Securing Good Health for the Whole Population
Derek Wanless
February 2004

Securing our Future Health: Taking a Long-Term View
Review of the trends affecting the health service in the UK
Derek Wanless
April 2002

Factors affecting health service resources over the next 20 years
- The terms of reference specified:
  - Technology and medical advances;
  - Demography.
- 3 additional areas were identified in the Interim Report:
  - Patient and public expectations;
  - Changes in health needs and different patterns of disease;
  - Workforce roles, pay and the productivity of the health service.
- Over this decade, the commitments in the NHS Plan and the National Service Frameworks add significantly to cost.
- The current method of financing is not itself anticipated to be a factor leading to additional resource pressures.
Interim Report: where were we in 2001?

Outcomes
- Poor health outcomes;
- Not meeting the needs of an ageing population.

Capacity
- History of under-investment;
- Too few doctors, nurses and other professionals;
- Too many old, inappropriate buildings;
- Late and slow adoption of medical technologies.

But apparently significant scope for productivity improvements.

Interim Report findings: Looking forward

- Patients will want more choice in future and will demand higher quality services;
- While ageing is an important factor, demographic change is not the main factor driving up health care costs;
- Main cost pressures to be:
  - medical technologies;
  - more staff;
- Improving the use of ICT in health services is a key issue in improving quality and productivity;
- There is scope for major changes in skill mix and the ways in which professionals work in health services, including an enhanced role for primary care.

Health Services in 2022

- Patient-centred and meeting expectations:
  - Safe, high quality treatment;
  - Fast access;
  - An integrated system;
  - Comfortable accommodation services.
- What services must look like against today’s reality:
  - Prepared for the future/ investing in resources;
  - Recruiting and retaining the required staff;
  - Integrated ICT leading to integrated services and better links with social care;
  - Need to deliver greater choice once access issues resolved;
  - In hospitals, better and more varied accommodation and food.
Examples of scenario assumptions

<table>
<thead>
<tr>
<th></th>
<th>Slow uptake</th>
<th>Solid progress</th>
<th>Fully engaged</th>
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</thead>
</table>
| UK life expectancy at birth by 2022 (years) | Men: 78.7  
Women: 83.0 | Men: 80.0  
Women: 83.8 | Men: 81.6  
Women: 85.5 |
| Smoking prevalence assumption | 27% by 2010 | 24% by 2010 | 17% by 2010 |
| Productivity growth assumption | 1.5% p.a in first decade  
1.75% in second | 2.25% p.a in first decade  
3% in second | 2.25% p.a in first decade  
3% in second |

Health care spending

Effective use of resources: Standards

- Standards and processes set by government:
  - NICE to look at older technologies and practices, as well as new technologies;
  - NSFs to include resource estimates;
  - ICT: common standards established, budgets ring-fenced, achievements audited.
- Public health expenditure; to be evidence-based.
- Rigorous and regular independent audit.
Effective use of resources: delivery

- Decentralisation of delivery; local governance and freedom to innovate;
- Balance of health and social care wrong;
- More diagnosis and risk management in primary care;
- Self-care: expansion possible;
- Public engagement;
- Further Review in five years’ time, i.e. 2007.

Total UK health spending

Given the projected increase in old people after 2022, as post-war “baby-boomers” reach old age, the potential benefits could be especially attractive.

Securing Good Health for the Whole Population

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Key determinants

A sample of the determinants of health was reviewed.
For these case studies, the review explored:

- Relationship with, and impact on, health;
- How are targets set?
- How are strategies developed?
- What evidence do we have about what works?
- How well are strategies implemented?
- What progress is being made?

Public Health

“the science and art of preventing disease, prolonging life and promoting health through the organised efforts and informed choices of society, organisations, public and private, communities and individuals.”

Key public health documents

- 1974 – Lalonde Report
- 1980 – Black Report
- 1981 – WHO Health for All by the Year 2000
- 1992 – Health of the Nation
- 1998 – Acheson Report
- 1998 – Smoking Kills
- 1999 – Saving Lives:Our Healthier Nation
- 2000 – The NHS Plan
- 2002 – Tackling Health Inequalities:Cross-Cutting Review

Sickness Service  
Chronic Disease Management  
Maintenance of Good Health
Smoking 2004 Report

Key issues:
- Nicotine the addiction: but not the nicotine that kills;
- Tobacco largely unregulated;
- Lack of national data;
- Lack of management information;
- Smuggling and counterfeit cigarettes;
- Coordination of efforts;
- How best to manage and target smoking cessation services?
- Limited success at population level;
- Manual groups target will be very challenging;
- Need another step change: How do we get "fully engaged"?

Target Setting

- Inequalities – 10% reduction in infant mortality and life expectancy gap (PSA);
- Smoking – 24% prevalence by 2010 ([Smoking Kills and supported by targets in NHS PPF);
- Salt – no national targets ([COMA recommendations of reductions from 9g to 6g per day);
- Obesity (no target since Health of the Nation – reductions in prevalence to 6% for men and 8% for women);
- Physical activity – increase participation in moderate activity (5 x 30 minute sessions) to 70% ([Game Plan]).

More Recent Targets include:

- Smoking for all adults (21% or less by 2010) and for manual groups (26% or less by 2010);
- Obesity for children under-11 (halting the year-on-year rise by 2010);
- Under-18 conception rate (reducing by 50% by 2010).
Health Inequalities

- Strong social gradient to many of the risk factors;
- Estimated that half the difference in survival to 70 years of age between social class I and V is due to prevalence of smoking;
- Inequalities may be “in-built” and persist for some time. Were past lifestyles taken fully into account in fixing the target?

Smoking and deprivation (Great Britain, 1973 and 1996)

Vital Need for Independent Advice

- Medical and managerial advice in a formal structure;
- Should be the basis for agreed objectives;
- Not just about health services;
- Not just about Government;
- Transparency of reasoning behind targets a vital benefit;
- Should help achieve buy-in;
- Should aid mobilisation of resources and activity, national and local.
Reasons for weak public health evidence base

- Under-investment in PH intervention research;
- Under-capacity to perform PH research;
- Practical difficulties in evaluating PH interventions;
- Lack of data;
- Low status of public health;
- Lack of evaluation of current PH practice and policy.

A cost effectiveness framework is needed for public health

To allow comparison of the cost-effectiveness of different public health interventions:

- within and across both risk factors and disease areas;
- with screening and treatment interventions within and across disease areas;
- with interventions directed towards the wider determinants of health.

Role of Government

- National Government:
  - Setting objectives for major determinants of health, with regular reassessment, and allocating appropriate resources to achieve these objectives;
  - Prioritising between interventions across government on a consistent basis;
  - Intervening where appropriate (including the use of economic instruments);
- Local Government:
  - Creating a delivery network;
  - Joint ownership of objectives;
  - Relationships with PCTs evolving;
  - Do common boundaries help?
Workforce capacity

- Specialist workforce thinly spread in PCTs:
  - Networks and sharing functions between PCTs;
- Full engagement means harnessing the resources within the wider public health workforce;
- Long-term strategic vision and workforce plan needed;
- Many organisations with similar needs;
- New skills vital.

PCTs

- Self care increasingly important;
- Pro-active not reactive;
- Potential of IT, including electronic patient record to:
  - Monitor population health;
  - Monitor risk factors at population and individual level;
  - Provide targeted risk management to individuals;
  - Provide targeted interventions to population subgroups.
- Pilots should be established to determine the benefits of such an approach, including the impact on inequalities.

Other Influences

- Local Government;
- Voluntary organisations;
- Employers;
- Market power;
- Almost all Government Departments.
Economic and social context

There are systemic, socio-economic failures in public health that influence decision-making at the individual level, including:

1. Lack of full information about preventive health action across the population;
2. Inability of individuals always to take account of the wider social costs of particular behaviours;
3. Failures in the social and environmental context that contribute to poor public health and health inequalities.

Principles for Government intervention

1. Interventions should tackle public health objectives and the causes of any decision-making failures as directly as possible;
2. Interventions should be evidence-based, though the lack of conclusive evidence should not, where there is serious risk to the nation’s health, block action proportionate to that risk;
3. The total costs of an intervention to the Government and society must be kept to a minimum and be less than the expected benefits over the life of the policy. Interventions should be prioritised to select those which represent best value;
4. The distributional effects of any programme of interventions should be acceptable;
5. The right of the individual to choose their own lifestyle must be balanced against any adverse impacts those choices have on the quality of life of others.

Wanless Social Care Review
King’s Fund  March 2006

- Social care for the elderly;
- Not well defined;
- Budget constraints, without a long-term view of need, result in increasingly concentrated help with moderately dependent and middle wealth individuals less well served;
- Real resources not well developed;
- Information incomplete;
- Dissatisfaction with funding system;
- Complex relationship with benefit system.
Estimates of future need: what outcomes for how many people?

- Outcomes are key and a method is needed to value them (c.f. NICE QALYs);
- Healthy life expectancy may be growing slower than total life expectancy;
- Three scenarios based on different definitions of care;

1. Current patterns continue;
2. Highest economically justifiable levels for personal care and safety;
3. As 2 plus improved well-being.

Total social care expenditure under current funding system

<table>
<thead>
<tr>
<th>Scenario</th>
<th>1.</th>
<th>2.</th>
<th>3.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Expenditure</td>
<td>£10.1bn</td>
<td>£12.2bn</td>
<td>£13.0bn</td>
</tr>
<tr>
<td>2002</td>
<td>(1.1% of GDP)</td>
<td>(1.3%)</td>
<td>(1.4%)</td>
</tr>
<tr>
<td>Expenditure</td>
<td>£24.0bn</td>
<td>£29.5bn</td>
<td>£31.3bn</td>
</tr>
<tr>
<td>2026</td>
<td>(1.5%)</td>
<td>(2.0%)</td>
<td>(2.0%)</td>
</tr>
</tbody>
</table>

More money is needed.

- But only to be available
  - at a pace the supply side can cope with; and
  - only after a commitment to re-configure services.
- Examples
  - increasing community based packages;
  - improving carer support;
  - tailoring care-with-housing to needs of the cognitively impaired.

But should the money be public or private?
The criteria to test systems

- Fairness;
- Economic efficiency;
- User choice;
- Physical resource development;
- Clarity;
- Sustainability/ acceptability.

Three Frontrunners. Tested against the current system

- Free Personal Care;
- Partnership;
- Limited Liability.

The costs of Scenario 2
(2002 volumes – 2005 prices)

<table>
<thead>
<tr>
<th>Funding system</th>
<th>Public Sector Spending (£bn)</th>
<th>Private Sector Spending (£bn)</th>
<th>Total (£bn)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Means tested</td>
<td>6.2</td>
<td>6.2</td>
<td>12.4</td>
</tr>
<tr>
<td>Means tested with limited liability</td>
<td>7.4</td>
<td>5.0</td>
<td>12.4</td>
</tr>
<tr>
<td>Partnership Model</td>
<td>9.7</td>
<td>4.0</td>
<td>13.7</td>
</tr>
<tr>
<td>Free Personal Care</td>
<td>11.6</td>
<td>3.3</td>
<td>14.9</td>
</tr>
</tbody>
</table>
The Partnership Model

- Weaknesses:
  More expensive than means testing;
  Differential between what the better-off and the poor pay is lessened;
  Needs to work alongside benefit system.

The Partnership Model

- Strengths:
  Universal and inclusive;
  Less expensive than free personal care;
  Provides incentives to save;
  Best value, closest to economic benchmark;
  Less need for individuals to dispose of assets;
  Sustainable, charging limiting use and raising revenue;
  Clear;
  Limits means-testing to the benefit system;
  Can be fine-tuned.

Good Health and Good Care
Taking a Long-Term View

Derek Wanless