Actual spending on modernisation of the NHS ICT infrastructure has followed neither the solid progress nor the fully engaged spending trajectories. And it has not been without its difficulties, with most progress tending to relate to systems that were not originally part of the modernisation plan. The well-documented problems and delays that have beset the

NPfIT have the potential to undermine seriously the productivity gains envisaged by the 2002 review. Future commitment not only to implementing core ICT systems but also to realising patient benefits and productivity gains is vital. The programme needs to be audited comprehensively to ensure that benefits will outweigh costs and to assess the precise impact on future productivity.

Overall, in terms of resources this places the NHS much closer to the solid progress scenario.

OUTPUTS: THE SERVICES DELIVERED

Chapter 8 examines how investment in human and other resources has been translated into activity in terms of hospital services, mental health care, primary care, prescribing and other activities, including NHS Direct, walk-in centres and ambulance services.

Between 1998 and 2005, overall elective (planned) admissions to hospital rose by just over 605,000 – an increase of 11 per cent. A decline of more than 4 per cent in the numbers of people treated as inpatients was more than offset by a 20 per cent increase in the numbers treated as day cases. However, the largest source of overall growth in hospital activity has been an increase in emergency admissions, with a net increase of around 1.6 million (35 per cent) admissions between 1998 and 2005. Attendances at A&E departments remained broadly static between 1987/8 and 2002/3 but have since grown by more than a third to nearly 19 million in 2005/6. These dramatic rises are hard to explain but were probably caused by changes in clinical behaviour and lower A&E waiting time targets, as well as changes in GPs' out-of-hour cover arrangements, which saw PCTs assume responsibility for out-of-hours care in 2004.

Since 2002/3 there has been a reduction in the number of new attendances at maternity outpatient departments, probably reflecting a shift to community-based antenatal care. Similarly, the number of episodes of consultant treatment and admissions related to mental illness fell by 10 per cent and 16 per cent respectively between 1998/9 and 2005/6, also reflecting a shift towards outpatient and/or community treatment. Crisis resolution/home treatment teams and other community-based services designed to manage acute episodes of mental illness were set up between 2001 and 2004, and the evidence suggests these innovations have been effective in reducing hospital admissions.

Attendance figures at GP surgeries – a key activity measure – are not routinely collated by the NHS at national level. The available (limited) data suggests that GP consultations rose by more than a third between the early 1980s and 2005; it stood at around 250 million in 2005. A lack of robust information relating to primary care makes it impossible to estimate activity since 2002/3.

Prescriptions dispensed rose by more than a fifth (135 million items) between 2002 and 2006, with drugs prescribed for cardiovascular conditions – particularly lipid-regulating statins – accounting for the lion's share of the growth but at a lower-than-expected cost. The 2002 review assumed an increase in UK NHS expenditure on lipid-regulating statins from around £700 million in 2002/3 to £2.1 billion by 2010. In fact, although the number of prescriptions for statins dispensed since 2002 has risen by 138 per cent to 39.7 million, the total cost has risen by just 0.3 per cent, with the real cost falling by almost 10 per cent. This is because of a significant increase in the prescribing of low-cost statins, such as

simvastatin, which has reduced in cost by almost 90 per cent since 2002. Thus, the actual cost to the NHS of prescribing statins has diverged from the review's projections since 2004, resulting in a cumulative saving.

Calls to NHS Direct seem to have reached a plateau of just under 7 million a year, while NHS Direct Online, launched in 1999, has seen a rapid increase in use and currently receives about 1.5 million visits per month.

By May 2006 there were 75 walk-in centres in England, which cumulatively attracted more than 2.5 million visits in 2005/6.

Although emergency calls on the ambulance service in England nearly doubled to almost six million in the 10 years to 2005/6, the number of planned journeys fell, leading to an overall reduction in ambulance journeys.

Outputs: an overall assessment

With increased resources, the NHS has been able to do more work in most areas. Elective admissions increased by 7 per cent between 2002/3 and 2005/6 and outpatient attendances by 3 per cent. There have also been very large increases in emergency care (+21 per cent) and accident and emergency attendances (+33 per cent). Three-quarters of the 20 per cent increase in prescription items dispensed between 2002/3 and 2006/7 is due to just 10 drugs. Lipid-regulating drugs (statins) account for nearly a fifth of the total increase and are on target for achieving the 2002 review's recommendations at a lower-than-expected cost.

Overall, in terms of outputs, this places the NHS between slow uptake and solid progress.

OUTCOMES AND DETERMINANTS OF HEALTH

The 2002 review's vision was that the health of the population would improve through a combination of better, more responsive health services and changes in health-seeking behaviour. Chapter 9 examines the impact of recent health policy on known *determinants* of health – such as smoking, diet and other lifestyle behaviours; it also considers aspects of the care process that have an impact on health, and general measures of population health.

Broadly speaking, the health of the population has improved, with a fall in overall mortality rates and an increase in life expectancy, although both of these are continuations of long-term trends. It is estimated that by 2022 life expectancy at birth for both females and males is likely to exceed that envisaged in the slow uptake scenario and be marginally higher than for solid progress.

Cancer survival rates have also increased, and infant and perinatal mortality rates have improved a little since 2002, although they remain higher than for many other European countries. Various measures of morbidity, such as longstanding illness, remain unchanged. And inequalities between socio-economic groups, as measured by infant mortality and life expectancy at birth, have grown rather than diminished.

Public health expenditure

The 2002 review estimated health promotion expenditure in England at around £250

million – less than the NHS spends in a day and a half. All three scenarios projected an increase in health promotion spending, with the fully engaged scenario assuming the largest and most rapid rise, doubling to around £500 million by 2007/8. However, it is impossible to track trends in public health or health promotion spending since 2002 as no official figures are kept. Given the lack of accurate information, it is impossible to assess whether the fully engaged aspirations for a doubling in public health spending by 2007/8 have been met.

It is also indicative of the relatively low priority given to public health that, while non-public health medical staff numbers have increased by nearly 60 per cent since 1997, the number of public health consultants and registrars has gone down overall.

Investment in public health is designed to impact on the key determinants of health. A population's health is, of course, determined by many factors, including genetic inheritance, education and welfare services, income, housing and lifestyle choices. While there has been evidence of improvements in some areas, progress in other areas has been slow. Here four key factors are assessed: smoking, obesity, physical activity and diet.

Smoking

Smoking prevention has been successful in general, with England on track to achieve the 2010 targets set out in the government White Paper *Smoking Kills*. However, since the 2002 review, more demanding targets have been set and formalised as a Public Service Agreement (PSA). The 2004 PSA target is to reduce overall adult smoking rates to 21 per cent or less by 2010, with a reduction to 26 per cent or less for routine and manual socio-economic groups. The evidence suggests that England is on track to achieve these headline targets, but large variations between socio-economic groups persist. Progress to date on achieving national smoking targets therefore places England on a solid progress trajectory. Although the tougher targets set since the 2002 review exceed solid progress, they are less demanding than the fully engaged scenario.

Obesity

At the time of the 2002 review, the 1992 White Paper (*Health of the Nation*) target for obesity was for just 6 per cent of men and 8 per cent of women to be classified as obese by 2005. Between 1995 and 2005 the proportion of adult males classified as obese rose by half to 23 per cent of the male population, while the proportion of obese women rose by 42 per cent to around 25 per cent of the female population. Childhood (2–15 years) obesity increased by a similar extent over this period, with the proportion of obese boys and girls rising by 65 per cent and 51 per cent respectively; nearly one in five children are classified as obese. A continuing rising trend in obesity to 2010 is predicted, when some 33 per cent of men, 28 per cent of women, one-fifth of boys and more than one-fifth of girls will be obese. The evidence on obesity is therefore of great concern and while it would be wrong to hold the NHS responsible for this adverse trend, it does mean in terms of achievement that the results are now at a much worse level than even the slow uptake scenario.

Physical activity and diet

Since 1996, the government has recommended that adults should participate in at least 30 minutes of moderately intense activity five days a week. Over a third of men and a quarter of women met these guidelines in 2004, an improvement since 1997. Progress has also been made in increasing children's physical activity. Eighty per cent of pupils in

partnership schools – those participating in a national school sports initiative – participate in at least two hours of high-quality physical education and school sport in a typical week – an increase of 11 per cent over the previous year and an improvement on the 2006 target. While progress has been made on salt consumption with rates falling, they remain 50 per cent higher than the recommended 6g per day.

The government is on track with its children’s activity targets and may also achieve its interim target for adults, but this will require sustained effort up to and beyond 2011. At best this could be classified as solid progress. This mirrors progress made on diet which is on a solid progress trajectory at best, but is probably somewhere between this and slow uptake.

Process of care

While survey evidence suggests an improvement in patient safety, rates of MRSA infection in hospitals remain high, and other hospital-acquired infections, such as *Clostridium difficile*, may pose an even larger threat in future.

Waiting times for inpatient and outpatient treatment have improved considerably since the last review, although this is unlikely to have had a substantial impact on health outcomes.

Evidence from surveys on patient experiences suggests that the quality of NHS care has been improving over time, particularly in areas of the service that have been subject to co-ordinated action – for example, waiting times and cancer care.

Health outcomes and determinants of health: an overall assessment

The 2002 review’s vision was that health would improve through a combination of better and more responsive health care services and changes in health-seeking behaviour. On broad measures, the health of the population has improved. Tackling the causes of ill health is an ongoing long-term task. Continuing reductions in smoking and improvements in levels of physical activity and diet suggest a future close to the solid progress scenario. But over-optimistic targets – such as those relating to obesity – make it difficult to assess engagement levels in relation to the 2002 review scenarios. In addition, tackling recent financial difficulties in the NHS by raiding public health budgets has not been in the long-term interests of the public health of the nation.

Overall, the evidence suggests that the population is a long way short of the fully engaged scenario and is on a path between slow uptake and solid progress.

PRODUCTIVITY: EFFICIENCY AND QUALITY

A crucial issue for the 2002 review, with a significant impact on its funding projections, was the ability to do more (in both volume and quality terms) with each health care pound. Higher productivity offered the potential to restrict growth in the long-term costs of delivering the health care outcomes likely to be sought by 2022.

The 2002 review made an important distinction between two aspects of productivity it assumed would improve over time: those relating to inputs (that is, reductions in unit costs) and those related to outputs or outcomes (that is, improved quality). Chapter 10 attempts to clarify the meaning of productivity, as distinct from efficiency, and goes on to track recent changes in NHS productivity, taking account of quality outcomes as well as unit costs.

It was assumed that under the solid progress and fully engaged scenarios, productivity would improve by 2–2.5 per cent a year in the first decade and 3 per cent in the second. The slow uptake scenario predicted lower productivity improvements of 1.5 and 1.75 per cent a year respectively. The importance of these assumptions becomes evident when they are converted into monetary terms. In the fully engaged and solid progress scenarios, the value of the productivity gains by 2022/3 (at 2002/3 prices) amounts to £46.5 billion – around half of the additional forecast growth in spending over and above the 2002/3 level of £68 billion.

Official measures of NHS productivity are inconclusive and indicate that changes in productivity may have ranged from -7.5 per cent to + 8.5 per cent between 1999 and 2004. The 2002 review's assumptions of annual unit cost reductions of 0.75–1 per cent between 2002/3 and 2007/8 have not been achieved and, broadly, unit costs have increased for all hospital services. Lack of data makes it impossible to draw reliable conclusions about movements in unit costs in mental health and primary care services. However, the cost per prescription dispensed in the community has fallen significantly, largely because of reduced unit costs for lipid-regulating statins, which were available in new generic forms from 2003.

Some attempts to quantify changes in quality over time (in relation to the increased use of statins, for example) suggest significant gains. However, the development of precise measures is hampered by a lack of routinely collected data on changes in patients' health status arising from NHS interventions.

Although indicative measures of quality, such as patient safety, waiting times and satisfaction with the experience of care, suggest improvement, 'hard' measures of quality, valued in monetary terms, are not available to compare with the 2002 review's assumption that the quality of care would improve year on year.

Productivity: an overall assessment

Official measures of NHS productivity provide inconclusive evidence of improvement.

The 2002 review's productivity assumptions of annual unit cost reductions of 0.75–1 per cent between 2002/3 and 2007/8 have not been achieved; broadly, unit costs have increased for all hospital services. Although indicative measures of quality, such as waiting times, and patient satisfaction, suggest improvement, 'hard' measures of quality, valued in monetary terms, are not available to compare with the review's assumption that the quality of care would improve year on year.

Some evidence suggests that the failure to reduce unit costs may have been partially offset by improved quality. However, the NHS has failed to generate the relatively modest improvements in unit cost productivity that might have been expected and were assumed by the 2002 review. Overall, in terms of productivity, this places the NHS closer to the slow uptake scenario.

The policy framework

This section considers whether the health policies that the government has pursued over the past 10 years have supported or hindered the improvements in NHS performance envisaged by the 2002 review. It examines how effective the policy process has been and

whether health policy is moving in the right direction – or whether there is a better alternative. The chapter on policy examines four main routes to improvement, comparing developments in these areas with the recommendations of the 2002 and 2004 reviews, where relevant, and assessing their impact on performance.

The effectiveness of government policy-making in this area has been judged against the government's own criteria for good policy-making, as well as against recommendations made in both the 2002 and 2004 reviews. It is important to note that the 2002 review did not offer a policy blueprint for the government to follow and did not recommend a deviation in policy direction from the NHS Plan. In addition, while the review points to various shortcomings, it must constantly be borne in mind that change does take time and that in many cases it may be too early to tell whether improvements will be realised over the next few years.

Policy development

The New Labour administration that came to power in 1997 initially relied heavily on central direction, with improvements, such as waiting list reductions, enforced through national targets. However, from 2002 a new approach was gradually developed, aiming to:

- reduce central targets and allocate a larger share of NHS budget directly to local purchasers, with incentives to improve performance
- give patients a bigger voice and a greater role in self-care
- promote diversity of supply by introducing independent providers
- improve monitoring arrangements and reduce risks to health.

In broad terms, this new policy framework was in line with the recommendations of the 2002 and 2004 reviews. But how effectively was it implemented – and has it improved NHS performance? The review looks for answers to these questions across a range of policy initiatives, including patient choice, new elective care provision, financial incentives, new commissioning arrangements, personal engagement in health, and Payment by Results.

The review concludes that, although the move away from centralised governance was sensible, implementation of the new framework has been slow and uncertain, with some critical areas, particularly the financial framework, remaining work in progress.

With some initiatives, such as patient choice, not yet fully implemented and others, such as practice-based commissioning, not fully worked out, the new policy framework has had only a modest impact, while targets and central direction have remained the main drivers in the system.

In terms of public health, policy formation has not followed the framework proposed by the 2004 review. Instead, piecemeal, often modest initiatives have continued to emerge.

Organisational change

Since 2002, the government has introduced radical structural changes to the NHS, including abolition of health authorities, creation of strategic health authorities, creation and subsequent re-creation of primary care trusts, introduction of foundation trusts and a strengthening of the regulatory framework.

The new structure embodies a number of the key features proposed in the 2002 review and has a good chance of being more effective than its predecessor; but because it has taken so long to emerge, it remains largely untested with its benefits yet to be realised.

The review also points out that the process of organisational change has been costly, not just financially but in terms of disruption, loss of experienced staff and changes in working relationships both within the NHS and with external organisations.

Service redesign

The NHS Plan of 2000 committed the government to a massive programme of capital investment in hospitals and smaller premises. Other elements of service redesign have included:

- cancer care collaboratives and other learning programmes
- national service frameworks (NSFs)
- initiatives to shift care from hospitals to community settings.

The review concludes that the government was right to make service redesign a key policy objective to improve service quality, costs and access, although it has not yet committed itself to a continuing programme of NSF development as envisaged in the 2002 review.

Question marks remain over the robustness of the evidence for the different types of hospital reconfiguration that are needed to raise quality and about how far hospital services can be transferred to other locations without loss of quality or increased costs. The review emphasises the need for flexibility in the light of uncertainty over the future balance of care, particularly with regards to the government's commitment to the rapid development of new hospitals.

Support programmes

The NHS Plan and the 2002 review recognised that a number of supporting elements were needed to underpin policy and service reforms. These included:

- staff reforms, including large increases in the workforce, changes in role mix and the introduction of new contracts
- implementation of a comprehensive information and communication technology (ICT) programme
- introduction of systematic clinical governance processes to support the improvement of clinical care.

Important flexibilities within the workforce have been achieved, but the reform of the NHS pay structure through three new major pay deals for consultants, GPs and nurses and other non-clinical staff have been costly and has yet to prove itself in terms of improved performance and productivity.

Implementation of the ICT programme has been slow, with its main anticipated benefits not yet achieved. And, although clinical governance now comprises a wide range of policies at individual, service and organisational levels, their specific impact on performance is hard to detect.

How effective has the policy process been?

The review makes two key criticisms.

- Pressure to produce quick results has led to some policies and initiatives being introduced without adequate preparation. For example, policies on the management of long-term conditions were introduced with little prior evaluation; NHS Direct was implemented nationally before the results of pilot studies were available; and the early design of the Payment by Results system took too little account of international experience.
- The government has failed to take full account of the impact of new policies on the system as a whole and to understand how the various elements fit together with each other and with the various resources. These failures were key to the system-wide deficits that emerged from 2004/5 onwards. They are also evident in the shift from hospital to community care, which threatens the economics of acute hospitals.

Is policy moving in the right direction?

The review acknowledges a number of major successes, including:

- identifying more local ways to manage health policy while retaining central direction in key areas
- establishing an improved performance assessment regime with a new regulatory structure, comprising of the Healthcare Commission, Monitor and the Audit Commission, looking stronger than its predecessor
- offering sustained support for self-care and beginning to address the needs of people with long-term conditions
- consistently promoting the need for service redesign and supporting the creation of flexibility in professional roles
- promoting a wide range of measures aimed at improving the quality and cost-effectiveness of clinical care.

The NHS is now in better shape than in 2002 to deliver improved quality and increased productivity, although huge challenges remain around commissioning and choice, competition between providers, the balance between targets, standards and incentives and between central direction and local discretion, and the shift towards local provision of care.

However, the new policy framework deserves only conditional approval at this stage as it will be some time before a clear view can emerge about its effectiveness. And, even if the general direction is right, there can be no guarantee that sufficiently improved performance, in terms of outcomes or productivity, will be achieved at the levels required by the solid progress or fully engaged scenarios of the 2002 review.

The 2007 review identifies two significant issues that the government still needs to get to grips with:

- improved demand management across the NHS as a whole
- full clinical engagement in the process of policy reform.

Is there a better alternative to the current system?

The review concludes that it would be dangerous to embark on further significant change before the new combination of levers to enhance performance has had a chance to prove itself.

The emphasis now should be on developing the new policy framework rather than subjecting it to further fundamental reform. Although changes in policy and practice must continue, structural change should be avoided wherever possible.

The review makes a range of recommendations designed to address some of the problems identified and help take forward policy on health and social care. These are summarised in the following section.

Recommendations

The review includes a number of inter-related recommendations designed to help the government take forward policy on health and social care and address some of the shortfalls identified.

CONTINUE TO ENCOURAGE USE OF RECENT SYSTEM REFORMS TO ACHIEVE THE DESIRED RESULTS

- Commissioners should be encouraged to use available data and processes more effectively to design and monitor outcome-based policies for a range of health service providers. Information should be made available to help local commissioning bodies commission services in the most appropriate ways, incorporating best practice in health and social care.

MONITOR AND ASSESS POLICY AND PERFORMANCE

- Policy-making and implementation has been weak in a number of key respects since 2002. The government needs to strengthen its analytic capacities to monitor the effectiveness of its policies, and be prepared to change direction or pace if policies are unlikely to have the desired impact. In so doing, it needs to take full account of the impact of further change and consider how best to manage any potentially negative effects. In addressing weaknesses, the government must strengthen its capacity to link clinical and service objectives with the resources needed to achieve them.
- Given the potentially high costs of local service reconfiguration, detailed research should be carried out into new models of delivery before they are implemented to assess their impact on patients and their cost effectiveness. Rules about failure of institutions and services that prove unable to generate adequate income as services are reconfigured around them should be clarified before significant commitments are made by local commissioners and providers. It is also recommended that a primary care experiment recommended by the 2004 Wanless review, to assess the benefits of additional resource in information systems, in monitoring risk and in services, be carried out to provide important learning for the future.
- ICT deliverables are critical to many future productivity and service enhancements. However, despite some positive developments, there have been serious criticisms

about the implementation of the Connecting for Health programme. Connecting for Health should be subject to detailed external scrutiny and reporting so that forecasts of long-term costs and benefits can be made with more confidence.

PRODUCE REGULAR LONG-TERM RESOURCE ESTIMATES

- There are good reasons for carrying out forecasting exercises on a regular basis, given the long-term nature of many decisions that need to be taken; and the use of scenarios to capture variations in health status, choices and demands makes for a robust approach. The Treasury/Department of Health should establish a mechanism for commissioning and publishing regular independent estimates of the long-term resources likely to be needed for health and social care services either on a five-yearly basis or ahead of each comprehensive spending review. All forecasts should include ranges based on different scenarios, and the forecasting models used in this work should be made publicly available.
- In order to forecast resource requirements it is necessary to define the scope and nature of the health and social care services to be funded. Updated and new National Service Frameworks (NSFs), incorporating costings, resource requirements and research needs, should form the basis of centrally determined standards for health care. The combination of all the NSFs should enable commissioners use a range of local levers to achieve national standards. The meanings of ‘comprehensive’ and ‘high-quality’ are not yet defined for social care, and a work programme should be established to fill the huge gap this creates in understanding the long-term financial implications of an ageing population.
- Data that would assist the monitoring of NHS performance remain so limited that some central questions about the relationship between costs and outcomes cannot be answered. The Health and Social Care Information Centre should work with those commissioned to produce long-term resource forecasts, relevant analysts within the Department of Health and the Treasury, and other researchers, to define improvement to health and social care information that could assist the modelling of future spending forecasts.
- Future forecasting of long-term resource requirements in health and social care should pay particular attention to the workforce plans produced by the Department of Health. This will allow for an assessment of whether sufficient staff will be available, able to deliver the volumes of services likely to be needed and also to capitalise on the systems designed to help them produce the required standards of service and efficiency. Full-scale evaluations of the recently introduced staff contracts should be carried out to assist national and local efforts to obtain adequate benefits from them.

MEASURE AND MANAGE PRODUCTIVITY

- Assessment of future productivity is important because public perceptions about how productively resources are used will continue to influence attitudes towards health and social care services. Incentive systems to improve productivity should focus on clinical quality and health outcomes, and the present system of incentives and standards should be progressively developed and refined in the light of experience of their impact. Continuing work into productivity should consider the whole system.

- Although nationwide surveys record the population's self-assessed health status, no equivalent information is collected routinely on NHS patients. Recorded measures of individual health status would aid measurement of productivity and performance as well as helping purchasers and individuals make decisions about prevention, treatment and commissioning. Large-scale trials should be carried out to explore the potential benefits and costs of routinely recording the health status of people treated and advised by all providers working for the NHS.

A FRAMEWORK FOR PUBLIC HEALTH

- The 2004 Wanless review recommended a conceptual framework to take forward public health in England in a systematic way. It envisaged quantified national objectives for changing the prevalence of all the important determinants of health status for the medium and long term, based on advice from a wide range of organisations and people. This framework was not taken forward and, as a result, health policy has remained focused on short-term imperatives, public health practitioners feel undervalued and significant opportunities have been lost. It is recommended that the recommendations of the 2004 review be now implemented.

Conclusion

The five years since the 2002 Wanless review have witnessed unprecedented levels of government investment in the NHS – real spending has risen by nearly 50 per cent, while the proportion of the UK's GDP devoted to health care spending has grown to 9–10 per cent, within striking distance of the EU average. This rate of funding growth broadly matches the recommendations of the 2002 review for the first five years of its spending trajectories.

The funding increase has helped to deliver some clear and notable improvements – more staff and equipment; improved infrastructure; significantly reduced waiting times and better access to care; and improved care in coronary heart disease, cancer, stroke and mental health. Although difficult to attribute directly to the NHS, life expectancy has also continued to improve.

Our Future Health Secured? concludes that the direction of health care policy now being pursued by the government should be correct to address the key challenges identified in the 2002 review.

However, what is clear is that thus far the additional funding has not produced the improvements in productivity assumed in the 2002 review – costs of providing health services have increased and there is patchy and conflicting evidence on the impact on productivity overall, including little information about community-based care. Hospital activity has increased, but the biggest increase has been in emergency, rather than planned, admissions. In addition, some key measures of the determinants of ill health are below the assumptions of the 2002 review, particularly the unforeseen rise in adult and childhood obesity.

Even with higher productivity and greater engagement by individuals in their own health, funding for health services will need to increase substantially. However, without significant improvements in NHS productivity, and efforts to tackle key determinants of ill health,

such as obesity, even higher levels of funding will be needed over the next two decades to deliver the high-quality services envisaged by the 2002 Wanless review. Such an expensive service could undermine the current widespread political support for the NHS and raise questions about its long-term future.

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