

# closing the gap: a round-table discussion



On 21 May the Smith Institute convened a round-table discussion chaired by Wilf Stevenson, Director of the Smith Institute, on the gap in NHS funding that may occur by 2015, to examine whether the envisaged policy instruments for managing demand and improving productivity will be adequate to meet that challenge.



**Mark Bassett**  
Head of Public Policy  
at BUPA



**Edward Bramley-Harker**  
Associate Director at  
National Economic  
Research Associates



**Andy Burnham MP**  
Minister of State for  
Delivery and Quality in the  
Department of Health



**Howard Catton**  
Head of Policy Development  
and Implementation  
at the Royal College of  
Nursing



**Dr Penelope Dash**  
Senior Research Associate  
in Health at Cambridge  
Health Network



**Nigel Edwards**  
Director of Policy with the  
NHS Confederation



**David Furness**  
Researcher in Health Policy  
at the Social Market  
Foundation



**Dr Richard Horton**  
Editor of *The Lancet*



**Duncan Innes**  
Public Affairs Manager  
at BUPA



**Fergus Kee**  
Managing Director of BUPA  
Health Insurance



**Professor Julian Le Grand**  
Professor of Social Policy  
at the London School of  
Economics & Political Science



**Nicholas Timmins**  
Public Policy Editor of the  
*Financial Times*

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## Round-table discussion

*Wilf Stevenson*

Welcome to this round table about a possible gap in funding for the NHS that may occur, if present trends continue, by 2015.



*Edward Bramley-Harker*

I am going to set out some thoughts on the challenges that the NHS faces, going forward, as we move into a period of lower funding growth. To do that, I'd like to draw on some modelling work that National Economic Research Associates has completed over the last few years, which is summarised in a report we prepared for BUPA.<sup>1</sup> The model was initially developed in 2002 and was used to assess how the changes outlined in the NHS plan would turn out to impact on activity levels, on expenditure and on waiting lists. In the current environment, we can now use it to assess what the consequence of a slowdown in capacity growth would be.

In a model exercise of this type, what you get is a simplification of what goes on in reality. But we found this process to be quite useful as a way of demonstrating what order of change is needed on the demand side or the supply side, as the funding growth slows, to bring the NHS back into some kind of equilibrium. The model is assumption driven. In this particular case our model looks at 2014/15, so we have to make assumptions about how wages, staff numbers, productivity and demand patterns might change over time. Our general approach is that current trends continue, except where there is good evidence to suggest otherwise: for example, we built in productivity improvements post-2008, and wage growth slows.

<sup>1</sup> Bramley-Harker, E, Boer, T, Ridge, M and Bell, M *Mind the Gap: Sustaining Improvements in the NHS Beyond 2008* (National Economic Research Associates, 2006). At: [www.nera.com](http://www.nera.com)

Putting the assumptions in the model together, we estimate that the need for NHS funding after 2008 is around 4.9% real-terms growth per annum. If you set that in the context of the work that Sir Derek Wanless did for the Chancellor, it is in the middle of his range of forecasts for required long-term funding. In the 25 years prior to 2002, health funding grew on average at around 4.2% in real terms per annum. When you consider that over that period there is a consensus that the

be done now and you would not feel the consequences for quite a number of years. Of course, it would mean we would start to undo the investment and upgrading achieved in recent years. But capital spending alone isn't enough to cover the funding shortfall that I am referring to.

A second area where savings might be achieved is to cut wage growth. In our modelling, we have already allowed for this, with



wage growth dropping to economy-wide levels for most staff groups after 2008. Restraining NHS wage growth below economy-wide norms is really not sustainable for a long period. If you do it for too long, there is pressure for catch-up. So I don't think pinning wages back for significant periods of time is an answer to addressing the funding gap. You can, obviously, try to restrain rises in other input prices, but wage growth has the biggest impact.

If you don't think cutting capital spending or squeezing pay increases will close the funding gap on their own, then a third option is to start cutting capacity and reducing activity levels so that the service maintains some kind

NHS was subject to underinvestment, then the model's 4.9% figure of underlying funding need does not look wildly out of line.

When we completed our report for BUPA, our assessment was that actual growth in NHS funding would be around 3.5% in real terms per annum after 2008. So we have a gap opening up between the 4.9% that the model suggests the NHS will need and the 3.5% that is our assessment of what the public purse can afford. If you play that through to 2015, you get a shortfall of 10% of the NHS budget – or about £11 billion by 2015 in today's prices.

So, the core question to discuss today is: how do you think the NHS copes with such a funding slowdown and a potential funding gap? One possibility is that the NHS will try to muddle through, which is probably a fair description of what has happened historically. What would muddling through look like in practice?

To live with a funding shortfall, perhaps the first thing that would be cut is capital spending. This is something that could

of financial balance.

There are other ways the NHS could respond. For example, what would happen if the NHS managed to slow growth in emergency admissions and make better use of day surgery? That frees up resources for more elective care and makes better use of capacity. In one scenario we examined with the model, this reduced the need for funding growth by about half a percent, from 4.9% to around 4.4% per annum.

Another scenario – a more positive scenario – is to think about the scope for the NHS to make more general productivity improvements and make better use of the resources available. A couple of comments on that: first, in the modelling work that I have described, we already assume that productivity improves by about 1% per annum on current levels.

A second comment on productivity is that sustaining improvement in productivity across something as diverse as the NHS is really difficult to achieve. We have a lot of tools in place to help drive through productivity improvements, such as stronger commissioning and payment by results, but nobody really

knows how, when or how much these reforms are going to deliver. You all know, better than me, that there are success stories throughout the NHS of delivering productivity locally, but the challenge at the aggregate level is to deliver these gains system-wide in all parts of the service.

In my personal view, this is the part that the NHS is going to find really difficult. Finding savings here and there in areas of the NHS is one thing, but what we mean by productivity in this context is sustained improvement over time, and not occasional gains here and there. I think it means addressing demand level at the top of the system; changing the referral process; and changing the way patients come into the system. These ideas are not new, but so far they have proven very hard to achieve on a meaningful scale in practice.

One final comment I would like to make relates to the extent to which we will notice the impact of any slowdown in funding. I think historically the link between healthcare funding and activity level has been difficult to nail down. There was not a one-to-one link between funding and output, and I suspect lack of transparency in NHS budgets has reinforced this. The widespread historic use of block budgets that are not directly linked to activity levels implies that in the past the NHS has taken time to respond to changes in funding, and I think in some sense it makes it easier for the NHS to muddle through when funding growth is lower than what is needed.

Focusing on the here and now, with payment by results the link between funding and activity levels is much stronger. And the consequence of this is that if money is short in primary care trusts then the impact on activity levels and hospitals will be pretty immediate. I suggest that if funding growth is less than the NHS "needs" and capital spending reductions cannot cover the whole hit, then the consequences of a funding shortfall are going to be felt much more quickly than would historically have been the case.

*Andy Burnham MP*

First, I would like to thank NERA for the report: it is an extremely good one and a very fair summary of the broad questions that we all face as a country.

I think it is just worth saying something about the NHS model, and some of the inherent strengths it has, before we discuss how to close any funding gap – if, indeed, there is one.

The NHS is the model that enables you to come top of a comparative list for health, while at the same time bottom of the spending league  
*Andy Burnham MP*

Obviously, there are big assumptions that you have made that may or may not pan out in practice. They are reasonable assumptions to make at this stage.

Nick wrote today in the *Financial Times* about a report, which has just come out from the Commonwealth Fund, that compares the health systems of English-speaking countries and Germany. We have up until now been in the middle, but this year the British system comes out top – and not just on questions of equity and efficiency, areas where we have always scored well. We are also beginning to improve our rating on quality of care, safe care – these kinds of indicators. Overall, Britain comes top.



That is amazing, because Nick has also printed a graph that shows expenditure on health as a proportion of GDP, and we are at the bottom of that. Take those two things together: the NHS is the model of healthcare system that enables you to come top of a comparative list for health, when you are at the same time bottom of the spending league! So there are huge strengths in our system. Whatever else happens, certainly from the government's point of view we would not want to see anything jeopardising the progress that has been made in the NHS since 1997. Equally, if we don't want to step backwards there is a need to be up front and open about the issues that the NERA report raises.

You mentioned payment by results, Edward. I don't think the NHS has yet felt the full effect of the efficiency and the sets of challenges it can bring to the system. I think we are beginning to see that. Also we are beginning to see people ask some difficult questions about the running costs versus the income generated by each hospital site. Payment by results will, in my view, deliver substantial efficiencies for the NHS going forward, and particularly when you get to a point when there is greater bundling, to use the jargon, of the tariff.

I think some of the things that have been done in the last 10 years will have a positive benefit in the next two or three years, such as the prescribing of generic drugs on a much greater basis than before. There are other things that will bring the productivity gain that we are not yet perhaps fully seeing.

Also, I think the changes that are implied by the reforms, generally, will substantially alter the way the system works. I am thinking of the 18-week target here. It won't be achieved by people simply throwing money at the problem or doing more of the same. It will be achieved by people critically challenging what they are doing, restricting access, restricting referrals to secondary care by reshaping pathways, doing much more in primary care, and I think some of these things will be very significant in the overall scheme of things.

However – and this is a big “however” – is all this sustainable, with rising expectations? Given the demographic pressures we face, we will have a problem in responding positively to this. And, at the same time, there is emerging evidence already available from around the NHS that the better you make it in consumer responsiveness, the less responsible the use of those services becomes. So if you are being offered appointments within two weeks, it feels different from an appointment in four months' time. People are much more likely to keep the latter one, and we may find the number of people not attending their appointments increases when waiting lists are shorter, and that in turn will put pressure on the system.

We have scored badly on patient-centred care, and indeed we still do, in this Commonwealth Fund survey report. But once you address some of those inherent weaknesses in the NHS, what is the sustainability in the long term and does it have implications for the long term?

There is huge scope for major efficiency, and it might be a paradox that the slowdown in funding focuses people's attention on that  
*Nigel Edwards*



I will stop there: I hope I have said enough to show that while I recognise some of the issues that NERA have drawn out of their report, I would not necessarily accept the premise that there is an £11 billion funding gap. I think there is an issue about how much we, as a country, can afford to put into the system, and at what pace we should be putting pressure on the system. Maybe there is always a gap between those two things.

But in all of my responses to doctors for reform – the British Medical Association and others – I think we can demonstrate that the NHS model is the right way to get high-

quality healthcare to a whole population. We should start with the premise that if there is a gap in the order of £11 billion, perhaps the NHS might be the most efficient system to achieve a new equilibrium. It is fairly cost-effective and it has the capacity to deal well with the big problems of access and patient responsiveness. These questions are going to emerge again as we get towards the 60th anniversary of the NHS.

*Professor Julian Le Grand*

I am with Andy on this: I think the best is yet to come. It is interesting that on this Commonwealth Fund survey we scored well for the use of IT in GP services! It is absolutely extraordinary that we are now doing so much better in things like this than so many other countries, in particularly the USA, which is always assumed to be the gold standard.

What we are scoring well on are a lot of process indicators, and to me that implies that, throughout the system, we have very nearly got all the right incentives in places: the combination of patient choice and payment by results on one side, and supply side on the other. All the government has to do, basically, is hold its nerve and just keep on with these reforms.

I do have one worry – so it is not all good news – and that is on the demand side, and particularly about some of the points you have been making on commissioning. I have always been for practice-based commissioning, as I do think it is a way of managing demand. It needs to be taken forward more strongly.

*Nigel Edwards*

One thing Edward did not mention in the report is the question of society's willingness to pay. Is there a correlation between GDP and how much you want to spend on health? Most countries seem to choose more. I wonder whether you thought of that.

Secondly, on co-payment: just how much money do you actually raise? The problem always seems to be that, if you need to raise enough money to close the gap, we will have to start giving exemptions, which requires a huge administrative



machinery, which may eat into the funds available. It would be interesting to know what the purpose actually is of co-payment: is it to deal with demand or is it to raise money? It strikes me, either way, that tax is a fairer and easier way to generate money. On the payment side, I would be more optimistic that, to produce the outcomes, we may find people are willing to pay.

On efficiency: I think there is huge scope for major efficiency in healthcare, and it might be a paradox that the slowdown in funding focuses people's attention on that.

We have very nearly got all the right incentives in places. All the government has to do is hold its nerve and just keep on with these reforms  
*Prof. Julian Le Grand*

We could spend a lot of time pursuing not very useful efficiencies – like shifting work between sectors, which often increases cost – rather than looking at the system. My anxiety about commissioning, if it is done badly, is that it will entirely focus on micro-efficiency and ignore the major efficiencies available from reshaping the system. The key is the way things are run. There is still scope to get to grips with the sort of efficiency savings that are about making major changes in care as delivered. It may be another case where finding oneself in a tighter environment might well help.

As for the idea that there won't be rationing, it is not realistic – there is rationing now, and I think it is one of the solutions to the problems the minister posed about the expansion of service, and people's expectation of what more the NHS might do for

them. We do have to face up to what the priorities are, and particularly how we deal with some of the expensive and often not hugely cost-effective new therapies that are coming down the track.

*Wilf Stevenson*

What we are hearing is that if you stand back and look at the system, the NHS has got more ability to self-correct and solve these problems than it is given credit for. It has in the past and it can do so again. And we are also hearing that the gap may



not actually be there, because the system could be far more productive than it ever has been, if it would only learn to change how it does the day-to-day work. Do people have different views? Those who work in the system?

*Dr Penelope Dash*

Before one pronounces the whole system dead, I feel that there are certainly three big opportunities that absolutely need to be taken before we get to that point.

The first is productivity in the broadest sense. For example, why do we have CT scanners that are routinely only in use for five or six hours a day; GP practices that are open for three hours in the morning and three hours in the afternoon, and not used for the other 18 hours a day and not used on Saturday and Sunday? We have enormous opportunity for improvement in hospital care; enormous opportunity to get better at prescribing practices; lots of things which would mean we got

dramatically far more out of the system, and that includes staff utilisation. Take maternity care: why is it that in New Zealand midwives deliver 64 babies a year, but many hospitals in England achieve less than 30?

The second opportunity is around appropriateness. We know that many outpatient appointments are not necessary and have no impact on health; similarly for many diagnostic tests and some drugs that are prescribed. These are relatively easy things to tackle. There are also harder things. For example, we know that joint operations on fat people do not get a good result, so should we be doing them? It is arduous, it takes time, but we could begin to look at these things.

The third area is addressing much harder questions around prioritisation – for example, how much intensive care should we provide for terminally ill patients over the last few months of life?

But my view is that all of those things essentially are achievable. I agree with Julian that the right people are starting to talk about it. But, on productivity, it is largely down to providing much better management – managers need to be encouraged to move

forward and push ahead much quicker. For the other two areas, we need much, much, much better commissioning.

*Andy Burnham MP*

I want to ask a question: one of the drivers we use is the tariff; if we went for an indicative tariff rather than a mandatory tariff, so that services could be provided at the highest standard relative to the price, would you say that would be a step too far?

*Dr Penelope Dash*

Certainly not. We ought to be saying that we know there are places around the country who can do this process at such and such a price.

We are starting to see people saying: "I can actually do a dermatology outpatient for £50." They shouldn't do it for less than that; so that is one benchmark. There is now a private company contracting with a primary care trust to provide dermatology at £90 a go, when the tariff is around £130; then

There is an issue about whether people are prepared to pay more for the NHS model if additional resources are not seen to go direct to patient care  
*Howard Catton*

maybe we should set an indicative tariff of £50: that would really put the pressure on trusts.

The problem is trusts are carrying a massive overhead of all their buildings – they need to be encouraged to sweat their assets and be pushed to use their staff in a more efficient way. So I think you could start to push the envelope and to say, "Well, at best practice we would expect the tariff to be around this," rather than the national average.

*Howard Catton*

There is overwhelming support from the workforce in terms of the NHS model, but there is a problem at the moment that people aren't sure whether that basic model has a shelf-life beyond, say, the next few years, or whether further market-based policies, co-payments and user fees will be introduced that could threaten this model. I think staff will immediately look at what this would mean for quality and inequality, and this has a potentially huge turn-off effect in terms of even considering other funding initiatives.

There is also an issue here about whether people are prepared to pay more for the NHS model if additional resources are not seen to go direct to patient care. Failed private finance initiative contractors being compensated, money to advertising agencies and management consultants raise big questions about whether the NHS pound is always finding its way to the patient. It is always politically tough to increase taxes for public expenditure, but if revenue isn't being seen to go to direct service provision this becomes almost impossible – and that has big implications for the NHS as a future tax-funded model.

I think there are also significant issues here for staffing, around quality. The Healthcare Commission report, just last week, was fascinating because the patient choices it puts into the top 10 were all around the relationship between clinician time and information. But the choices that are being offered, around information over different hospitals and the time of appointment were in the bottom 10 of choices. It appears that the choice policy the government is offering is not the choice policy that the public want.

As for staff, the reaction to deficits, where the

workforce has been regarded as a soft and easy target, particularly from a nursing perspective, is another apparent policy contradiction. Matron and specialist nurse consultant are relatively new nursing roles but ones that have delivered real improvements to services and will be critical in terms of achieving the ambition of moving more care closer to home.

Yes, we would like more evidence of the effectiveness of these roles, such as the pilot in Cornwall showing that matron posts are delivering significant reductions in emergency admissions. However, to identify these for short-term savings makes the workforce not only sceptical about the motives of reformers but also less inclined to engage in finding new and innovative ways of delivering care.

Finally, tariffs: these remain medically driven (and I would say this, wouldn't I?) but the nursing workforce is arguably the most important part of the workforce in order to make the shift from acute to community, yet within payment by results their contribution is effectively hidden. Nurses need to not only hear warm words that value them but also see their value reflected in pounds and pence.

*Dr Richard Horton*

These issues are being faced by other countries and we should not feel we are in isolation here. I was sitting around the table in Oslo a couple of weeks ago with a similar group to this, and they talked frankly about an "impending health crisis" and of looking to increase their proportion of GDP spend from 10% on



health to 15% in the next 10 years with no way of knowing how to manage it. They are saying, "We have to accept a 15% of GDP spend and we need to find a way to work with that."

I think the government has done something remarkable in this public health white paper that we haven't talked about, in that it has started a process of refashioning the entire way we think about staff in the NHS, and it is a debate that hasn't begun yet. The white paper has this focus on moving away from doctors, moving away from the professions, and thinking much more about self-care and the expert patient. And that is something that the third sector, and these other groups that the medical profession have been studiously avoiding, have been arguing for.

The doctors don't want that discussion, and yet we have to have it, because the figures are quite astonishing. Who is going to deal with the over-65 age group in 2015? Not doctors. Some nurses, but actually it's going to be serviced by a whole group of people who aren't yet engaged in the health system.

So then you think: looking out at that length of time, what sort of health service do you want? A lot of the problems raised by NERA around financing are important, but they are not the whole story. The key questions are: is stewardship at the top of the NHS to be independent or non-independent? How do you deliver at the local level? We have professional self-interest, from my profession in particular, who are resisting innovation at the moment. And I see every day people in primary care trusts, chaired by influential doctors from particular groups, who will block ideas for innovation because it will somehow encroach on their territory. And if we look forward to the problems that face us in 2015, we have to allow that kind of innovation.

#### *David Furness*

I want to echo the positive response to the NERA report as it stands. One thing that has occurred to me is: what do we do when we hit this funding gap? I wouldn't want to comment on the figures, but I do wonder what we are doing, not just in terms of service delivery but in terms of the politics as well. That is an area that is neglected in the debate: how do we actually engage with people about their health service? It strikes me that we have a health service that can be opaque and distant from

people, and one in which we don't necessarily build incentives for people to look after their own health and actually engage with the health service that way. I don't think it is the right time to draw conclusions about how to fill any funding gap with charges, co-payments or whatever, but it strikes me that it all has to start with the politics of healthcare.

The public individually think they are being well treated, but if you ask them collectively they think the NHS is getting worse  
*Andy Burnham MP*

#### *Andy Burnham MP*

Can I pick up on a few of the points that have been made? The politics of it is the crux of this discussion, really. We are all talking about it in the department, and more broadly in parliament, at the moment. The money has gone in; Julian is right to say it is now producing extraordinary results, and in my view the right mix of levers is now in place to ensure (despite NERA's claim) that there isn't a black hole.

Of course, we have this problem that the public individually think they are being well treated, but if you ask them collectively they think the NHS is getting worse, and that is a really difficult conundrum. It is important in its own terms, as David has pointed out. But it is also important for the future funding question. If we were to take the option that we wanted more tax for the NHS, that would be an incredibly difficult debate to have at this moment in time, because people would say, "Well, no, because it has been wasted." That would be the perceived wisdom. I would be confident of arguing them round, because the evidence says that it hasn't been wasted. Indeed, the evidence is that the funding has been used to good effect. But it would be a difficult debate to have.

David, you have put your finger on the problem, and it chimed with something I have been mulling over, which is that I think the 10-year reform process that we have been through had to be top-down in nature in order to get the progress we wanted as quickly as we wanted. So I think it was inevitable and right that the targets had to be national. They had to be focused, otherwise there would have been a lot of waste of money. The strength was that the system came up with clear priorities and the money went in after those priorities, and it has delivered those priorities and in many cases tremendous results are being achieved.

But there is now clearly a sense of people resenting top-down processes. I think that might go in some measure towards



explaining this conundrum of high patient satisfaction individually and low esteem collectively of the NHS. Because obviously staff don't feel this has been their achievement; they feel it has happened to them, without it being their NHS, however well the system now performs.

The next few years, for me, should consist of a decisive step in favour of local decision making, local priority setting, exactly the things that Richard is talking about; putting staff in a position to lead change rather than feeling powerless in the face of it. There are big questions for the NHS around productivity and innovation, but I think that it goes with the grain of a fully decentralised structure, with a much better chance of achieving what people want post-2008, when the last remaining national targets will be achieved.

Articulating that vision is a challenge that I happen to be working on at the moment. It can be done, but it will be different.

*Nicholas Timmins*

My basic problem is that we could have had this discussion at

any time in the last 60 years. You sit there and say that there is this gap and that there isn't enough money, that demand is rising exponentially, and that technology is racing ahead. And yet similar reports were written in the 1960s, 1970s and 1980s, and we are still here. And I am not saying that it is not worth doing. It is worth doing, and we should run these numbers to see what they show. But what they show is that there is clearly a gap between demand and supply, as there is in every other health system around the world. So it is nothing new to the UK. The question is how you handle it.

The way we measure productivity is so awful you can't actually improve services with the management tools they give you  
*Nicholas Timmins*

And people also talk about the terrible slowdown in funding. Well, it is true we go from 7% real growth per annum to 3% real growth, but there is a difference: we are talking about 3% of £90 billion, which is a lot more cash than 3% of £40 billion, which is what we were spending per annum only a few years ago. That is still an awful lot of money in anyone's language, and it would be mad to suggest that you couldn't do quite a lot with that, going forward.

Secondly, to go back to Nigel's correlation between GDP and health spend: what are we saying? The richer the country, the

more it spends on health services. Equally, if things get tighter, we will spend less on it.

The other problem is to do with productivity: the way we measure productivity is so awful you can't actually improve services with the management tools they give you. We count things like inpatient and outpatient appointments as though these were outcomes of health, but that is not a way of measuring health. You get better healthcare or worse healthcare for your money depending on what you do. So the argument about the need for 1% or 2% productivity



improvement is daft, because the currency is wrong. We are talking about something for which the currency isn't right; it is not that we aren't asking the right question, but that we don't have the right means with which to begin to answer it.

So I am very sceptical about this basic argument that the world will come to an end in 2015 because that is what the numbers seem to show. That is not to say that I don't have ideas about what might be done about that, and I would like to identify two particular problems with the current situation.

One is tariffs: I accept that if you have a more transparent funding system than the present payment by results scheme then this may create lots of questions, but the key question for me is: does payment by results hold as a tariff if you have a fixed price, because surely people will begin to peter on priority and quality.

My second worry is capital. We probably need to sustain priority spending on capital. If you go to the USA and visit, as I did, a cancer outpatients facility in midtown Manhattan, you will find it is full of airline-type chairs. People sit down and have their chemo and, after a rest, go home. It has four beds in case of emergency, but that is what they do. Patients love it. We stick people in hospital for God knows how long. If you switch from one system to the other, it requires a lot of capital and probably some training. So cutting capital is a worrying point for me.

*Wilf Stevenson*

Andy was saying that the regime in place for the last 10 years, the top-down lever-pulling system, is over. What is going to happen now, if he stays around, is a more decentralised approach. How could you see your scenario of forced changes in the process of managing disease being implemented in that sort of decentralised approach?

*Nicholas Timmins*

That is pure political rhetoric. What I think has happened is that Labour went through a completely bananas experience shifting from command and control to decentralisation and found it didn't work. So we are back on the

20-year-old train introduced by the Conservatives, where the government, with some success, is now trying to find the incentives to make people behave better.

*Dr Penelope Dash*

We need the political will to see these changes through if we are going to get the step change in practice exemplified by Nick's oncology story. Of course, we also need a step change in the way staff operate. It is a challenge, but I think it is do-able. But I am worried about the political will locally, because it does mean changing some local hospitals and getting GPs to work in a more appropriate facility than their converted sitting room. Will the politicians back these changes? If they will, we can achieve a really great service. If not, we will stagger through as we always have done, and it could go either way.

What will the centre do to take on the doctors? If you read the British Medical Journal it is doom, gloom, week in, week out  
*Dr Penelope Dash*

The other big one is: what will the centre do

to take on the doctors? Because there is an interesting dynamic going on. On the one hand, you can see some medical directors who are fantastic, and who are really grasping the implications of what is required to change the service at the moment. They are getting into this, looking at the costs to deliver various treatments and finding ways to improve quality. But, on the other hand, if you read the *British Medical Journal* at the moment it is doom, doom, gloom, gloom resistance, week in, week out. This needs to be tackled from the centre, with senior doctors willing and able to encourage their colleagues to support the improvement of services rather than continually resisting change.

*Dr Richard Horton*

I wish it felt like that within the profession. It doesn't feel like that at the moment at all. How do you drive improvement? It really is an important question. Looking at the USA, I think the competition for patients really is driving huge improvements, and the implication is that that has to be the way to improve the NHS. Some of the best centres in the USA are no longer able to compete on outcome; the doctors are all so good that what they are competing on is the patient experience. So all the advertising is on the basis of experience: it is not choice, it is experience. So the way they are improving care is using competition between different doctors, and that is what we have to introduce.

Unfortunately, it comes back to this rigid professional self-interest: that if you introduce competition, doctor against doctor, it undermines the power that doctors have. In the NHS that ridiculous attitude needs to be tackled and some government, some time, is going to have to defeat the doctors. Unfortunately, now is a bad moment. It is really a bad moment because doctors are in complete disarray and they don't know how to get out of the corner.

*Professor Julian Le Grand*

I rather agree with Nick that I am not sure that fixed prices can hold, so we will see tariffs change. In the USA, fixed-price competition tends to drive up quality almost exactly along

The mindset in healthcare is that quality costs you money, whereas actually it is the opposite  
*Nigel Edwards*

the lines of what you are saying. If you have price competition as well, the evidence tends to suggest that you lower prices and cost, yes, but you lower quality, or there are mixed results on that. So there is a slight danger from price competition. I used to be a strong advocate of it. I do worry that in some sense it is almost inevitable that it will occur, but we need to be careful about that, and a better policy might be to use a basis of quality and price.

*Nicholas Timmins*

Then you end up with a tariff which is a benchmark price. So it still has an effect.

*Professor Julian Le Grand*

But if you bid below, there is no way to cut corners.

*Nigel Edwards*

The mindset in healthcare is that quality costs you money, whereas actually it is the opposite. One of the things on competition which strikes me when I talk to clinicians is a problem they have with the current reforms, particularly in primary care, which is that they want high-quality access to special advice and support. They want integrated systems. They want their colleague down the end of the corridor. It might be some poly-clinic corridor, but they want to work in a system.



*Mark Bassett*

I would like to address what might be a misapprehension about the views of the authors of the report. I don't think that we ever intended to suggest in the report that the NHS financing system is broken or will at some future date be broken. But what we did want to suggest is that there is a significant problem at the margin. We have, I think, to evaluate whether the scale and pace of envisaged policy instruments to improve productivity and manage demand are likely to be adequate to address that potential gap.

Secondly, I challenge Nick Timmins' assertion that this report could have been written in any time in the last 60 years. My reason for doing that is because we have seen a significant growth in capacity as well as financing over the last five years. I think that as we retrench there is a significant risk of finding it impossible to reduce demand, because patients and NHS staff will be slow to adjust their behaviours.

I would like to come back to financing briefly. There is no disagreement that the NHS is efficient at collecting funds, and that a tax-based system for the principal funding component allows maximum opportunity to reallocate for equity purposes. But where our NHS is weak is on the issues of fund management and commissioning. I have to say that fund management is a neglected policy issue. BUPA as well as the NHS is 60 years old this year. BUPA has significant reserves and a proper solvency structure in place. We need to get our

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*David Furness*

primary care trusts on a stronger financial footing too.

*Fergus Kee*

Building on what Mark is saying, in his opening remarks the minister highlighted one of the greatest strengths of the NHS public funding, which is the quantum of health output for what by international comparison is a relatively small percentage of GDP. I think preserving that has to be a priority.

As we look around the world and operate in different countries, we find that the systems that work the best have at their core a really efficiently run, publicly funded system that is then supplemented in some way. As Mark says, the purpose of this report is not to focus on that supplementary role but, I think, to highlight what, on reasonable assumptions, is a probable financing gap by 2015. That reinforces the need to drive productivity, whether it is through commissioning or other initiatives, to get the maximum value to spend over the next few years.

*David Furness*

I just want to come back to a point that Richard made about the impact of quality when doctors are competing for patients in America. I just wonder whether we are making an assumption there that the patient experience is necessarily commensurate with the quality of care. There is some evidence to suggest that people are quite bad judges of the quality of care. If you wanted to improve patient experience, you might put patients on the ward and have an old style of oncology which people think is much better, rather than having them sitting in airline seats and receiving treatment that way.

One other point about engaging with doctors: if you want to change an organisation, you have to bring people with you, the staff that work in the service. Obviously, the doctors are key deliverers of the service that the NHS provides. I wonder if that brings us back to the nature of the NHS – not in terms of money or anything like that, but actually is it manageable? Can you manage a £90 billion organisation that does something extremely complex that is literally a matter of life and



death? I wonder whether that is a growing challenge for the NHS as we devolve more responsibility to local providers.

*Duncan Innes*

I am, in some senses, still a fully paid-up member of the Wanless church. Can I just briefly mention all three Wanless reports? The first report, if you remember, was about investment and reform. The investment was couched in terms of catching up, and this has now happened. The question is whether, having caught up with the resources, we are getting our bang for our bucks. The second report was about reform: I don't feel, personally, that we have had as much reform as we should have.



And the third report, which we haven't talked about today, is public health and the need to stop people carrying on with the behaviours that are going to lead to them getting the diseases they do at present. I don't think, as a society, we have seriously taken to heart what Wanless said about health and prevention issues.

*Professor Julian Le Grand*

On healthcare, a lot of the Wanless messages were in the white paper we have been talking about. We do struggle with this central problem, myself included. There is no silver bullet, but it seems that, while we do want to change behaviour, individual behaviour and the behaviour of institutions, and we recognise that both institutions and individuals will benefit from changing behaviour in the long term, actually translating that into public policy is really difficult.

*Edward Bramley-Harker*

Our report is much more about highlighting an issue that we think is growing in the background. I believe it needs to be addressed and managed properly if the system isn't to undo a lot of the progress that it has made in recent years. I am encouraged by the discussions today, which have really moved the debate on, but I have a couple of reservations.

The first is this notion of unbundling the tariff and introducing

more price competition into the delivery market. I wonder whether the infrastructure that we have in place is actually set up to deal with this. We have a system at the moment that is based around full-service hospitals with high fixed costs, and within current structures they cannot unpick the bits of the tariff they want to deal with in a price-competitive system. I am not sure that the public are ready or that the political will is there for the kind of reconfiguration that a price-competitive system and a move away from a full-service system would imply.

The question is whether, having caught up with the resources, we are getting our bang for our bucks  
*Duncan Innes*

We are also talking about significant reconfiguration as a way of helping to achieve productivity gain, at a time when capital spending in the NHS is likely to start coming under pressure. I also struggle to think of any other health system that has achieved productivity gain on the sort of scale that we are talking about here. The US system made progress back in the 1980s at restraining spending, but at the time there was an enormous amount of fat in the system and it

was a relatively easy task to suck that fat out. In this context, we are really talking about a fundamental change in the configuration of the system and in how we identify and treat disease. I am not saying we can't achieve it, but it's a huge and complex task.

*Wilf Stevenson*

Thank you very much for a very good discussion.

### **The Smith Institute**

The Smith Institute is an independent think tank that has been set up to look at issues which flow from the changing relationship between social values and economic imperatives.

If you would like to know more about the Smith Institute please write to:

The Director  
The Smith Institute  
3rd Floor  
52 Grosvenor Gardens  
London  
SW1W 0AW

**Telephone** +44 (0)20 7823 4240  
**Fax** +44 (0)20 7823 4823  
**Email** [info@smith-institute.org.uk](mailto:info@smith-institute.org.uk)  
**Website** [www.smith-institute.org.uk](http://www.smith-institute.org.uk)