Healthcare and the economy 2:

Going with the flow

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2020 HEALTH WELLBEING RESPONSIBILITY

Briefing paper

Summary

The public hear the future of the NHS frequently debated by politicians, commentators, economists. This paper identifies some of the themes of the current debate and looks beyond 'the NHS must change' mantra and rhetoric to actually consider how to change, what needs to be communicated to people about these themes, how potential solutions can 'go with the flow' of public behaviour and what are the consequent trade-offs that need to be understood. Above all, we need managed public debate to de-politicise the NHS and involve us all in decision making that will determine how best to ensure we have an NHS for the future.

Recommendations include:

A Produce a National Financial Plan and work towards a National Service Guarantee

B Promote stewardship and accountability

C Be honest about what's available and enable people to spend on themselves

D Enable clarity on choice

E Use technology to deliver choice

F Develop 'Payment by Results' benefit for those who make positive behavioural choices

G Initiate strategic review and development of National 'Blue' Specialised Hospitals

H Initiate strategic review and development of Local 'Red' General Hospitals

I Encourage public involvement

Introduction

The public hear the future of the NHS frequently debated by politicians, commentators, economists and those with any number of insights into the financial, clinical and demographic challenges the NHS faces. They catch from the news reports of good and poor services, wasted money and value for money, services should be localised and national, that care must be based more in the community and hospitals must change but we must not close A&Es.

It's not surprising therefore that the public are confused. What problem are these debates trying to solve? People just want to be seen without hassle, hear an assessment of their problem, understand the action to be taken, obtain treatment where possible and get on with their lives.

Considering that policy makers claim to be listening to the public's wishes on health, we don't think that these wishes are being reflected in health policy deliberations. This paper is not a comprehensive review of healthcare in England; we have simply looked at the 'wisdom of the crowds' and thought about how we can capture their energy and enthusiasm for the NHS and build solutions based on this. These are the first steps, and this paper is the first of several on the subject. We have tried to avoid jargon. No one outside the health sector recognises the terms primary care or tertiary services, or understands the different between urgent, acute and emergency. So we have deliberately tried to avoid 'NHS speak' and used simple language to contribute to what we know is a complex debate.

The Themes

This paper identifies some of the themes of the debate, what needs to be communicated to people about these themes, how potential solutions can 'go with the flow' of public behaviour and what are the consequent trade-offs that need to be understood. The solutions are not all that is required, but a starting point for a national conversation and returning the NHS to a sustainable basis which will be fit for the next generation.

The first three themes we are addressing in this paper are:

- **Funding of the NHS**
- **Choice**
- **Models**

Within each of these we will consider what the public need to understand, suggest how potential solutions can 'go with the flow' of public behaviour and what then needs to be debated more broadly with the public. The public are a willing audience: their experience of the NHS may be mixed, but they appreciate that we in the UK have pioneered one of the fairest health systems in the world. No one wants to return to times of uncertainty and fear.

Understanding the Themes and Suggesting Solutions

1. Funding the NHS

Understanding the funding issues that face us, and the responsibility the public has in making choices that impact on the economy, is vital for informed and proficient decision making. When we hear NHS funding debated in public, a rarely mentioned fact is that UK debt is still increasing by over £5,000 per second (National Debt Clock, 2014). We spend more on paying interest on our debt than we do on defence. Our current health budget is 6.2% of GDP. 15 million people (and rising) are living with chronic, long-term conditions (LTCs). 70% of the health budget is spent on them. The current trends in long-term conditions are mind-boggling:

- a doubling of the number of people living with dementia over the next 30 years;
- an increase in age-related vision loss of 30% by 2020 (Owen, 2012);
- a rise of 60% in the number of people with diabetes over the next 20 years (YHEC, 2014).

By the end of the next decade, nearly a quarter of the population will be over 70 years of age. People of working age fund a large proportion of healthcare provision through taxes, and the ratio of those of working age to those aged 70 or over is projected to fall from 5.3:1 in 2010 to 3.7:1 in 2030 (ONS, 2009). This is a staggering 30% drop in the proportion of income tax payers to retirees. Increasing tax or NI may offer short term relief but in the long run would represent a huge burden on those of working age.

Already the higher proportion of older people in the population, the increased prevalence of long-term conditions, flat real-terms funding and our current ways of working mean that there is a massive projected funding gap in the NHS of at least £30Bn even if we managed to make all the required 'efficiency' savings over the next 8 years. So the questions policy makers need to be collaborating with the public on are: Do the public understand the financial pressures; How national and local planning and accountability will help; How do we meet the health needs of our population in years to come and what role the public can play?

The answers initially have to be to go with the flow, be honest and be fair.

A. National Solution

Produce a National Financial Plan and work towards a National Service Guarantee

The founding principle of the NHS is fairness. People are featured almost daily in the press because they feel aggrieved at what has been denied them locally by the NHS – lack of awareness of the funding crisis and variation between areas mean that people want reassurance that access to treatment is uniform across England. It flies in the face of having a "National Health Service", and a "National Institute for Health and Clinical Excellence" (NICE) which can recommend a new medicine or technology, to then have local areas determine whether they will make it available. At a national level a public facing Financial Plan needs to be produced to outline spending, demonstrate cost-effective and high quality stewardship, current and future strategic planning and outline the financial decisions being deliberated. The reality is that to re-shape services will require dealing with health provider's debt and some double-running funding as new services replace old. Ideally it should also include a review of transaction costs, a 'swot' analysis of the purchaser-provider split and incentivising prevention across health economies.

At the same time we need to instigate a national assessment of what can be provided. This requires understanding on all sides: local organisations [see below] need to be more open about what they spend, their losses and their

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plans for the future; we the public need to reflect on the way we use services [see personal aspects below]. But out of all this should flow a greater certainty on what the NHS will provide: we recommend national criteria – a National Service Guarantee - to be brought in as a sincere attempt to reduce frustration and inequality. This does not take away local discretion, as treatment will still ultimately be based on the clinical judgement of an individual's suitability.

The National Service Guarantee would proscribe some existing treatments which are commissioned in some places but not others, and consider what, over time, is to be excluded, i.e. what cannot be provided on the NHS. A previous national example of this is when medicines were taken off the prescription list in 1984, but there are many different local examples of variation: IVF, varicose veins, certain travel medications, lumps and bumps removal being denied in some areas and available in others. There has to be a national consultation on this. Rationing is axiomatic where there is a finite budget but the years of secrecy, denial and rejection have to come to an end. Enabling the public to be engaged through what will need to be a series of consultations and opening up the conversation about the cost pressures that the NHS faces in the right thing to do.

B. Local Solution

Promote Stewardship and Accountability

There is a lot of money in the NHS. All NHS institutions should look to consolidate assets, be more accountable and diversify. McKinsey estimated the value of hospital estates alone which could be freed up and sold at £8.3bn – more realistic now the economy is improving. Fraud is estimated to be at least 3% of the NHS budget and along with waste it requires much greater scrutiny. Alongside a national Financial Plan there should be clearer local plans to demonstrate to the public the expenditure of their local NHS economy, which after all is funded by their taxes. Hospitals are already able to diversify to produce income, and as Boards consider business plans, they should be pro-actively looking to see how they can develop as drivers of the local economy – they are often the largest local employer already. The public are attached to their local hospital and a much better understanding of what their hospital can provide and how - and whether - it can become sustainable will tap into public sentiment. The coordination between services, removal of boundaries between budgets, as well as the snail's pace at which patient electronic records are being enabled, all need to be accelerated.

C. Personal Solution

Be honest and enable people to spend on themselves

The public are not stupid, they know the NHS cannot afford, from a finite budget, to give everyone the 'best' – which usually implies the latest, most proficient, technologically advanced option. The whole ethos behind medicine was to remove fear and uncertainty by creating universal access, and as far as possible, restore people to being able to function again in their communities. No one ever said this also meant that you could have access to the best treatment or unlimited choice. If I need a cataract replacement, I can't have the latest 'accommodating' lens implant in my eye on the NHS, but I can have one that enables me to see really well. If I lose an arm in an accident, I can have a prosthetic that will allow me bilateral function again, but not the latest Mercedes engineered bionic arm. We have not managed public expectations well in other ways too: of always walking away with a prescription; of maternity services; of hospital acquired infections etc.

With the proviso that significant (e.g. opportunity based) inequalities should not result, politicians should commit that the NHS will provide the best possible, not the best, and allow people to use their own money or insurance to fund the latest technology which ultimately, as it becomes more available, will drop in price and be accessible to

Understanding the Themes and Suggesting Solutions

more people. Today's landscape where people spend vastly more on themselves – leisure, cosmetics, plastic surgery, fitness – is a clear indicator that we are willing to spend on ourselves and that this is the flow of discretionary expenditure. 'Topping-up' has been derided as an ineffectual way to raise more money for the NHS; this is not the primary aim; the aim is to allow people to use their own resources if they chose to buy the best-in-class as the more who do so, the quicker the cost will drop to make the latest technology more accessible to all.

2. Choice

Choice has been a mantra of politicians, but it has been too simplistic, seeming to conflict with other messages of specialisation and consolidation. The public like choice when it promotes convenience and understanding. We also like competition when it improves choice and quality, but not when it creates tension and division.

D. National Solution

Promote clarity on choice

Choice cannot be universal; there are practical and financial limitations and the public know this. We need to acknowledge that beyond some core choices, giving choice can actually jeopardise quality, eat up management time and consume too much money. Where choice is available this should be made clear to the public. We understand that a rare disease needs to be seen by an expert, but for routine care we want to be reassured about quality and safety. As we detailed in our 2010 response to the 'Future Forum' (Manning J., Beer G. 2010) genuine, safe, affordable choice can be shown as follows:

Choice	
Free	**Limited**
Treatment of minor illness location / provider	Specialised surgery / treatment for rare conditions needs to be determined by quality and safety
When and where to receive diagnostics / short-term treatment	Where to receive on-going long term condition care: Chopping and changing between complex elements within each pathway is not feasible
GP location should be based on convenience, with people understanding the issues with choosing a practice away from home.	
Upgrading to (top-up for) new technology e.g. type of implant	
In-home monitoring, self-care as an alternative to frequent journeys to clinics	
Planned and managed medical or surgical intervention	Emergency medical and surgical intervention

Understanding the Themes and Suggesting Solutions

A national Financial Plan and local strategic plan will help the public understand what their choices are and the reasoning behind some restrictions. Choices also raise issues for commissioners and the fees paid (tariff) for services, both of which need further national review.

E. Local Solution

Use technology to deliver choice

That said, much more choice can be facilitated locally through the deployment of technology. The NHS remains very labour intensive and we have not taken advantage of new technology used elsewhere in our lives and applied it to health. Nor have we thought about training and using the workforce in a way that takes advantage of technology. Digital communications have transformed other sectors enabling them to meet extra demand and reserving face-to-face consultations for when essential. This has yet to happen widely in UK healthcare, with some notable exceptions (e.g. Airedale Hospital remote care provision to prisons; Jubilee GP practice in Tower Hamlets using on-the-day telephone call-back). We highlight many of the opportunities for technology in our 'Healthcare without Walls' (Cruickshank J. 2011) and 'Making Connections' (Cruickshank et al 2013) reports.

Online access and agencies will also mean that Personal Health Budgets (PHBs), their management and options, will become more of a reality for the public. PHBs enable people to take more control of and be more involved in their care. Evidence also indicates that PHB users spend less than NHS commissioners providing for the same need (Beer G., Paxman J. 2013).

F. Personal Solution

'Payment by Results' benefit for those who make positive behavioural choices

In sharing responsibility for our own health, new ways of engaging with the public must be found to enable a better understanding of the actions needed to prevent illness or self-manage. We propose 'Payment by Results', a financial reward for people who become active partners in their health, whereby if you e.g. keep your blood sugar levels down, quit smoking, keep weight off, take on more self-care there will be a tax rebate or an end of year bonus. This could be monitored by the GP, linked to QUOF or facilitated by electronic patient records. Incentives have been used for some years in Scotland to help people quit smoking with more success than other interventions. GPs are currently getting fees for improved patient outcomes, when the patients have done most of the work! More money spent on making healthy choices rather than pursuing unachievable choices [see above] would be the best stewardship of NHS funds and taps into our human desire to save money.

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3. Models

Public concern has been heightened by some of the high-profile debates on the future of hospitals. Threats of 'downgrading' have left people confused as to what their hospital will or won't offer. Often, as far as they are concerned, their hospital is in their community already so talk of 'moving services into the community' doesn't really make sense. For those who need care out of GP opening hours, it seems obvious to go to the local A&E. All the terminology now – minor injuries, urgent care, out-of-hours, walk-in – is incredibly confusing for the public. There is no doubt that there are too many hospitals trying to offer specialist services, and this is both a drain on resources and not safe for the public. Once again we need to go with the flow, stop telling people not to go to hospital, start simplifying the messaging and enable more strategic planning. We propose starting to colour code services, level the financial playing field and involve the public much more in decision making.

Understanding the Themes and Suggesting Solutions

G. National Solution

Strategic development of 'Blue' Specialised Hospitals

The large specialised hospital would provide for serious A&E cases and complex trauma, with emergency surgery available as well as scheduled operations. 24 hour consultant cover in A&E would be provided including for children in some. The public would know the designation by the simple labelling of specialised hospitals as 'Blue'.

Already there has been some consolidation of some specialised services – for severe trauma, heart attacks, stroke units; other specialist centres have grown up around rare disease research e.g. uveal cancer of the eye at St Paul's Eye Unit, Royal Liverpool University Hospital. The hyper-acute-stroke-units (HASUs) were established by Healthcare for London to improve the quality of stroke care in the capital, reducing the number of hospitals that treated the public who had suffered a stroke from 30 down to 8. The death rate dropped by 12%.

To improve how and where specialist care is delivered requires a strategic overview of hospitals and an ability to make decision based on quality and safety. A competitive market in specialist care doesn't work: the public need to know that they will receive high quality, safe care no matter to which Blue hospital they go. This does not mean there will be a monopoly – the hospital Board will be accountable for the standards of care and if services fail, they will be replaced. Likewise there will still be 'competition' between services; specialist teams want to have the best reputation, the best outcomes and this is good for patients.

H. Local Solution

Strategic review and development of Local 'Red' General Hospitals

We need to recognise that public are not going to let their local hospital go. They like visiting it – despite the parking, the waits and the scandals! Staying in it is another matter, but that's not what most people think about. A new vision for hospitals needs to be articulated, one that enables the public to have confidence that services they need are where they need them and when. It doesn't mean with that they are all in one place.

The Local Red Hospital would offer general services, with a hub and spoke model to allow some services e.g. diagnostics, to be co-located with larger GP surgeries. Where space is freed up by more specialised services moving to major centres, the hospital needs to work with the community on using the space for GPs, Out-of Hours (OOH) providers, community care including e.g. children's centres, rehabilitation, research collaborative, small business and enterprises, adult education, biotechnology start-ups and companies, university satellites, voluntary sector etc. Services in Red hospitals would be provided using safety as the criteria, that is, what is it safe to provide and what gives the best outcomes; also what may compromise the safety and health of local population if it is not there or what would enhance it.

The Local Red Hospital would provide simple elective surgery, with much of it being day cases. Other more complex operations would move into the specialist Blue hospitals. As the average length of stay has reduced significantly over the years, this has answered many of the arguments on issues for relatives visiting people a long way from home.

Due to all the adverse publicity, the public are anxious about their A&E services. We have lost confidence to care for ourselves and there has been a real loss of confidence in the OOH service. The public express fear about what happens at night if they need medical care, especially as many still have a problem with getting to see a GP at short notice, so many just go to their A&E. So let's provide the services where they want to go. Providing a 24/7 emergency service in a one place can make the most of the OOH GPs, with the support of nurse consultants,

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emergency nurse practitioners, paramedics, social care and pharmacists. They can be the treatment or triage centre. These centres can give advice, run education programmes on health and follow people up. The hospital would have some facilities for overnight elective surgical stays but would primarily be focused on the management of medical conditions, would provide maternity services and would have full consultant cover. People think about 'their' local hospital and 'their' local GP. We need to build on these sentiments and encourage the involvement of the neighbourhood in a meaningful way.

To enable this reorganisation to Blue and Red hospitals to happen will require some brave decisions: NHS Trusts with rebuild (PFI) debt will have to have it written off by the government, which would cost the tax payer about £11Bn, to enable the strategic planning required for Blue Hospitals. (This sounds a lot but if left to term, PFI payments will cost the taxpayers £65Bn). Every hospital will have to review its sustainability business case, and the reality is that some existing sites will not be viable, even with diversification. Some hospitals are currently 'Foundation Trusts' (FTs), which means little to the public, but theoretically gave those hospitals greater freedoms to develop. This was a nod towards the 'mutual' model but without the full freedoms and potential that mutual models offer. Despite the fact that two million people are 'members' of FTs, the vision of engagement and mutuality has not been realised, with little information exchange and no real public voice or representation happening. Financial freedoms given have not been used in the way they were envisaged either. FT status should be abolished, but work should start on how to really enable any hospital to develop into one of the genuine mutual models.

I. Personal Solution

Promotion of public involvement

The concept of the Big Society (politicians may be talking about this less, but the public do get it) is all about taking more responsibility. It is about "giving you the initiative to take control of your life and work with those around you to improve things". Applied to health there should be an increasing sense of 'community' at the heart of health which encourages everything from informal partnerships in care (such as between those with the same long-term condition e.g. Patients like me) to a preparedness to help look after family and neighbours, to more appropriate use of A&E. Likewise, the NHs can facilitate people taking the initiative through real time feedback apps (such as the Talk To (DLS, 2014) used in Birmingham Children's Hospital)

If we are to 'go with the flow' we need to articulate the situation above much more clearly so the public understand that they are part of the solution and that their lifestyle choices matter. The naysayers reject any proposal to take behaviour into consideration when considering NHS treatment, but there are common sense requirements that should be applied universally because not to do so is to increase physical and economic risk to an unacceptable level e.g.to stop smoking before heart surgery, to stop drinking before a liver transplant, to lose weight if pre-diabetic. Support should be given to people to make these changes, and this is where personal health budgets can once again make a real difference, because they stimulate conversations on what actually matters to the individual – what's their motivation, their hopes and goals? They recognise the people as participants in their health.

We would also like to see a new type of national service promoted, not unlike that already undertaken by 40,000 Royal Voluntary Service volunteers, where volunteering and caring become part of the accepted culture of the NHS in the community and with older people. Feeding, playing games, reading, running errands are all an important part of holistic care and restoring the cachet of caring can only be of benefit to us all.

Conclusion

If adapting the NHS to be fit for the 21st century was easy, it would have been done by now. Debate has been stifled by party political point scoring and vested interests polarising the debate, not least confusing the public with claims of 'privatisation'. As we addressed in our last paper 'Business and the NHS (Manning J. 2011) the latter is disingenuous - the NHS has always been a public-private partnership and their is no de-nationalisation party political agenda on the table. If anything, the opposite is true, with talk now more of GPs becoming NHS employees, rather than being self-employed as most are now.. The financial pressures require that a mature, managed public debate is planned, with clarity on the financial pressures and the call for us all to be involved – both to promote understanding and appropriate use of our precious, national, health service.

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2020health's mission
Making Health Personal

2020health is an independent, social enterprise think tank whose purpose is to both improve individual health and create the conditions for a healthy society, through research, evaluation, campaigning and relationships.

2020health's vision
We will Make Health Personal through:

- Identifying issues of healthcare, wellbeing and personal responsibility and their economic, educational, cultural and technological components then bringing informed people together to produce insight and create sustainable solutions.
- Working with people (individuals, charities, leaders) as members of society to share an understanding of the challenges and the rites of passage that engender ownership and enable sustainable change.
- Building on our track record of in-depth research, implementation leadership and uptake by government and agencies to further improve determinants of health.
- Recognising that those caring for people and their communities are essential foundations of economic success (a caring economy) and that this should be reflected in policy.

2020health research and activity includes the following workstreams

Fit-for-school:
To create a holistic picture of wellbeing and what children need in order to thrive at school, and identify ways of enabling more children to flourish and break the cycle of failure.

Fit-for-work:
To continue looking at the importance of work for health and health for work, and ensure that those who experience illness receive timely and appropriate support, understanding that worklessness impacts on economies and society as a whole.

Fit-for-later life:
To look from active retirement, to increasing dependency and end-of-life care and consider new models of provision, raise the status of caring, embed respect for ageing and ensure inclusion.

Forgotten conditions:
To ensure that people with rare or unusual health conditions have their needs met by the NHS.

Integration:
To promote integrated care that uses technology to empower people and enable management of their healthcare and wellbeing.

Innovation:
To ensure that people have access to innovation in all of its forms and keep the UK at the forefront of R&D.

"Determined to improve healthcare provision."
Dame Carol Black, Principal of Newnham College, Cambridge

"Always striving to keep people's needs at the centre of what the NHS delivers."
Dr. Johnny Marshall, GP, Head of Policy, NHS Confederation

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