

Controlling Public Spending: The NHS in a period of tight funding

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Executive Summary

Soon after the 2009 Budget, the NHS Chief Executive suggested that a future public spending squeeze would require the NHS to make efficiency savings of £15 - £20 billion over the period 2011 to 2014.¹ The scale of the figures have since been confirmed as possible by the King's Fund and Institute for Fiscal Studies analysis of future funding scenarios for the NHS.²

In response to these warnings of efficiency savings there has been a repeated commitment by the Conservatives to protect NHS spending in real terms should they be returned to Government following the 2010 General Election.³ However, we believe that the state of the public finances are such that the even if the NHS were to receive real terms increases in funding they are likely to be very much smaller than the health service is used to. Since 1948, the NHS has received historic average real annual increases of approximately 3%; and since 2000, it has received real increases averaging nearly 7% per year.⁴

This commitment to protect NHS spending has given rise to criticism because it gives the impression that the NHS will not need to adjust to the forthcoming pressures on public spending.⁵ The NHS is working on an assumption that it will receive a 'flat cash' settlement from 2011 to 2014. But even this level of funding will require changes in working practices since effects of the ageing of the population and technological change are normally assumed to drive up NHS costs by more than the trend rate of inflation.

A key element of the NHS reforms in recent years has been the focus on overall quality improvement, but the NHS still suffers from widespread variation in clinical care. For example, the average length of hospital stay ranges from 10.9 days in the top ten NHS trusts to 44.5 days in the lowest performing trusts for patients with a broken hip.⁶ Another area of focus has been on reducing reliance on expensive acute hospital care, yet 25% of patients in hospital beds don't need to be there and could be looked after by NHS staff at home.⁷ If the NHS budget is to be protected compared to departments such as education and defence then there will be pressure on the NHS to show that it can deliver value for money.

Our research, which included a roundtable discussion with a number of senior academics and business leaders with expertise in the NHS, considers some of the options for the NHS in a period of tight funding. We believe that in order to protect the NHS into the future the next Government needs to make bold decisions on:

- **Performance related pay:** The NHS now employs 1.6 million people and the pay bill accounts for around 40% of overall expenditure and up to 70% in acute or mental health trusts.⁸ However, almost all NHS staff are automatically awarded incremental increases on an annual basis at a cost of **£420 million per year.**⁹ We believe that these incremental pay increases should be linked to improvements in organisational, team or individual performance.

- **Reducing variations in clinical practice:** Until recently the work of the NHS Institute for Innovation and Improvement involved the spread of best practice, innovative technologies and new ways of working from a quality perspective rather than focussing the costs savings they could deliver. However, a range of programmes by the NHS Institute shows that if all NHS organisations were performing as well as the top 25% this would yield a productivity gain of approximately **£7 billion per year**.
- **GP fundholding:** Deciding what clinical services to buy and where from is currently performed by Primary Care Trusts (PCTs) and is widely recognised as being a weak point for the NHS. However, evidence from GP fundholding in the 1990's was that giving GPs real budgets, and allowing them to buy services for their patients, actually reduced elective hospital admissions by 3% and drove hospital efficiency by 1.6%.^{10,11} We estimate that successfully implementing GP fundholding across the country has the potential to deliver savings from reduced admissions of **at least £1 billion per year**.
- **Decommissioning services:** In the National Institute for Health and Clinical Excellence (NICE), the NHS has a mechanism to exclude non-cost-effective treatments and technologies. However, NICE does not have to consider whether or not the NHS as a whole can afford the number of treatments that might be required. We believe that NICE should have to consider its recommendations within the NHS' budget and that its remit should be extended to include evaluating existing NHS treatments, so that those that are not clinically effective – such as homeopathy – or do not represent value for money can be excluded from the NHS.
- **Transformational change projects:** The Department of Health is testing ways to get the NHS working more efficiently through integrated care pilots, but the current studies are too small. We recommend that a full scale integrated care pilot should be set up covering any one of a number of hospital trusts in deficit and their local health economies. For example, Hinchingsbrooke Health Care NHS Trust has well documented financial difficulties – a £40 million deficit on a turnover of £81 million and is currently being offered on a franchise basis to the private sector. It would be an ideal site for an integrated care pilot.¹²

One issue that is often overlooked when considering transformational change in the NHS is management capability. We believe that there is considerable advantage to be had from improving the quality of NHS managers, not just reducing the quantity. For example, by focussing attention on developing more doctors into managers could deliver disproportionate benefits, especially in the short term. But good managers do not come cheap. Currently, bonus payments for very senior managers in the NHS are restricted to 7% of pay,¹³ whereas smaller and less complex private sector organisations offer executive bonuses of between 50% and 100% of salary. Top performing NHS managers should receive **performance related bonuses of around £30,000**.

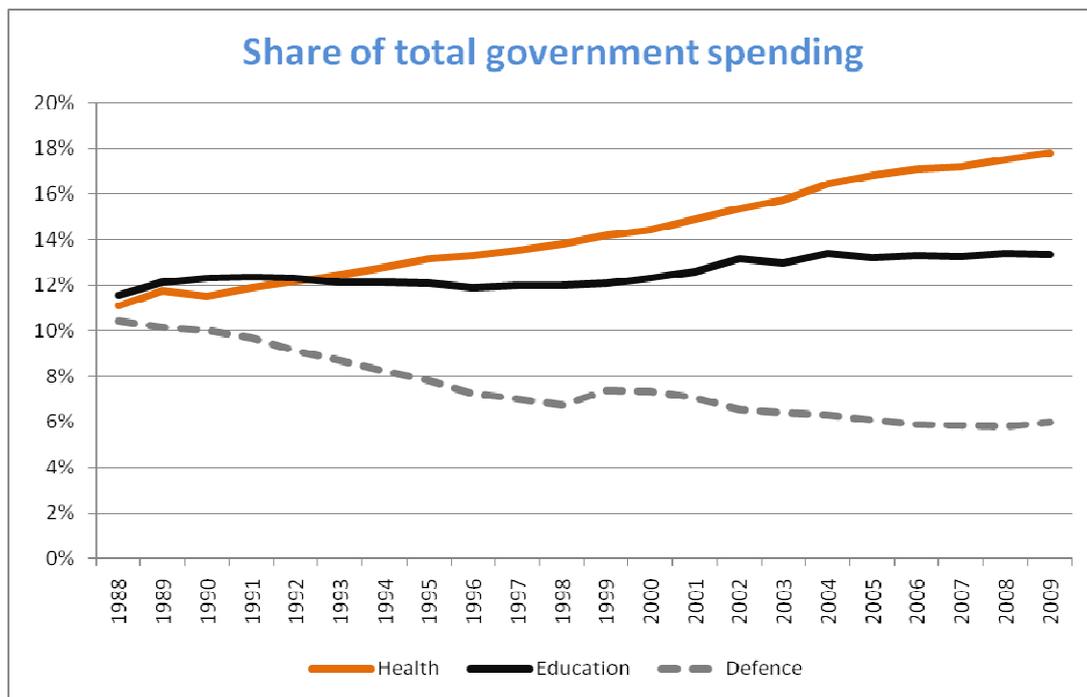
Crucially, however, the productivity and efficiency gains outlined above do not release cash savings unless capacity can be taken out of the system. **This means facing the charged political debate of closing wards, imposing recruitment freezes, reallocating staff and, in the longer term, closing hospitals.** All of the experts we spoke to said that this was an inevitable, and even desirable, position in order to protect the future of the NHS. Indeed as one said, "There are big buckets of savings to be had, we just don't address them."

	£ billion (at 2007/08 prices)											
	1999-00	2000-01	2001-02	2002-03	2003-04	2004-05	2005-06	2006-07	2007-08	2008-09	2009-10	2010-11
Health NHS (England)	52	56	64	67	73	77	82	85	91	94	101	103
	51	55	63	65	71	74	80	83	89	92	99	101

Source: authors calculations from HM Treasury Public Expenditure Statistical Analyses 2000, 2007 & 2009.

Introduction – Is it going to be cold for the NHS?

Governments always face difficult policy choices. Over the last twelve years the choice has been to support the NHS and as a consequence it has received proportionately more funding than other departments such as education and defence. Of course demand for healthcare has grown, but so has that for defence and national security. The next Government will face different and, perhaps, more difficult policy choices.



Source: HM Treasury. Public Expenditure Statistical Analyses 2009

This note uses as a starting point the detailed work by the King's Fund and Institute for Fiscal Studies (IFS) which considers three funding scenarios for the NHS beyond 2011 and the possible impact on other spending departments. The King's Fund and IFS paper concludes that if the next government is to protect NHS spending from 2011 this will require either large cuts to other departmental budgets, or tax rises.¹⁴ The paper outlined three funding scenarios for the NHS and the impact for other departments:

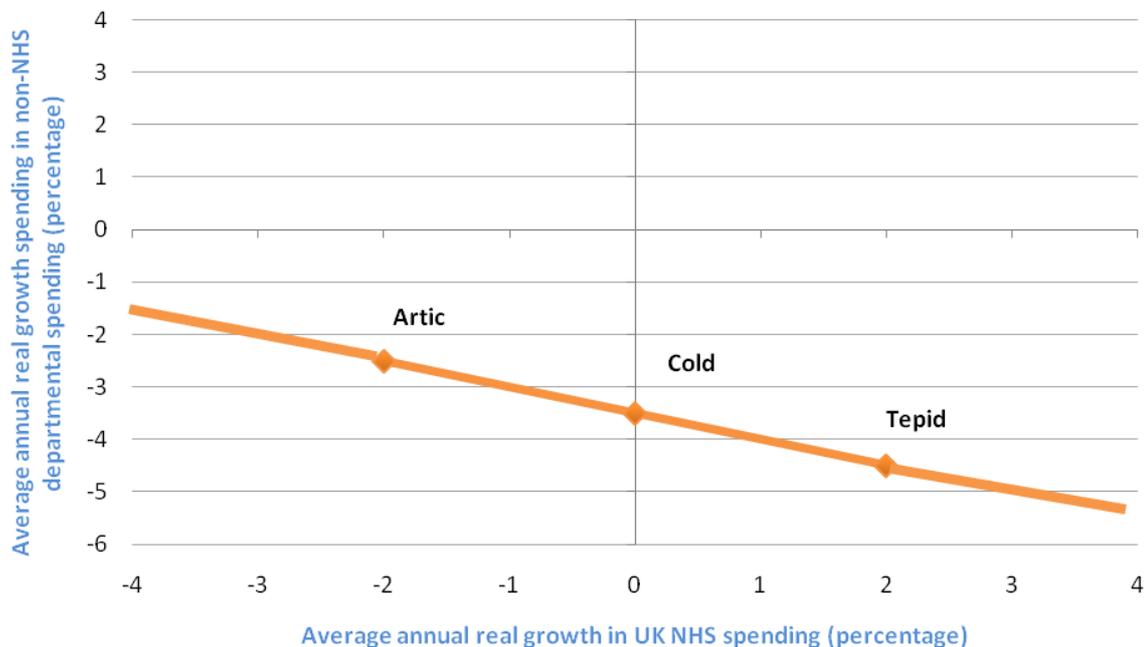
Tepid – the NHS receives annual increases of 2% from 2011-14. Other departments would need their budgets cut by 4.5% per year from 2011-14.

Cold – the NHS receives zero real terms change until 2014. Other departments would need their budgets cut by 3.4% per year from 2011-14. This scenario is the lowest level of NHS funding increase consistent with the Conservative Party's commitment to protect NHS funding.

Arctic – the NHS receives annual reductions of 2% from 2011-14. Other departments would need their budgets cut by 2.5% per year from 2011-14.

The King's Fund and IFS paper also considered funding scenarios further into the future from 2015 to 2017; however, as was acknowledged at the time, assessing the impact for other departments beyond 2014 is made difficult since there were no departmental spending projections in the 2009 Budget.

The trade-off: NHS vs. other departmental spending



Source: How cold will it be? Prospects for NHS funding: 2011-17. John Appleby, Rowena Crawford, Carl Emmerson. July 2009.

However, for the NHS a 'cold' funding scenario would actually feel like 'arctic' cuts because the NHS is geared for growth. Since 1948, the NHS has received historic average annual increases of approximately 3%; and since 2000, it has received spending increases averaging nearly 7% per year.¹⁵

From 2011 and beyond, changing demographics; the rise in long-term conditions; increasing patient demand for healthcare; the growing burden from public health epidemics such as alcohol misuse, smoking and obesity, as well as inflationary pressures from national NHS wage settlements will all put upward pressures on the NHS budget. These changes in healthcare costs are difficult to predict, although the increase in funding required to meet demographic pressures alone has been assessed as in the region of **£1.1 – 1.4 billion per annum** or an annual increase at constant prices of around 1% of the NHS budget.¹⁶

So what is the 'right' level of funding for the NHS? In 2002, HM Treasury's 'Wanless review', *Securing Our Future Health: Taking a long-term view*, attempted to answer this question and made detailed estimates about the demand for and supply of health care up to 2022. It proposed three scenarios based upon differing levels of public engagement in health:

Slow uptake – there is no change in the level of public engagement: life expectancy rises by the lowest amount. The health service is relatively unresponsive with low rates of technology uptake and low productivity.

Solid progress – people become more engaged in relation to their health: life expectancy rises considerably and health status improves. The health service is responsive with high rates of technology uptake and a more efficient use of resources;

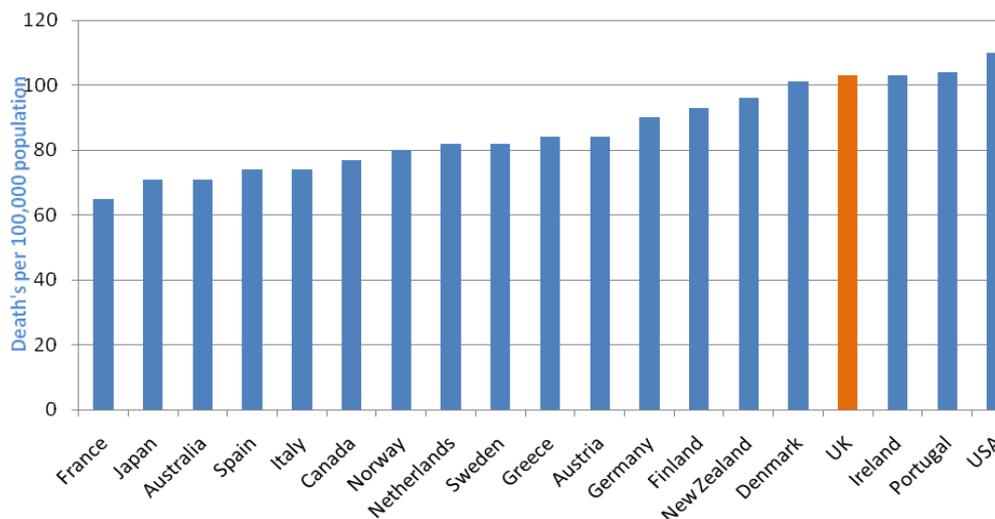
Fully engaged – high levels of public engagement in their health: life expectancy increases beyond current forecasts, health status improves dramatically. The health service is responsive with high rates of technology uptake, particularly in relation to disease prevention. Use of resources is more efficient.

The ‘fully engaged’ scenario was the most optimistic view of the future and the one which required the least growth in NHS funding, but it also assumed that the NHS would need to deliver year-on-year productivity gains of 2.5-3%.¹⁷ But, in the last decade, NHS productivity has fallen by an average of 0.4% per year.¹⁸

Over the last decade NHS funding growth has been following that suggested in the Wanless review. The King’s Fund and IFS analysis found that the difference in funding between the ‘cold’ scenario of zero real growth and this ‘fully engaged’ Wanless scenario is **£11 billion per year by 2014**, increasing to £21 billion by 2017.¹⁹ This might even be an optimistic outlook because the UK is not currently on a path to meet the ‘fully engaged’ scenario.²⁰ The King’s Fund and IFS assessment echoes that of the NHS Chief Executive, “we will need to release unprecedented levels of efficiency savings between 2011 and 2014 – between £15 billion and £20 billion across the service over the three years.”²¹

We are in a major recession and there have been an argument made by some that public spending should be cut across the board, including the NHS: the ‘arctic’ scenario.^{22,23} Indeed, one or two of the business leaders we consulted suggested that because the NHS and public would view the necessary changes in the ‘cold’ scenario as so severe, that the NHS budget might as well be cut so that waste would be tackled and greater efficiencies achieved. It is ultimately a political decision as to whether funding to the NHS should be protected or not and in the past NHS funding has not been consistently cut during times of public spending restraint. In the last 35 years, NHS funding has been cut in real terms just twice - in 1977 and 1996. There are now political commitments by the Conservative Party to achieve health outcomes in the UK equal to or better than the European average, and our most recent comparative performance against other developed nations shows that we have some way to go.

Mortality Amenable to Healthcare 2002-03



Source: Noltye E, McKee C M, Measuring the Health of Nations: Updating an Earlier Analysis, Health Affairs, Jan/Feb 2008 27(1):58-71

The consensus from our discussions was that the 'cold' funding scenario was the most likely after a General Election – zero real changes from 2011-14. The 'tepid' scenario was considered far too optimistic given the scale of the public debt – currently £1.01 trillion²⁴ - and the likely impact on other spending departments. The 'arctic' scenario was deemed to be politically impossible, since it involved cutting NHS spending in real terms, and would therefore go against a number of political assurances given so far.

Without necessarily endorsing that view, we believe that it is critical to note that the figure of £15-20 billion identified by the NHS Chief Executive is not about the level of cuts to existing NHS services; rather it is the value of the gap between expected future levels of funding and the nation's growing healthcare requirements. In the past, the NHS has dealt with increases in demand by simply employing more people to deliver more services in the same way. If the next Government maintains NHS spending increases in line with inflation from 2011-14 – the 'cold' scenario – the NHS will still need to make significant changes just to deliver the same level of healthcare. We consider some of the options where the NHS itself could make efficiency savings.

Cool runnings: the NHS in a period of tight funding

"We always overestimate the change that will occur in the next two years and underestimate the change that will occur in the next ten. Don't let yourself be lulled into inaction." Bill Gates

The scale of the challenge for the NHS is such that there is a need to think radically, and differently, on how to realise the level of savings required. Past experience and our discussions with experts has led us to conclude that the focus should be on the big numbers and that we should not get side-tracked with smaller areas of spending. Indeed, as we heard throughout our research the NHS tends to resist small changes enormously but, perversely, not the bigger reforms.

During our research and interviews two seemingly competing themes emerged. The first was a common view that the next Government needed to be bold and radical in dealing with a financial squeeze on the NHS. The consensus was that tough decisions should be made as soon as possible after the election by whichever party forms the next Government. One expert told us, "During the honeymoon period [the next government] should operate with strategic intent rather than blind panic." Abolishing the NHS' internal market in 1997, only to re-create it a few years later has been a key criticism of the current Government's record on health.

The second theme that emerged from our discussions was recognition of the political realities of trying to achieve major change. There are an almost limitless number of ideas on how to curtail costs in the NHS, but delivering many of these would be politically difficult. "It has to be politically feasible," remarked one of our experts.

What are the options for reducing costs?

Overview

Over the last twelve years the choice has been to support the NHS so spending in England has risen in real terms at 2007/08 prices from £51 billion in 1999-00 to £101 billion in 2010-11.²⁵ This overall spending total can be broken down in a number of ways, in the table below we show the breakdown between different levels of care – hospital, GP and drugs – with which people might be more familiar. In order to do this data has been collated from a number of sources and this highlights another common theme that emerged from our research - the unnecessarily complex and impenetrable nature of NHS costs and accounts. The table below

shows that in the highest proportion of NHS spending goes on hospital care at 76%; GP services, however, where most people interact with the NHS, are much less at 11% and the drugs budget accounts for 12%.

Component of PCT spending	£ billion (from 2006-07 PCT returns)	% of PCT spending
Hospital and Community Health Services	46.8	76.3%
<i>of which</i>		
General and acute	26.9	
Mental health	6.5	
Maternity	1.6	
Accident and emergency	1.6	
Learning difficulties	2.0	
Community health services	5.5	
Other contractual	1.8	
HIV/AIDS	0.4	
Prescribing	7.5	12.4%
Primary Medical Services (general practice)	6.9	11.3%

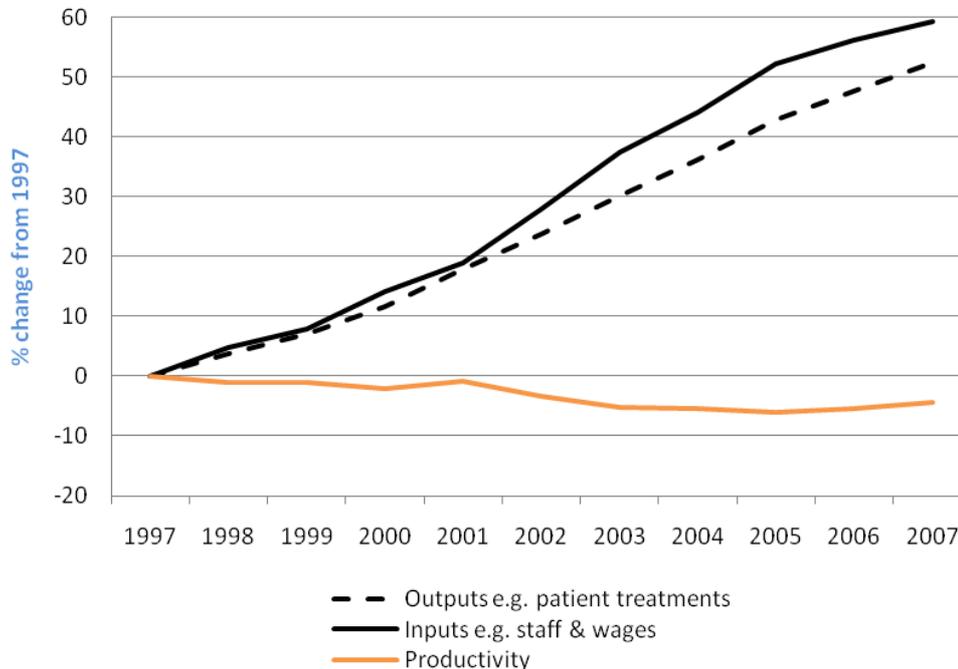
Source: Department of Health: 2009-10 and 2010-11 PCT recurrent revenue allocations exposition book. Table 4.

The NHS has benefited from huge spending increases in recent years and there has been political pressure on it to show that these past increases have been well spent. Protecting NHS spending in the future compared to other governmental departments such as education and defence will merely add to these pressures. The NHS needs to show that if it is treated as a special case and is protected from spending cuts it can deliver value for money. In other words, the NHS needs to become more productive. Indeed, the conclusion from the Kings Fund and IFS paper was that the only realistic option of meeting the £15-20 billion funding gap is to tackle NHS productivity.

Productivity is a measure of the efficiency with which an organisation uses its resources to deliver particular outputs and outcomes. Office for National Statistics (ONS) figures show that between 1997-2007 productivity in the NHS fell by an average of 0.4% per year, while that for the public sector as a whole fell by 0.3% per year.²⁶ Pouring money into the NHS has not delivered value for money.

But in healthcare productivity is not a straightforward measurement because in addition to volume of activity many of the outputs are in the quality of the service and are difficult to measure. The ONS measurement of productivity is to some extent contested by the Department of Health (DH) as they argue that does not take sufficient account of improvements in the quality of care.²⁷ For several years, the DH and the ONS have been attempting to develop a better measure which accurately reflects quality; but no new agreed measure is available.

Components of healthcare productivity, 1997-2007



Source: Office for National Statistics. Total Public Service Output and Productivity. June 2009

Increasing productivity and efficiency

The King's Fund and IFS suggested that gains in productivity of 6% per year over the period 2011-14 would be required to bridge the gap between the 'cold' scenario and the Wanless 'fully engaged' scenario.²⁸ But NHS productivity has fallen by an average of 0.4% per year in the last decade, so the turnaround would need to be on a scale not seen before. It would need to be over three times that in the private sector, where typically increases in productivity are about 1.8% per annum.²⁹

So there is a productivity conundrum for the NHS: although the total amount of healthcare provided has increased the resources used have grown at an even faster rate. And there is no escaping the fact that a significant part of the increase in NHS funding in the last decade has gone on employing more staff and paying them improved salaries.³⁰ The NHS now employs 1.6 million people and the pay bill accounts for around 40% of overall expenditure and up to 70% in acute or mental health trusts.³¹ So a logical solution for any government dealing with a 'cold' funding scenario might have to include reducing staff numbers, staff pay, or both. In this context, our discussions highlighted the NHS pay deals of the last few years, particularly Agenda for Change, as not always producing value for money for the taxpayer.

Since 2000, as part of a strategic plan for the NHS the Government has sought to increase pay across all staff groups in order to improve recruitment and retention.³² Agenda for Change covers all staff except for doctors and senior managers, but there have also been new contracts for consultants and for GP services. It is interesting to note that the Department of Health's business case to HM Treasury for all three pay deals expected year-on-year increases in productivity of up to 1.5%.

Agenda for Change

The objective of the Agenda for Change programme was to reform and simplify the pay and conditions of around 1.1 million staff in the NHS in England. Following its implementation, the annual cost of employing staff on Agenda for Change in the NHS rose by £7.4 billion (36%), increasing from £20.8 billion in 2003-04 to £28.2 billion in 2007-08. Of this £7.4 billion increase, 13% was due to growth in staff numbers and a further 22% was due to an increase in employers' pension contributions. However, 65% of the increase (£4.81 billion) was spent on higher levels of pay, through pay awards and pay progression as people simply moved through the pay system.³³

In a series of reports the National Audit Office has examined all three pay deals and a common conclusion emerged for both Agenda for Change and the new consultant contract: neither has shown value for money.^{34,35} A common failing was that no productivity measures were introduced along with these pay deals, which has not allowed improvements in productivity and quality to be measured and aligned in return for improvements in pay. The new contract for GPs was found not to have improved productivity, although with the introduction of the Quality and Outcomes Framework (QOF) there has been an element of pay for performance.³⁶

Both main political parties have committed to wage freezes in the NHS - a signal, perhaps, that they both understand the difficult choices that the NHS is yet to face. However, although NHS pay freezes are anticipated to save the NHS about £1 billion³⁷ per year, they are only part of the problem of pay inflation in the NHS, since almost all NHS staff are automatically awarded incremental increases on an annual basis.³⁸ The NHS, like most other public sector organisations, operates on salary bands with incremental pay points within each band. These annual increments equate to a salary uplift of 2.9% for a newly qualified nurse, or 4.7% for an NHS manager reaching the top of their salary scale.³⁹ The total cost of this incremental movement has been estimated by the Department of Health to 1% of the NHS paybill – some £420 million.⁴⁰

We believe that a system of staff appraisal should be introduced across the NHS which links incremental increases in salary to improvements in performance and productivity. This could be introduced on either a ward, team or organisational basis and linked to measurable improvements in productivity from a range of indicators which are considered later.

NHS Pensions

If we accept the widely held view that private sector involvement and competition in the NHS is necessary in order to help drive system wide efficiency, then the inability to access the NHS pension scheme is one of the largest obstacles to private involvement with the health service. As with most public sector pensions, the cost of the pensions offered is “the elephant in the room” for the NHS. The table below shows that NHS pensions are accounted for separately from core NHS spending. In addition to the £98.2 billion spent on providing NHS services a further £12.5 billion goes on NHS pensions. Public sector pension schemes are referred to as ‘unfunded’ because when the Government receives contributions from public sector employers and employees it spends the money immediately rather than investing it for the future as a private sector organisation is compelled to do.

	2009-10 (£ billion)
Total public spending in Department of Health	116.8
<i>Of which:</i>	
NHS	98.2
NHS Pensions	12.5
NHS Capital	5.4
Personal Social Services	1.6

Source: Department of Health: Departmental Report 2009. Annex A. Tables A.3, A.4

The NHS pension scheme asks employees to make a contribution of 5% - 8.5% of pay and employers for an additional contribution of 14% of pay – a total of up to 22.5% of employee pay.⁴¹ However, over 40 years a typical public sector worker will need to have paid 48% of their salary into the scheme in every year in order to cover the pension benefits received. And for some high-earning public sector employees, such as GPs, the annual pension contributions required are up to 69% of annual pay.⁴²

The competitive pressures for private sector employers to provide the same generous pensions as in the NHS could be addressed by allowing employees to carry over their existing NHS pensions into the private sector. However, this would not help tackle the wider issue of reducing the costs of public sector pensions. During our discussions for this report it was suggested that NHS trusts should have to meet the full costs of their employee's pensions. This echoes recommendations in Policy Exchange's earlier work, *Public Sector Pensions*, that public sector employers should have to pay a cash amount each year equivalent to the full market value of the pension benefits accrued by staff in that year. This would highlight the generosity of the current scheme and allow a more informed debate with NHS workers as to reform and cutting costs.

What is the NHS doing already?

So the scale of the challenge for the NHS is huge. During our research we came across warnings that 'salami-slicing' existing services or wide scale redundancies would prove counterproductive in the longer term.⁴³ But if the NHS is to become more efficient at delivering high quality outputs what are the specific gains in productivity that the NHS needs to achieve?

In recent years quality has become the buzz word in the NHS. Quality is defined in the Darzi review as, "safe and effective care of which the patient's whole experience is positive", but the emphasis on improving quality has also resulted in considerable cost savings.⁴⁴ In expectation of challenging financial times ahead there is a centralised NHS resource of evidence based quality improvements and interventions. NHS Evidence has plenty of improvement programmes on the shelf, but implementing them is the key. Indeed, as was noted repeatedly during our discussions, "Where's the incentive for a hospital to become 30% more efficient?"

A criticism of the NHS in recent years is that it uses far more hospital beds than are necessary.⁴⁵ Length of hospital stay is one of the greatest variables between NHS trusts, but with simple measures hospitals can both improve the patient experience by reducing the number of days spent in hospital, and save money. For example, the average length of hospital stay ranges from 10.9 days in the top ten NHS trusts to 44.5 days in the lowest performing trusts for patients with a broken hip.⁴⁶ Until recently the focus of the work of organisations like the NHS Institute for Innovation and Improvement has been on the spread of best practice, innovative technologies and new ways of working from a quality perspective rather than focussing the costs savings they could deliver.

Better Care, Better Value Indicators

The NHS Institute for Innovation and Improvement has produced 15 high-level indicators of efficiency that identify potential areas for improvement in NHS productivity. Geared towards acute trusts and PCTs the indicators include measures such as reducing patients' length of stay in hospital, preventing emergency admissions to hospital and reducing the number of pre-operative bed days. For example, in many hospitals over 25% of all beds are used for pre-operative patients for both elective (planned) and emergency admissions to hospital.⁴⁷ The NHS Institute for Innovation and Improvement says that if all hospital trusts with above average indicators for elective pre-operative bed days were reduced to the average, it would save at least 390,000 bed days. At around £200 per bed day, the potential saving is £78 million.⁴⁸

However, Better Care, Better Value are indicators, not targets. There is no specified level which trusts must achieve on each indicator. Instead their purpose is to enable managers and clinicians to identify areas where productivity or efficiency might be improved in their organisation. Based on all organisations achieving the performance of the top 25% trusts, **the total productivity opportunity for the NHS is about £3 billion.**⁴⁹

The suite of NHS Institute for Innovation and Improvement programmes include the Productive Series which applies lean thinking and methodologies to pathways and modes of care, such as the Productive Ward and the Productive Operating Theatre. In these programmes the NHS Institute supports NHS teams to redesign and streamline the way they manage and work. For example, the Productive Ward programme consists of a number of modules aimed to systematically increase the time ward staff spends on direct patient care.⁵⁰ The focus is on developing measurement systems to rate performance; reorganizing the ward to create more efficient workplaces, and increasing patient information to improve patient experience and flow. Reviews of the programme are still underway, however Shewsbury and Telford Hospitals NHS Trust have already found that direct care time has increased by 12-15%.⁵¹ **The total NHS productivity opportunity from the Productive Series initiatives is another £2.2 billion.**⁵²

The most recent initiative in the Productive Series is the Productive Community Services programme. Over the next few years community services will play an increasingly crucial role in the NHS as part of an effort to shift care away from expensive acute services in hospital into caring for patients in local settings. Community services account for 10% of all healthcare purchased by the NHS - £7.1 billion in 2008/09 – and grew by 13% from the year before.⁵³ That the NHS Institute for Innovation and Improvement should highlight the potential to release savings from community services echoes the views of experts consulted during our discussion that community services offer a huge potential for efficiency savings of up to 30%. We believe that 30% is a conservative estimate, but even so this equates to a **potential productivity saving of £2.1 billion.**

However, there are no direct incentives for acute hospitals or Primary Care Trusts to utilise the best practice programmes on offer, and as a result there are unacceptably wide variations in clinical care across the country for seemingly similar procedures and pathways. For example, across the East Midlands in Q1 2009 day case surgery rates vary from 82% to 22%.⁵⁴

Policy Exchange's previous work, *All change please*, has highlighted the poor spread of new technologies and best practice through the NHS. Amongst other things, the report recommended that a greater proportion of the £2.4 billion spent on creating new ideas should be redirected towards spreading these innovations through the NHS. Specifically, it recommended that the introduction of pay-for-performance bonuses to

clinicians and managers delivering organisational objectives, such as improving the uptake of best practice. The success of QOF in incentivising GPs to deliver against agreed performance measures is evidence that in the NHS pay-for-performance works.

Releasing cash savings

Crucially, however, productivity and efficiency gains do not release cash savings unless capacity can be taken out of the system. This means facing the charged political debate of closing wards, imposing recruitment freezes, reallocating staff and, in the longer term, closing hospitals. All of the experts we spoke to said that this was an inevitable, and even desirable, position in order to protect the future of the NHS, “There are big buckets of savings to be had, we just don’t address them.”

However, as we have seen in recent years, closing hospitals, or even wards requires political will and support. The case for service change and the need for less hospital services must come from the NHS itself, especially if the public are to accept these changes as part of the national economic recovery. Programmes that have been developed in partnership with clinicians, and which have a strong value base and a focus on quality and safety, have delivered widespread clinical and public engagement. These efforts are at their most powerful when a visible coalition of managers and clinical leaders support these efforts.⁵⁵

Decommissioning services

In the National Institute for Health and Clinical Excellence (NICE), the NHS has a mechanism to exclude non-cost-effective treatments and technologies. Its recommendations are based on a review of clinical and economic evidence, so that new treatments offered are both clinically effective and also represent value for money. However, NICE’s remit covers only new treatments and technologies - there is no remit to consider which older treatments are no-longer cost effective and should not be provided on the NHS. There is no decommissioning function in the NHS. We believe that the remit of NICE should be expanded to include deciding which existing NHS treatments are not clinically effective – such as homeopathy – or no-longer represent value for money and should be excluded from the NHS.

A second criticism of NICE is that it does not have to consider its advice or recommendations within an overall resource ceiling. In conducting an appraisal NICE decides only whether the new treatment or technology is clinically effective and whether represents value for money, not whether the NHS as a whole can afford the number of treatments that might be required. A recurrent suggestion to remedy this is for NICE to consider its guidance with the limits of a constrained budget, just as PCT Chief Executives are required to do. We agree and note that a similar suggestion has just been put out for consultation by the Department of Health in relation to National Specialised Commissioning. This consultation has suggested that the National Specialised Commissioning group has both responsibility for assessing the effectiveness of new technologies for very rare conditions and also purchasing all those services within a confined budget.⁵⁶

In view of the tight funding it faces, it is clear that the NHS might need to face up to the reality of having to do less with less – i.e. excluding certain services from the core NHS offering. This avenue of thinking highlights another way in which NHS costs can be considered and potentially contained – by disease area. Below is the NHS programme budget data, which although not completely accurate is able to show the major disease areas and their respective costs to the NHS.

NHS expenditure by disease area	£ billion
Mental Health Disorders	10.2
Problems of Circulation	7.2
Cancers and Tumours	4.9
Problems of the Musculo Skeletal System	4.0
Problems of the Gastro Intestinal System	4.0
Problems of the Respiratory System	3.8
Problems of the Genito Urinary System	3.6
Neurological	3.4
Problems due to Trauma & Injuries	3.0
Dental Problems	3.0
Maternity & Reproductive Health	2.9
Problems of Learning Disability	2.8
Endocrine, Nutritional & Metabolic	2.4
Social Care Needs	2.0
Healthy Individuals	1.7
Problems of the Skin	1.6
Problems of Vision	1.5
Infectious Diseases	1.3
Disorders of Blood	1.2
Conditions of Neonates	0.9
Adverse effects and poisoning	0.8
Problems of Hearing	0.4
Other (inc. GP services, NI contributions & SHA's)	25.4
Total	93.1

Source: Department of Health. Estimated England level gross expenditure by Programme Budget. 2007-08

The figures given are only estimates, although it often comes as a surprise to many people that mental health is by far the largest disease area for NHS spending with £10.28 billion. The point about highlighting this programme data is that concentrating NICE's decommissioning efforts in the largest spending areas, such as mental health, cardiovascular disease, cancer, musculo skeletal and gastro intestinal disease could yield greater savings than trying to exclude smaller often marginalised services, such as *In Vitro Fertilisation (IVF)*, from the core NHS offering. As one expert noted, "the noise from cutting smaller services is often the most difficult to counter."

System transformation

Transformational change is the current emphasis across public services. But transformational change by definition is radical in nature ... *"It requires a shift in assumptions made by the organisation and its members. Transformation can result in an organisation that differs significantly in terms of structure, processes, culture and strategy."*⁵⁷

Within the internal market of the NHS there are two mechanisms by which costs can be contained. The first is by having strong and effective commissioners of healthcare services – i.e. the people that decide what to buy and where from. The second is through the price paid which is the national tariff system of Payment by Results (PbR).

Shifting commissioning responsibility

All the experts we consulted agreed that whichever political party wins the next general election, the role of commissioning will be key, since commissioning is essentially control of NHS finances. The Department of Health allocates 80% of NHS resources to Primary Care Trusts (PCTs) on the basis of the relative health needs of their populations. Under these allocations, PCTs will receive a total of £164 billion over the two years from 2009 to 2011.⁵⁸ This is equivalent to 5.3% of GDP per annum.

Commissioning is a complex process of ensuring that the health services provided in an area meet the needs of its population, but evaluations by the Department of Health suggest that current commissioning arrangements by PCTs are weak.⁵⁹ The NHS commissioning programme has been re-launched as 'World Class Commissioning', but expertise in commissioning in the NHS is to some extent being delivered by expertise and services bought in from the private sector.⁶⁰ Practice Based Commissioning (PBC) is an attempt to engage General Practitioners (GPs) in commissioning services, although budgets are indicative, not real, and so GPs have not engaged in the process. Neither PCTs nor GPs think that PBC has yet delivered benefits for patients.^{61, 62}

In the future of commissioning there is a fundamental divide between the political parties. If the Conservatives win the General Election they intend to delegate all commissioning and budget holding responsibility to GPs, whereas a Labour Government would continue to invest in Practice Based Commissioning (PBC). So beyond 2010, the key objective for commissioners – in whichever form – will be to ensure that productivity and efficiency gains elsewhere in the system accrue to them as cash. Commissioners need to ensure that increased efficiency in acute hospitals and community care services translates to fewer admissions or attendances at hospital, or reduced prices, or ideally both.

But which system of commissioning is most likely to be able to deliver cashable savings? The 2009 Budget report outlined how £500 million would be saved in the NHS through, amongst other things, improved commissioning and lower hospital, community care and mental health costs. However, the Audit Commission has found that last year's funding increase to PCTs has been spent on yet more costly hospital care.⁶³ So as currently arranged, NHS commissioners do not seem likely to be able to deliver cash savings for the NHS, yet the evidence from GP fundholding in the 1990's was that giving GPs real budgets and allowing savings to be re-invested, actually reduced elective hospital admissions by 3% and drove hospital efficiency by 1.6%.^{64,65}

Under a system of fundholding GPs would act with a dual role, simultaneously acting as clinical expert on behalf of the patient and a rationing expert on behalf of the taxpayer. Since GPs operate on a small business model where any surpluses accrue to them as profit there is an inbuilt incentive for them to have greater regard for the financial implications of clinical decisions. We calculate that if GP fundholding could be successfully implemented across the country, it has the potential to deliver **savings from reduced admissions of up to £1 billion.**

Payment by Results - the NHS tariff

The NHS Plan in 2000 introduced a system of paying hospitals for all the activity that they undertake. This system, known as Payment by Results (PBR), requires that a tariff is attached to many hospital procedures. In theory, this national tariff setting system provides an opportunity to drive costs out of acute hospitals by reductions in the tariff. Indeed, Lord Darzi's Next Stage Review recommended that best practice tariffs be introduced and from 2010-11 four high-volume treatment areas - cataracts, broken hips, gall bladder removal, and stroke care - will have a best practice tariff.⁶⁶ In other words payments will reflect the costs of the most efficient providers.

However, the current Payment by Results (PBR) system was designed to reward increased activity in order to drive down waiting times in an NHS that was growing. Using the tariff as a tool to drive down system wide costs in the short term does seem to be beset with two major problems:

- Large areas of clinical spending are not yet covered by the tariff. For example, spending on mental health costs £10.6 billion and tariff in this area is not likely to be implemented until 2013/14 at the earliest.⁶⁷
- Acute hospitals, which are not always the most cost effective setting for care, derive almost all their income from the tariff and are very effective at using this to increase income. For example, the Audit Commission found that when the tariff was increased by 2.8% acute hospital funding increased by 6.8%, which suggests that the tariff is not an effective mechanism for reducing costs.⁶⁸

Certainly, use of the tariff will be a useful tool in reducing costs but we do not believe that it offers a panacea, especially in the short term.

Who is going to deliver change?

Much of the change effort in the NHS in recent years has focused on structures: changing organisational boundaries, responsibility for resources, introducing new jobs, or targets. However, change efforts that modify structures alone are not sufficient to bring about the transformation we need, especially in the short timescale available. The capability of NHS management is an important issue in this respect. During our discussions we often heard that, in the context of innovation and commissioning, PCTs are often reluctant to make use of their powers because the risks of failure are simply too high. In short, there is no freedom to manage. Innovations are regarded as “too progressive” and failure in the short term is often not accepted, especially by the regulator.

Good management involves getting things done through people, but managers need key skills in order to deliver against set goals: risk, freedom and competence. The NHS is an increasingly complex people-management organisation; it needs the best managers available. It is commonplace to hear criticism about the number of managers, but not their quality. Internal NHS reviews show a significant deficit in project management skills across the NHS, specifically in the management workforce.⁶⁹ If efficiencies are going to be achieved through increasing market involvement in commissioning or innovation then managing these frameworks requires strong and capable managers.

But attracting NHS Trust chief executives with the right capabilities is a perennial problem. The overall NHS Chief Executive, David Nicholson, laments that only one suitably qualified candidate applies for each vacant post. So where are the new managers going to come from in the short term? Since 80% of all NHS costs stem from clinical decision making, involving clinicians in system management is a critical step. In the NHS there is a rich talent pool of doctors on which to draw and medical engagement is one of the key factors to influence organisational performance.⁷⁰ Focussing attention on developing doctors into managers would deliver disproportionate benefits in the short term.

We also believe that the bonus framework for very senior managers should be revised. Currently, bonus payments for very senior managers in the NHS are restricted to 7% of pay⁷¹, whereas smaller and less complex private sector organisations offering executive bonuses of between 50% and 100% of salary. We believe that bonus payments of up to 30% of pay should be allowed for very senior NHS managers. The best performing NHS managers could receive **performance related bonuses of over £30,000.**

The role of technology

The use of technology in healthcare is often cited as a key driver for both increasing and reducing healthcare costs. In the context of finding savings from the healthcare budget a number of experts in health technology have told us that trying to utilise improvements in technology will drive up healthcare costs, at least in the short-term although they will deliver savings in the longer term. Technology also suffers from the same issues that make improvements in productivity and efficiency difficult levers for politicians to be able to reduce total healthcare costs: successful implementation requires less hospital beds and less staff.

Integrating healthcare

A longstanding debate in healthcare, and indeed for the NHS, has been to what extent can an integrated system of healthcare both improve care for patients and reduce overall costs.⁷² At present the interface between primary care and secondary care doesn't always produce seamless care for patients, not least, because the hospital payment system, Payment by Results, incentivises admissions to hospital rather than facilitating treatment closer to home.⁷³

The focus of an integrated care system is to achieve the best outcomes for the limited funds that are available. The overriding principle is that care would be better co-ordinated by achieving vertical integration of the primary care team (GPs, nurses, physiotherapists, etc) with secondary care which mainly consists of hospital based specialists. Another form of integration links the primary care team into social care.

The final report in Lord Darzi's Next Stage Review last year has signalled integrated care as a possible direction of travel for the NHS.⁷⁴ The Darzi Review has sparked 16 integrated care pilots in which new Integrated Care Organisations (ICOs) bring together health and social care professionals from a range of organisations – community services, hospitals and local authorities.⁷⁵ Two of these pilots look at integration between primary and secondary care although one expert suggested there is little evidence that vertical integration of care between primary and secondary providers actually reduces costs. There is, however, a body of evidence which shows that integrated systems deliver higher quality care for given level of funds.^{76,77} And in the NHS quality is a proxy for efficiency, and cost savings.

During our discussions, the integrated care pilots received criticism, as it was felt that they were simply too small to be effective and should be covering a population of around 200,000 - about the size of a small PCT. One suggestion was that it would be possible to offer, say, 85% of the costs of providing NHS healthcare to a consortium of providers in one geographical area and allow them to, "get on with it". This would be a true integrated care pilot which would build the evidence base around whether integrated care could deliver the scale of cost savings required. We believe therefore that a full-scale ICO pilot should be run at one of any number of financially challenged acute trusts with large historic deficits. For example, Hinchingbrooke Health Care NHS Trust acute hospital services to Huntingdonshire and surrounding areas, a population of approximately 161,000 people. It has well documented financial difficulties – a £40 million deficit on a turnover of £81 million and is currently being offered on a franchise basis to the private sector.⁷⁸

Conclusion

Given that the NHS is going to face a challenging financial environment from beyond 2011, we believe that options for reducing costs are much more politically palatable than fundamentally altering the principles of the NHS and relying on top-up or co-payment mechanisms to introduce additional funds. We believe that introducing pay for performance across all NHS staff and linking increases in productivity and efficiency to incremental increases in pay has the potential to deliver half of the savings required. Successful

implementation of GP fundholding will also deliver efficiency savings and a system more responsive to the needs of patients.

In the long-term the economy will recover and we will almost certainly be spending much more on healthcare than we do now. One of our experts noted that it would not be inconceivable that the UK could spend up to 20% of GDP on healthcare and that people would consider this entirely acceptable, and even desirable. Whether that funding comes from State or private sources is a different question for another time.

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