Securing Good Health for the Whole Population

Derek Wanless
February 2004

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Securing our Future Health: Taking a Long-Term View

Review of the trends affecting the health service in the UK

Derek Wanless
April 2002

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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.

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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.

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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.

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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.

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Examples of scenario assumptions

	Slow uptake	Solid progress	Fully engaged
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	1.5% p.a in first decade 1.75% in second	2-2.5% p.a in first decade 3% in second	2-2.5% p.a in first decade 3% in second

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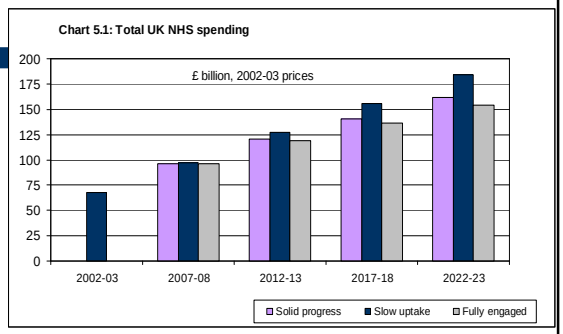
Health care spending



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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.

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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.

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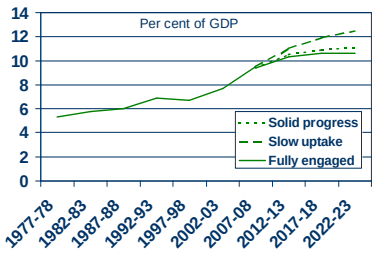
Total UK health spending



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

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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?

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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"*

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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

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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”?

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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*).

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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).

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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?

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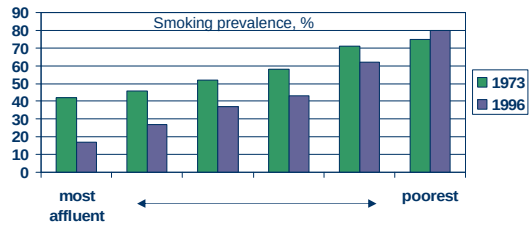
Smoking and deprivation
(Great Britain, 1973 and 1996)



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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.

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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.

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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.

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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?

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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.

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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.

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Other Influences

- Local Government;
- Voluntary organisations;
- Employers;
- Market power;
- Almost all Government Departments.

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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.

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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.

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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.

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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.

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Total social care expenditure under current funding system

Scenario	1.	2.	3.
Expenditure 2002	£10.1bn (1.1% of GDP)	£12.2bn (1.3%)	£13.0bn (1.4%)
Expenditure 2026	£24.0bn (1.5%)	£29.5bn (2.0%)	£31.3bn (2.0%)

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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?

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The criteria to test systems

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

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Three Frontrunners. Tested against the current system

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

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The costs of Scenario 2

(2002 volumes – 2005 prices)

Funding system	Public Sector Spending (£bn)	Private Sector Spending (£bn)	Total (£bn)
Means tested	6.2	6.2	12.4
Means tested with limited liability	7.4	5.0	12.4
Partnership Model	9.7	4.0	13.7
Free Personal Care	11.6	3.3	14.9

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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.

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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.

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Good Health and Good Care Taking a Long-Term View

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