

*Securing our Future Health:
Taking a Long-Term View*

Summary of consultation responses

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CONTENTS

Chapter 1	Introduction	1
Chapter 2	Expectations for the health service and delivering high quality	6
Chapter 3	Changing health care needs	12
Chapter 4	Technology and medical advance	18
Chapter 5	The future workforce	22
Chapter 6	Differences within the UK	30
Chapter 7	Other issues raised in consultation	34
Annex A	List of those consulted	37

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1 INTRODUCTION

Introduction

- 1.1 In March 2001, the Chancellor of the Exchequer commissioned Derek Wanless – former Group Chief Executive of NatWest - to undertake a Review of the long-term trends affecting the UK health service and the resources required over the next 20 years. The Terms of Reference for the Review are set out in Box 1.1 below.

Box 1.1: Terms of Reference

1. To examine the technological, demographic and medical trends over the next two decades that may affect the health service in the UK as a whole.
2. In the light of (1), to identify the key factors which will determine the financial and other resources required to ensure that the NHS can provide a publicly funded, comprehensive, high quality service available on the basis of clinical need and not ability to pay.
3. To report to the Chancellor by April 2002, to allow him to consider the possible implications of this analysis for the Government's wider fiscal and economic strategies in the medium term; and to inform decisions in the next public spending Review in 2002.

The report will take account of the devolved nature of health spending in the UK and the Devolved Administrations will be invited to participate in the Review.

- 1.2 The Review published an Interim Report on 27 November 2001 identifying the key drivers of health need and cost over the next two decades and the evidence gathered during the first stage of the Review. It set out 32 specific questions for consultation relating to each of the key drivers identified. The Review's Final Report was published on 17 April 2002. Copies of both the Interim and Final Reports are available on the Review's website: www.hm-treasury.gov.uk/wanless.

1 INTRODUCTION

- 1.3 The Review consulted widely both before and after the publication of the Interim Report. It began with a firm belief in the need to consult key stakeholders as well as those working in both the health and social care sectors and, not least, patients and the public.
- 1.4 This document outlines the Review's consultation process and provides a summary of the written consultation responses received. These submissions and the comments made at consultation events around the UK were taken into account in the preparation of the Final Report. The Health Trends Team would like to thank all the individuals and organisations who met with the team during the various stages of the Review, attended the consultation events and responded to the Interim Report.
- 1.5 A list of all those who the Review met and visited and who responded to the consultation in writing is at Annex A.
- 1.6 The various elements of consultation throughout the Review period are described briefly below. Subsequent chapters summarise the main points from the written consultation responses.

Early engagement of stakeholders

- 1.7 The Review held a series of one-to-one meetings with a range of key stakeholders during the summer and autumn of 2001, including medical Royal Colleges, other professional organisations and patient groups. These meetings outlined the purpose and process of the Review; sought initial views as to which experts should be involved in the Review and how best to do so; and took initial views on the issues to be addressed.

Stakeholder workshops

- 1.8 In the first phase of the Review, one-day stakeholder workshops were held with The Nuffield Trust, the Association of the British Pharmaceutical Industry (ABPI) and the Association of the British Health Care Industry (ABHI), and the King's Fund. Each workshop was attended by around 25 to 30 of their key contacts. Presentations were given at the workshops by leading academics, researchers and industrialists. The Nuffield Trust workshop discussed its recent research on policy futures. The ABPI and ABHI workshop considered likely developments over the next 20 years in pharmaceuticals, medical devices and genetics. The King's Fund workshop discussed the likely key drivers of future expenditure. Workshops were also

1 INTRODUCTION

held in Edinburgh, Cardiff and Belfast to consider the issues in Scotland, Wales and Northern Ireland.

Health Trends Conference

- 1.9** A larger Conference, attended by over 100 people, was held at the Barbican Centre on 18 and 19 October 2001. Sir Richard Sykes, Rector of Imperial College, London, gave the keynote address. Experts in the fields of demographics, health technology and medical trends, quality and public expectations and the health workforce presented papers. A list of those who spoke at and attended the Conference is included in the Annex to the Interim Report. The proceedings of the Conference were published alongside the Interim Report and are available on the Review's website.

International visits

- 1.10** The Review visited a number of countries to examine and discuss their health care systems and the approaches which they adopt to long-term resource planning. In advance of the Interim Report, visits were made to the US, Canada and Australia. Following the publication of the Interim Report, the Review visited France, Germany and Sweden and held discussions with those involved in the planning and delivery of health care in the Netherlands. Meetings were also held with the World Health Organisation and the Organisation for Economic Cooperation and Development.
- 1.11** The Review commissioned a report from the European Observatory on Health Care Systems at the London School of Economics and Political Science. This examines the trends and challenges facing the health care systems in eight countries, including the UK. This was published alongside the Final Report and is available on the Review's website.

Consultation on the Interim Report

- 1.12** The Review undertook a wide range of discussions on the Interim Report throughout the UK. Over 400 people from the NHS and social care organisations, patient groups, academic and private sector organisations attended meetings held to discuss the Interim Report.

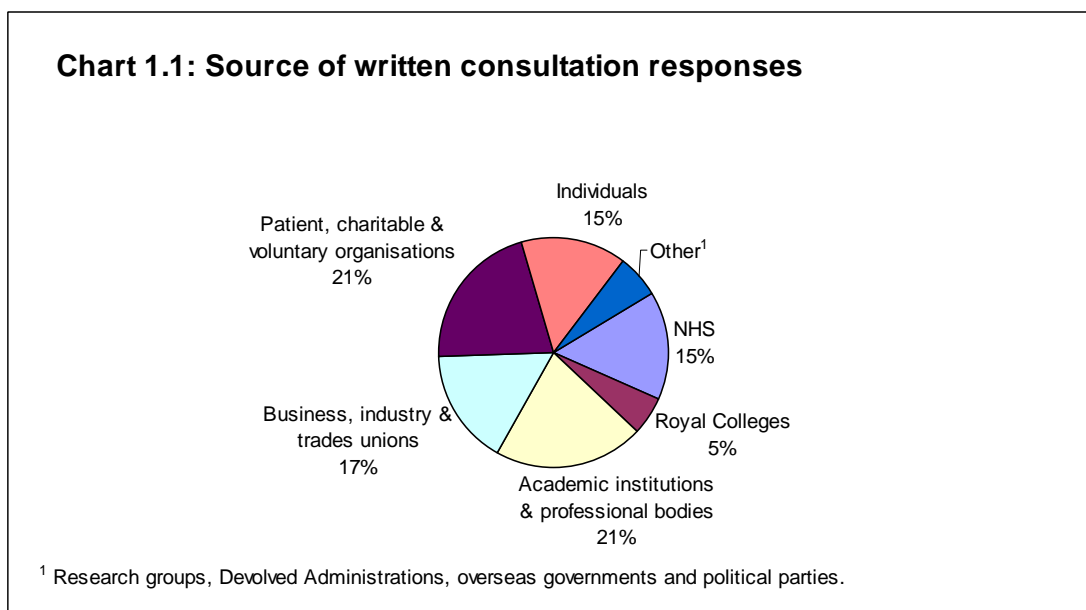
1 INTRODUCTION

1.13 Formal consultation events were held in England (Leeds, Birmingham and London) and in Scotland, Wales and Northern Ireland. The Review has also been involved in visits to many health care providers, including a number of hospitals and primary care organisations.

Written consultation responses

1.14 There were over 130 written responses to the Interim Report consultation. Submissions were received from a wide range of organisations and individuals. A full list of those who submitted responses is set out in Annex A.

1.15 A breakdown of the responses received is shown in Chart 1.1 below. Patient, charitable and voluntary organisations and academic institutions and professional bodies together accounted for around 40 per cent of the responses. Business, industry and trades unions, NHS bodies and individuals each accounted for a further 15 to 20 per cent of the responses.



1.16 The consultation responses largely endorsed the main drivers of expenditure identified in the Interim Report and agreed with the Interim Report's findings that:

1 INTRODUCTION

- patients are expected to want more choice in future and to demand higher quality services;
- while ageing is an important factor, demographic change is not the main factor driving up health care costs;
- improving the use of information and communication technology (ICT) in the health service is a key issue in improving quality and productivity; and
- there is scope for major changes in skill mix and the ways in which professionals work in the health service, including an enhanced role for primary care.

1.17 The following chapters of this document summarise the main points of the written responses in each of the chapter areas covered in the Interim Report and on which specific consultation questions were posed. A list of the consultation questions is set out at the beginning of each chapter:

- expectations for the health service and delivering high quality (Chapter 2);
- changing health care needs (Chapter 3);
- technology and medical advance (Chapter 4);
- the future workforce (Chapter 5); and
- differences within the UK (Chapter 6).

1.18 A final chapter (Chapter 7) summarises other key issues which were raised in written consultation; in particular, the importance of health promotion and the role of social care. Annex A provides details of all those consulted during the Review period.

2 EXPECTATIONS FOR THE HEALTH SERVICE AND DELIVERING HIGH QUALITY

Questions for consultation

Q7.1 The Review is based on the assumption that the core principles for the health service set out in the NHS Plan will remain valid over the next 20 years. Are there any further important principles that will emerge?

Q7.2 How do standards of health care in the UK currently compare with patients' expectations for a high quality, comprehensive NHS?

Q7.3 What will patients and the public expect from a high quality, comprehensive health service in 20 years' time? Is it right for the Review to base its projections on:

- safer, higher quality treatment;
- faster access, 'waiting within reason';
- a more integrated, joined-up system;
- more comfortable accommodation services; and
- a more patient-centred service?

Q7.4 In 20 years' time will patients continue to expect the health service to be equitable and fair?

Q8.1 Has the Review identified the main trends and cost drivers associated with 'universalising the best':

- delivering the National Service Frameworks;
- improving clinical governance across the NHS;
- reducing waiting times;
- modernising the NHS estate and improving accommodation services; and
- improving patient information, using ICT more effectively to help people to take more responsibility for their own care?

Are these the right areas and are the cost estimates robust?

Q8.2 Will patients in future want more choice? What aspects of increased choice in the NHS should the Review examine?

2 EXPECTATIONS FOR THE HEALTH SERVICE AND DELIVERING HIGH QUALITY

Introduction

- 2.1 Chapters 7 and 8 of the Interim Report identified how the NHS currently matches up to patient expectations, the extent of this quality gap, and detailed how the NHS is aiming to fill it. They stressed that patients want fast access to treatment and to be seen by high quality, empathetic health professionals who inform and involve them in decisions about their own health. The Interim Report highlighted how meeting such expectations requires modernising the NHS and implementing world class standards, enabling it to deliver a truly patient centred service.
- 2.2 Chapter 7 outlined a vision of the health service in 20 years' time that has subsequently underpinned the scenario modelling in the Final Report. It suggested that in the future the public will expect the NHS to provide a universal and fair service that contributes to social solidarity, but is nonetheless responsive to patient's individual needs.
- 2.3 In order to meet such challenges of rising expectations, Chapter 8 argued that this will mean:
- implementing and universalising best practice;
 - increasing the amount of protected time for health professionals to engage in quality improvement activities;
 - reducing the amount of time patients take to see health care professionals; and
 - improving the standard of NHS accommodation.

The Interim Report presented indicative estimates of what increase in spending might be needed in order to meet some of these challenges. These have since been refined and extended in the Final Report, in consultation with the Department of Health.

2 EXPECTATIONS FOR THE HEALTH SERVICE AND DELIVERING HIGH QUALITY

- 2.4 The Interim Report also highlighted the fact that in order to meet patient expectations around increasing choice, capacity would need to be expanded. Nevertheless, the Interim Report also observed that patients have a role and a responsibility in maintaining their own health and that there were potential benefits in expanding the role of self-care.

Overview of responses

- 2.5 Overall many supported the principles of the NHS, agreeing that they would remain valid over the next 20 years. Some argued, though, that the Interim Report had not given explicit prominence to important issues such as age discrimination, comprehensiveness or implicit rationing, although they agreed that the National Service Frameworks (NSFs) implicitly picked up many of these issues. Others noted that further consideration should be given expanding choice through the development of alternative funding systems. Few challenged the estimates provided or provided alternative modelling assumptions.

Key drivers of expectations and quality

- 2.6 Many argued that the importance of assessing, setting and then meeting consumer expectations could not be emphasised enough. Respondents noted that the rise of consumerism would stretch and challenge the universalism that underpins the values of the NHS. Many agreed that improving patient information and moving towards a more patient-centred service will be a major cost driver, raising patient expectations and underpinning demands for greater choice. Accordingly some respondents argued that a key challenge would be to develop mechanisms that allow consumers to contribute more of their own funds to purchase extra non-clinical amenities and facilities.
- 2.7 Many commented that, in the UK, standards of health care fall short of current expectations despite the best efforts of staff. The NHS was cited as particularly poor in terms of providing quick access and short waiting times as well as implicitly (and some times explicitly) discriminating against the elderly. Others pointed to problems of the lack of seamless service between the NHS and social care and the fact that the Terms of Reference did not address this important co-dependence. One respondent noted that “the gaps between the public’s expectations of the service and its delivery are widely documented and well understood”. There was a general consensus that

2 EXPECTATIONS FOR THE HEALTH SERVICE AND DELIVERING HIGH QUALITY

meeting current and future patient expectations will require a significant injection of resources if the future of the NHS is to be secured.

- 2.8 In responding to the Interim Report many argued, though, that the challenge was not just about meeting individuals' expectations. Some emphasised society's expectations arguing that the public should take a greater responsibility for their own health care, while others stressed the importance of maintaining social solidarity and public health. Concern was expressed that just because treatments are available they should not be automatically offered to patients who demand it.

Meeting expectations

- 2.9 There was widespread agreement with the vision of patient expectations in the future presented in the Interim Report as well as the proposed approach to costing it by focusing on NSFs, clinical governance, improving hospital accommodation and increasing choice and self care.
- 2.10 A few respondents noted that the cost of managing change and transition and delivering the high quality vision, at both an organisational and personal level, should be incorporated into the resource projections. Few, however, challenged the estimates presented in the Interim Report, or provided alternative estimates or modelling assumptions that could feed into the quantification of the costs of delivering a high quality service over the next 20 years.

Meeting expectations: National Service Frameworks

- 2.11 Many who responded to the consultation recognised coronary heart disease (CHD), cancer, renal disease, mental health and diabetes as being major cost drivers within the NHS over the next 20 years. At the same time many emphasised the fact that greater consideration should be given to prevention strategies.
- 2.12 Some respondents, however, were disappointed that the Report did not propose to explicitly cost the NSF for older people, or the implications of eradicating age discrimination, although it was noted that they were dealt with elsewhere by the Interim Report.

2 EXPECTATIONS FOR THE HEALTH SERVICE AND DELIVERING HIGH QUALITY

- 2.13** A number also highlighted the fact that the interdependencies between, say, diabetes, CHD and renal failure were insufficiently acknowledged. Others challenged the efficacy of some of the ‘best-practice’ interventions outlined in the Interim Report. For example, some questioned the wisdom of spending over £2 billion on statins when promoting better diet, more exercise and encouraging smoking cessation were cheaper, and arguably more effective, alternatives.

Meeting expectations: clinical governance

- 2.14** Few responses provided detailed advice on how to model and capture the costs and benefits of improving clinical governance. Rather it was more generally recognised that the pace of scientific advance, the fast changing expectations of patients, and the ever-changing structure of the NHS itself, all have implications for doctors working in the service.
- 2.15** The proposal that in future planning the doctors should devote 10 per cent of their time to devote to quality assurance work including clinical governance drew large support from professional bodies and organisations. It was noted, however, that protected time is but one element of the clinical governance and quality agenda – albeit the one with the largest costs attached.
- 2.16** Conversely some cast doubt as to whether some of the savings ascribed in the longer term to improving clinical governance will be realised, suggesting that aspects of the current programme of reform, unless properly managed and adequately resourced, may fuel an increase in litigious claims. Tackling long waiting lists with too few doctors is likely to increase the likelihood of mistakes and additional claims.

Meeting expectations: faster access

- 2.17** While poor access was raised by many as an example of the poor service provided by the NHS, surprisingly few respondents challenged or discussed the Interim Report’s proposal to model the assumption that in the future patients will expect to ‘wait within reason’. One charitable foundation, however, suggested that in the future patients will expect:
- primary care consultations with doctors or nurses of 10 minutes,

2 EXPECTATIONS FOR THE HEALTH SERVICE AND DELIVERING HIGH QUALITY

rather than 8 minutes today, within two days;

- outpatients appointments of 15 minutes available within 2 weeks for urgent cases and 6 weeks for non-urgent cases;
- access to urgent services, such as being admitted to hospital, within three months or less, and within 6 months for non-urgent services; and
- waiting at service points for less than an hour in 90 per cent of cases and trolley waits of 4 hours or less.

Meeting expectations: modernising the NHS estate

- 2.18** There were not many responses which addressed the patient environment and the capital investment programme directly. Those that did argued that the Interim Report was almost silent about the capital programme, the likely resource requirements and the consequences of alternative systems for raising and repaying capital costs. Some believed that there are likely to be long term cost implications arising from the use of the Private Finance Initiative that will impact upon NHS revenue and spending in the future.

3 CHANGING HEALTH CARE NEEDS

Questions for consultation

Q9.1 Are there any other key changes in the health needs of the UK population that are likely to have a significant impact on expenditure over the next 20 years? Are there data available so that their impact can be quantified?

Q9.2 How will trends in the number of elderly people, their morbidity and expectations affect social care and its relationship with health care in the future? How will the impact on health and social care differ?

Demography

Q9.3 How is life expectancy likely to change over the next 20 years? What do the changes mean for the assumptions the Review should make about the future size and structure of the population and the future patterns of disease?

Morbidity

Q9.4 Will there be a compression or expansion of morbidity among future elderly people?

Q9.5 What health promotion and disease prevention interventions over and above smoking cessation are likely to have a significant, sustained impact on health service utilisation over the next 20 years? To what extent will health inequalities change? What impact will this have?

Likelihood of seeking health care and expectations?

Q9.6 How are future elderly people's demands for health care likely to differ from the current elderly? How will their changing expectations relate to health service use?

Q9.7 What evidence is available on trends in the likelihood of people seeking care for a given health problem?

3 CHANGING HEALTH CARE NEEDS

Introduction

- 3.1 Chapter 9 in the Interim Report described three main areas that may lead to important changes in the health care needs and demands of the population: demography, including changes in both the overall size and the age structure of the population; the health status of the population at any given age; and the extent to which people seek health care to manage a given health problem.
- 3.2 The Interim Report highlighted a number of key uncertainties reflected in the questions for consultation outlined in the box above. Of the 130 responses received by the Review, 50 explicitly responded to one or more of the questions related to Chapter 9 in the Interim Report.
- 3.3 As highlighted in the Introduction to the Final Report, people largely agreed with the Interim Report's finding that while ageing is an important factor, demographic change is not the main factor driving up health care costs. The Final Report also highlights the prominence given during the consultation process to health promotion and the links between health and social care. These and the other points raised are discussed in detail below.

Additional impacts on health needs

- 3.4 There was broad agreement that the key cost drivers related to changing health care needs and demands had been identified in the Interim Report. A few commentators thought the impact of new or emerging infectious diseases could result in substantially different health profiles in the future and there was concern that this has been underplayed in the Interim Report:

“Infectious diseases could upset projections about health needs. The Chief Medical Officer’s report “Getting ahead of the curve” analyses the threat of infectious diseases from new or previously unrecognised diseases, animal diseases that can transmit to humans, poor hygiene, slack disease control, poor standards of medical care, or terrorism¹. The threat is unpredictable but ... where events occur, the costs of dealing with the health consequences are high”.

¹ Chief Medical Officer (2002), Getting ahead of the curve: a strategy for combating infectious diseases, Department of Health.

3 CHANGING HEALTH CARE NEEDS

- 3.5 Other responses expressed concern at the curative focus of the Interim Report and the need for greater emphasis on the root causes of ill-health, many of which lie outside the health system.

Social care

- 3.6 The need for the health and social care systems to be well integrated was highlighted in a number of responses. Key issues included:

- employment rates among older people and income levels in retirement;
- the impact that current shortfalls in social services funding and provision have on health service provision, particularly in relation to bed-blocking;
- the extent to which social services are able to provide preventative services that help older people maintain their independence will impact on the use of health services;
- which services are available free at the point of use and which are not;
- availability of informal carers; and
- availability of housing that meets older people's expectations.

Chapter 7 provides further details of the consultation responses on social care.

Demography

- 3.7 There was broad support for the use of variant population projections, outlined in the Interim Report. There was general agreement that life expectancy will continue to rise. The potential impact of higher rates of migration was also mentioned.

3 CHANGING HEALTH CARE NEEDS

Morbidity

- 3.8** In general, commentators suggested that morbidity in older age would be compressed into a shorter period – thus additional years of life would, by and large, be healthy. This was supported by evidence that future reductions in key diseases are “locked in” because of lower rates of smoking among the current middle aged compared to the current elderly. However, concern was expressed that “for morbidity to be compressed in the future, we believe that there will need to be changes to the funding and provision of health and social care services, to focus more on preventative and early intervention measures, and rehabilitation”. Similarly, “the likelihood of compression of morbidity will be increased by effective and sustained implementation of the national service framework for older people, particularly those standards concerned with preventing strokes and falls, mental health promotion, and the promotion of health and active life in older people.”
- 3.9** Some responses noted the potential exacerbation of inequalities in wealth and health in later life. Others were concerned that the Review focused excessively on health among older people at the expense of younger adults and children.
- 3.10** The potential impact of health promotion and disease prevention initiatives on both overall well-being and use of health services featured strongly in many consultation responses and events. In particular there was concern that the Interim Report’s focus on smoking cessation was too narrow and attention needed to be devoted to other lifestyle changes that could result in reductions in morbidity, mortality and health service use, for example, improving diets and increasing levels of physical exercise. Evidence of the potential impact of such interventions was also provided: “Now is the time to invest in the implementation of comprehensive national strategies to improve nutrition and increase levels of physical activity among children and adults. The immediate implementation of such strategies, focusing in particular on children and young people, could substantially reduce demands on the NHS in 20 years’ time due to preventable ill-health and could mean the elimination of death and disability from CHD among people under 65, in as soon as 40-50 years’ time. In the short-term, these strategies will reduce health inequalities, increase social inclusion and improve mental health.”

3 CHANGING HEALTH CARE NEEDS

- 3.11** There was a clear call for the Review to illustrate the full potential of a successful public health strategy. One commentator suggested the Wanless Review should address the question: “By how much can coherent and sensible public health policy reduce the need for health services – at least among the non-geriatric community – to enable proper provision for unalterable, or much delayed, medical need?” Others stressed the need to highlight the cost-effectiveness of key public health interventions, citing, for example the fact that smoking cessation is extraordinarily cost-effective compared to almost everything else the NHS does and yet, relatively speaking, it receives a small proportion of funding.
- 3.12** A number of contributors to the consultation advocated greater consideration of the resources and specifically workforce requirements of a high quality public health system. In particular there was concern that the Review’s work on National Service Frameworks factored in medical costs, “but not the public health resources required for the health promotion and public health interventions necessary to meet these standards.” There was general support for the national public health workforce plan which examines public health infrastructure requirements at national, regional, strategic health authority, PCT/local strategic partnership, and community/neighbourhood levels². Chapter 7 provides further details of the consultation responses on social care.
- 3.13** Several respondents raised the potential for continued increases in the prevalence of obesity. In particular it was suggested that without a step change in the funding and delivery of public health programmes to reflect world class standards, rates of obesity would rise further, threatening the incidence of a range of diseases and NHS spending.
- 3.14** There was relatively little commentary about health inequalities, although it was stated that smoking cessation interventions are successfully targeting lower socio-economic groups. There was concern that the Review was treating age, sex, ethnicity and socio-economic status as independent factors, rather than reflecting the real, and complex, interaction between them.

² Dunkley R and Speller V (2001), Public Health Workforce Development Plan, Report for the Department of Health, Health Development Agency.

3 CHANGING HEALTH CARE NEEDS

Likelihood of seeking care and expectations

- 3.15** There was general agreement that in the future people will be more likely to seek care for a given level of need, although this might be offset by earlier intervention, advice and prevention. In particular, the growing expectations of the future elderly were highlighted. Commentators noted trends towards increasing complaints by older people and increasing requests for screening.

4 TECHNOLOGY AND MEDICAL ADVANCE

Questions for consultation

Q10.1 Is it right to conclude that, in aggregate, technology and medical advance will increase expenditure?

Q10.2 Have the main drivers of future spending on technology been identified? Which do you expect to be the most important in terms of impact on the health service over the next 20 years?

Q10.3 Is the top-down approach the best way to estimate the historical impact of technology growth and does the Review's preliminary estimate that technology has historically contributed around 2 percentage points to health spending growth provide a plausible floor to what will be required in future?

Q10.4 What rate of growth of technology spending do you think will be required over the next 20 years?

Q10.5 How much of an impact do you expect genetics and stem cell technology to have over the next 20 years and what will be the implications for health spending?

Q10.6 What should be the main priorities for the health service in increasing investment in information and communication technology (ICT)?

Introduction

- 4.1 Chapter 10 of the Interim Report identified technology and medical advance as major drivers of health care expenditure, with significant potential to improve both the outcomes and efficiency of the health service. However, it also stressed the considerable uncertainties about the future direction, pace and impact of technology in health care.

4 TECHNOLOGY AND MEDICAL ADVANCE

- 4.2 The Interim Report presented estimates of the historical contribution of technology to health spending growth based on the commonly used 'residual' approach, suggesting that technology and medical advance have contributed around 2 percentage points to the annual growth of health spending over the past 20 years. With the UK having historically been a late and slow adopter of new medical technologies, the Interim Report concluded that spending on technology and medical advance will need to grow at a faster rate than in the past to catch up and keep up with other countries.
- 4.3 The Report noted the significant uncertainties surrounding advances in genetics and stem cell research which offer the prospect of radical changes in the way medicine is practised and have the potential for significant impacts on health outcomes and costs.
- 4.4 The Interim Report also highlighted the poor record of the UK health service in investing in information and communication technology (ICT) and the potential gains in quality, safety and efficiency from putting in place an integrated ICT infrastructure across the health service.

Overview of responses

- 4.5 There was little specific comment on the consultation questions posed. Almost all of the respondents who addressed the issue of technology and medical advance concluded that they would add to health spending over the next 20 years. A number of respondents expressed the view that the Interim Report had placed too great a focus on high-tech spending at the expense of cheaper preventive measures. Views on the likely impact of genetics varied significantly, ranging from those who expected profound effects to those who expected virtually none. The need for more effective use of ICT was universally supported.

Contribution of technology to health spending

- 4.6 There was little comment from respondents on the methodology of the residual approach, although one respondent called for further analysis aimed at isolating technological change from other elements of the residual. No specific alternative methodologies were suggested.

4 TECHNOLOGY AND MEDICAL ADVANCE

- 4.7 Views on the likely future contribution of technology to health care spending varied significantly. One response suggested that in future technology and medical advance might contribute less than 2 percentage points a year to health spending as a result of greater importance being attached to primary care, tackling health inequalities, prescribing incentive schemes and defensive medicine. Other respondents argued for a significantly larger impact – up to double the estimated historical contribution.
- 4.8 One organisation estimated that an 8 per cent a year real terms increase in hospital non-staff costs will be needed over the next 10 years to diffuse existing technologies more evenly, introduce new technologies and improve the quality of the NHS estate. Another expected real terms growth of around 8 per cent a year in spending on technology, with 30 per cent of the cost increases offset by cost savings elsewhere in the system.

Key drivers of future technology spending

- 4.9 The likely shift in the balance from acute to chronic conditions over the next 20 years was cited by several respondents as a key driver of technology spending. Developments in pharmaceuticals were also identified by many as an important driver. One respondent expected the pace of discovery of new pharmaceutical products to increase – having fallen from 70 new chemical entities a year in 1980 to 40 a year by 2000, they predicted a rise to 200 a year by 2022.
- 4.10 One respondent argued that the main driver of future technology spending would be how the NHS makes decisions about resource allocation. Others suggested the need to focus greater attention on technologies aimed at prediction, prevention and management of disease rather than concentrating exclusively on diagnosis and treatment. The need for the NHS to cut out use of techniques which have no benefit to patients but do have cost implications was also highlighted.
- 4.11 Several respondents emphasised the need to take account of quality of life gains and wider cost savings to the health service and the economy as a whole when assessing the overall impact of medical technology. One response stressed “the overall benefits of new technologies in terms of saving lives, improving patients’ quality of life, reducing NHS waiting lists, reducing the overall cost of health care provision and the associated benefits to the UK economy”.

4 TECHNOLOGY AND MEDICAL ADVANCE

Genetics

- 4.12** The consultation responses on the impact of genetics reinforced the uncertainties and differences of opinion described in the Interim Report. At the most optimistic end of the spectrum, it was believed that genetics will have a significant impact on health care spending over the next 5 to 10 years, while others expected little or no impact over the 20 year horizon of the Review.
- 4.13** One view was that the impact of genetics would be “limited” over the 20 year period. Another respondent assumed that genetics and stem cell research would start to make an impact on costs within 15 years. One organisation took the view that genetics would have a significant impact on health care spending over the next 5 to 10 years. Another said that “if NHS resources are not to be wasted, the potential role of genetic testing or screening in the prevention of major, complex diseases should not be over-estimated”.

Information and communication technology

- 4.14** Key ICT priorities identified by respondents were the delivery of the Electronic Patient Record (EPR) and the need to join information systems across primary and secondary care. Other responses pointed to the benefits of electronic prescribing and the gains from linking up health and social care providers.
- 4.15** A number of respondents stressed the importance of developments being firmly patient-centred and not restricted by organisational boundaries. There was common agreement about the need for stronger central direction in future to prevent resources being wasted. As one respondent put it, there should be “a national strategy for local implementation”.
- 4.16** The need to ring-fence ICT budgets to prevent the resources being used for other services and the importance of staff training were also recurring themes. In addition to the potential for cost savings, several respondents referred to the potential gains in terms of safety through increasing the accuracy of patient identification and prescribing of drugs.

5 THE FUTURE WORKFORCE

Questions for consultation

Workforce:

Q11.1 What are the key changes in the roles of health care professionals that are likely to occur over the next two decades, in particular:

- what is the scope for a significant expansion in nurse-led services;
- how will the use of health care assistants change;
- how will the roles of specialist and generalist doctors change; and
- how will partnerships with other professionals, especially social care, change?

Q11.2 Will the current training places give the UK the number and mix of health care professionals it needs?

Q11.3 How can a mismatch between the demand and supply of skilled labour in the health service be avoided? What implications will this have for the cost of the workforce?

Productivity:

Q11.4 What is the scope for significant gains in the productivity of the health care workforce beyond the 2 per cent a year growth which might be expected for the UK workforce as a whole? Will productivity gains be more likely to improve quality and outcomes or to reduce costs and improve efficiency?

Q11.5 What other factors will drive productivity gains and what are the potential barriers to achieving them? Is it skill mix, contact time or other workforce and organisational factors?

Q11.6 What would be the impact of patients becoming much more involved in their own care?

Introduction

- 5.1 Chapter 11 of the Interim Report examined the future trends affecting the health and social care workforce. Health and social care are labour intensive services; the NHS employs over 1¼ million people and pay accounts for two-thirds of the NHS budget. Together the health and social care sectors

5 THE FUTURE WORKFORCE

employ one in ten of the working population. Trends in pay and productivity will therefore be an important driver of future spending on health. Over the past 20 years, staff costs have increased by two percentage points more than inflation and above the rate of increase for earnings in the economy as a whole.

5.2 The Interim Report set out the evidence supporting the NHS Plan's conclusion that the UK does not have enough doctors and nurses. The UK employs fewer doctors and nurses per head of population than any of the seven comparator countries examined for the Review. The Interim Report argued that the next 20 years would see substantial changes in the roles and responsibilities of health care professionals.

5.3 The number of skilled staff can be an important constraint on the health service, at least in the short-term. But the quality and efficiency of a country's health service also depends on the skills of the staff, the way they are used and the other resources, particularly technology, which support them. The Interim Report argued that the cost of health care will depend on the scale of productivity gains that can be realised over the next two decades. The report argued that in the past health service productivity growth – at an average of two per cent a year - has been broadly in line with the trend for the economy as a whole. The Review identified four areas that appear to offer the most potential for improved productivity in the long-term. Better use of the skilled workforce was highlighted as a major source of potential productivity improvement alongside, more self-care by patients, better use of ICT and redirecting existing NHS resources towards treatments which are cost-effective.

Overview of responses

5.4 There was almost universal agreement that the UK has too few doctors, nurses and health care professionals and that addressing this capacity constraint is essential if the UK is to achieve the health quality health service which the Review's term of reference set as the Government's goal. Respondents confirmed the Interim Report's analysis that there is considerable scope for skill mix changes within the health service. Some respondents expressed concern that, whilst the Review highlighted the strong support for family doctor services from patients, the public and international commentators, some aspects of the vision of the future could put some of the efficiency and quality benefits of the UK's primary care service at risk.

5 THE FUTURE WORKFORCE

- 5.5 Almost all the respondents who addressed the issue of productivity pointed to the problems of measurement in this area and the limitations of the current measures. As a result there was considerable doubt about the actual efficiency gains which have been realised in the past. Most respondents felt that when quality was taken into account, the historic trend in productivity was lower than the two percent cited in the Interim Report.

International comparisons

- 5.6 The responses to consultation endorsed the Interim Report's analysis of the difference in the number of health care professionals in the UK compared with our EU partners. In this context one Charitable foundation highlighted some important additional facts:

- while the UK has fewer doctors and nurses per head of population than other European countries, the overall number of people working in the health service is not lower. This suggests that the UK has adopted a difference skill mix to other European countries;
- care needs to be taken in comparing the number of nurses per head in the UK and other European countries due to definitional problems; and
- not only does the UK have fewer doctors per head than other European countries but historically it has relied much more heavily on doctors in training to provide clinical care. This raises quality concerns.

Skill-mix

- 5.7 The consultation responses demonstrated considerable support for further expansion of nurse-led services. Almost all the organisations that responded considered this a positive development and many highlighted the potential for further progress in this area. There was general agreement that many of the roles currently undertaken by doctors could be referred to a nurse practitioner with an extended role. Respondents highlighted the scope for nurse-led services in chronic disease management, treatment of minor injuries and ailments and care of particular groups in the population such as the homeless. The NSFs and a greater focus on health promotion and disease prevention will also increase demand for nurse-led services such as screening services and healthy lifestyle advice. But, all the responses on this

5 THE FUTURE WORKFORCE

issue emphasised that the further development of nurse-led services is unlikely to save money. Some consultation responses highlighted the longer consultation times and higher referral rates for nurse practitioners compared with doctors. Respondents also pointed out that more highly trained nurse practitioners will be able to command higher pay. Some organisations emphasised that the pace and scale of expansion of nurse-led services will depend on organisation and cultural change. As Primary Care Trusts develop their attitude will be critical.

- 5.8** Some organisations expressed concern about the implications of further expansion of direct-access services within primary care. Whilst agreeing that there is scope for a significant expansion in the services provided by nurses, one respondent questioned the assumption that between 20 and 32 per cent of GPs' could be replaced by nurse practitioners. It argued that the evidence base for this was not as robust as it needed to be, didn't take account of the high level of co-morbidity and it understated the quality benefits of GPs providing holistic care for their patients.
- 5.9** Alongside general support for an extension of nurse-led services there was agreement that the next 20 years will see an extended role for Health Care Assistants (HCAs). Many organisations argued for a system of registration for HCAs. They also pointed out that there may be pressures on the supply of HCAs. Many of those employed as HCAs are nurses from other countries and they are likely to progress to registered status. Social care is also likely to expand this section of its workforce.
- 5.10** Many organisations pointed out that the scope for skill-mix changes extended beyond the boundary between nurses and doctors. They highlighted the scope for developments in the role of allied health professionals. One pointed to the benefit of some further extension of prescribing beyond nurse practitioner by, say, giving optometrists independent prescriber status.

Specialisation

- 5.11** The responses showed general agreement that the trend in health care is towards greater specialisation. However a number of organisations raised concerns about the need to ensure that the benefits of generalist services are retained. A number of medical organisations expressed fears that the UK is in danger of having health care professions fragmented into numerous specialty roles with no one able to take a holistic approach and to provide a totality of care and consideration. They highlighted the evidence that

5 THE FUTURE WORKFORCE

primary care services have the highest satisfaction rating of all public services and there is a considerable body of evidence showing that continuity of care brings health care benefits. For example, people are more likely to comply with treatment and attend follow-up appointments. Moreover, with an ageing population more patients will present with multiple health needs, on average people over 75 have four different health problems at anyone time. Some organisations, therefore argued that future trends pointed to an even greater role for generalists at the heart of the health service. Many organisations cited the need to ensure that greater specialisation does not lead to more rigidity and inflexibility in the delivery of health and social care.

Adequacy of training plans

- 5.12** Very many respondents expressed concerns about the potential for a shortfall in the number of skilled health care professionals. Whilst welcoming the expansion plans put in place by the Government, most of those who responded felt that the current training places will almost certainly not produce the number and mix of health care professionals required. A range of organisations expressed concerns about the plans for doctors, nurses and health care assistants suggesting that the demand for nurses would be greater than the Government's current plans imply.
- 5.13** A number of organisations pointed to the potential for significant changes in the working hours of doctors over the next two decades. The implementation of the Working Time Directive will further reduce the working week. In addition, the increasing number of women practicing medicine is likely to result in a greater focus on work-life balance. More doctors will want to work part-time for at least part of their career and the participation rate – the proportion of trained doctors currently working in the health service – may fall.
- 5.14** Many organisations raised concerns about potential shortages in particular specialisms such as public health professionals.

Pay

- 5.15** Respondents argued that pay would be an important factor in the recruitment and retention of the skilled workforce over the next two decades, although it was by no means the only factor. A number of organisations emphasised the importance of status and morale in addition

5 THE FUTURE WORKFORCE

to pay and terms of conditions in recruiting and retaining staff. Some highlighted the importance of status and training issues for staff in the social care sector. A number of organisations highlighted the problems caused by the inflexibility of current pay systems which make it difficult to respond to local requirements. They drew attention to the particular problems faced for staff in London and the South East.

- 5.16** Few respondents provided quantitative evidence on the scale of pay pressures over the next 20 years. Of those that did, estimates suggested that real terms health sector salaries will need to rise by between 1.5 and 3 per cent a year through the review period.

Productivity

- 5.17** The consultation responses highlighted the weaknesses of the current measures of productivity used in the health service. Many organisations were not convinced that the NHS has achieved two per cent a year efficiency gains and argue that better measures of efficiency are required. Current measures focus on the rate at which the NHS has been able to process patients per pound of public spending. This is misleading because it ignores quality and responsiveness and it is a snapshot which ignores current investment activity designed to secure future productivity gains.
- 5.18** A number of respondents noted that productivity growth as conventionally measured has fallen below economy-wide measures in recent years. Increased resources to improve buildings, cleaning and catering, waiting times and other aspects of service quality increase the unit cost per patient treated and hence show up as reductions in conventional measures of productivity. All respondents on this issue argued that there needed to be a new approach to productivity measurement which incorporated quality. Respondents argued that the NHS is cheap rather than efficient and with a high proportion of costs that are fixed in the short to medium term. As a result it is likely that efficiency gains will generally manifest themselves as improvements in quality of processes and outcomes or as non-cash releasing increases in levels of service.

5 THE FUTURE WORKFORCE

- 5.19** Although respondents were concerned about the limited scope for further cash-releasing efficiency gains a number of organisations argued that the NHS does not use its human or physical assets as well as it could. The health service in future needs to use the skills of its workforce appropriately and make more effective use of expensive equipment and technology.
- 5.20** Respondents argued that reducing the delays between tests and reporting and increasing or replacing diagnostic equipment would help to raise productivity, as would use of video links between primary and secondary care professionals and increased availability of Electronic Patient Records. Systems allowing effective transfer of data across the whole system will speed up treatment and reduce duplication of effort. Productivity could be increased by focusing facilities on the patient rather than the process, e.g. more local diagnostic equipment. Other respondents suggested that major productivity gains could be achieved by scheduling activity so that all staff, services and equipment are available at the right time. Respondents noted that nurses and medical staff spend a significant amount of time on administration and record keeping which could be reduced through automated data entry and presentation tools. They cite examples of such techniques increasing productivity in distribution centres by around 25 per cent through eliminating paperwork and reducing mistakes by 75 to 95 per cent. Key productivity barriers cited are contractual and professional arrangements, clinical custom and practice and guidance from professional bodies/Royal Colleges.
- 5.21** Few responses provided quantified evidence on the scope for productivity gains. One respondent identified the potential to improve efficiency by health process redesign involving:
- changing professional practice: 1.5-1.75 per cent a year;
 - use of ICT, particularly to increase patient contact time: 0.5 per cent a year;
 - developments in medical technology: 0.3 per cent rising to 1 per cent a year; and
 - investment in self care and health promotion: 0.3 per cent a year in years 10-20.

Overall this suggested a reasonable efficiency target of 2.5 per cent a year in

5 THE FUTURE WORKFORCE

the short term and 3 per cent in the longer term.

- 5.22** In contrast one respondent was circumspect about the potential productivity improvements by NHS staff. It was “not optimistic, at least in the short run, that the health care workforce in the NHS will achieve 2 per cent gains in productivity” due to due to shortages of experienced nursing staff in particular. It suggested that the productivity of NHS consultants will remain static over the next 10 years, although in the longer term the technical quality of service and admission rates might fall. GP productivity is assumed to fall marginally to reflect smaller lists and increases in length of consultation.

6 DIFFERENCES WITHIN THE UK

Questions for consultation

Q12.1 Are there any health trends that will affect different parts of the UK in different ways which need to be taken into account in the final report?

Q12.2 How much of the variation between countries of the UK is attributable to different levels of social deprivation?

Q12.3 What specific aspects of morbidity and mortality are likely to vary from the UK average in each country?

Q12.4 What impact, if any, will the differing forms of NHS organisation and management in the four countries of the UK have on resource needs?

Q12.5 Will diverging population trends require a different approach to health care in England, Scotland, Wales or Northern Ireland?

Q12.6 How will devolved responsibilities for health and social care affect technology diffusion and workforce development?

Q12.7 What variations in health need between the English Regions need to be taken into account in the Review?

Introduction

- 6.1 Chapter 12 of the Interim Report outlined the information gathered by the Review in its initial phase about similarities and differences within the UK. It suggested that while England, Scotland, Wales and Northern Ireland have different health needs reflecting differences in their populations, environments and economies, over the next 20 years the overall impact of major health trends is likely to be similar across the UK.

6 DIFFERENCES WITHIN THE UK

Overview of responses

- 6.2** Generally health trends were expected to be similar but consultation respondents pointed to the differences in population characteristics. For example, the population is growing more rapidly in Northern Ireland than in other parts of the United Kingdom. Wales is projected to have the highest proportion of people aged 75 and over. In Scotland, the variation in the number of older people between Health Board areas was cited as an important issue: a greater and growing need will exist in the more remote and rural areas during the next two decades.

Social deprivation

- 6.3** Respondents were not able to quantify in sufficient detail for use in the Review's modelling work the effects on health of differing levels of social deprivation.
- 6.4** A widening gap between health status in Scotland and the rest of the UK was highlighted. However, evidence was not produced on how much of this difference was attributable to social deprivation. It was pointed out by some that a relatively generous provision of funding for health care in Scotland has not succeeded in producing a healthier population. Evidence from a survey in Northern Ireland suggested that, despite having a younger population, health outcomes were worse than for England. In Wales, mortality rates in the most deprived electoral wards are 25 per cent higher than in the least deprived areas. Several responses noted that detailed comparisons between countries within the UK are hampered by differences in data definitions.

Morbidity and mortality

- 6.5** Evidence was produced indicating that while mortality rates are generally improving, gaps remain between the rates in the four countries of the UK. Scotland continues to have the worst 'all causes' mortality for males. Mortality rates by social class also vary considerably. For example, the rates for skilled manual and unskilled workers in Scotland are considerably higher than those for England and Wales. Cancer and stroke mortality rates are also higher in Scotland than in England, Northern Ireland or Wales.

6 DIFFERENCES WITHIN THE UK

- 6.6 It was suggested that respiratory disease is a particular problem in Northern Ireland compared with the rest of the EU. Life expectancy for females in Wales lags behind England by around six months. Wales also has the highest proportion of adults who say their health is ‘not good’.

Organisation and management

- 6.7 It was not generally felt that the diverging forms of organisation and management in England, Scotland, Wales and Northern Ireland outlined in the Interim Report would have any major impact on resource requirements over the next 20 years. However, the general level of patient and public expectations was felt to be a common factor, driving up standards and pressing for similar levels of service and quality across the UK. For example, one respondent stated that it would be difficult for any of the countries of the UK to avoid implementing the guidelines provided by bodies such as the National Institute for Clinical Excellence (NICE).

Different approaches

- 6.8 In consultation, people felt that divergences in population trends might impact on short-term and medium-term funding priorities, but that this would not make a difference to the long-term provision of care. Some felt that the smaller organisational scale might assist a faster rate of experimentation in Scotland, Wales and Northern Ireland with shorter feedback loops to the national level. One respondent believed that “smaller ‘units’ can provide good pilot sites and obtain relatively quick feedback since by their nature, there are not so many layers of management between the patient and the NHS Chief”.

Technology and workforce issues

- 6.9 International trends were felt to dominate both technology and workforce issues. On information and communication technology, some evidence was provided suggesting faster progress might be being achieved in Scotland than in the UK in general. On workforce, the pressures of an ageing workforce and the need to provide services in sparsely populated areas could be particular problems in Scotland.

6 DIFFERENCES WITHIN THE UK

English Regions

- 6.10** Very little evidence was produced about variations in need between the English Regions, although this was discussed at the consultation sessions in Leeds, Birmingham, London and Exeter. The particular needs of London, in terms of both health inequalities and the needs of ethnic minority groups, were emphasised by some respondents.

7 OTHER ISSUES RAISED IN CONSULTATION

Introduction

- 7.1 While the Interim Report posed a set of questions for consultation, it also sought views on the whole report. Most of the written responses received were focused around the specific questions, but several other points came through. In particular, views on health promotion and social care were made strongly.

Health promotion

- 7.2 Better public health measures could significantly affect the demand for health care. A number of respondents emphasised that, while much of the beneficial impact might occur beyond the end of the 20-year period, that should not prevent action being taken in the short term. For example, one respondent said “the one major area of government activity that can, but mainly over the long term, reduce demand for health care and other related services is public health promotion and sickness prevention”.
- 7.3 Others said that investment in changing people’s behaviour now, such as cutting out smoking, improving diet and encouraging more exercise, could significantly improve the population’s health status. This would potentially reduce demand and postpone the average age at which health need would become expensive.
- 7.4 Respondents stressed the need for clearer links between funding allocations and cost effectiveness of interventions. For example, one respondent commented that: “tobacco causes about one in three cancers and about one in seven deaths through CHD, yet the extra money is to be spent overwhelmingly on treatment, palliative care, and secondary prevention”.

Social care

- 7.5 It was also widely emphasised in consultation that further sustained investment in social care is vital because of current difficulties faced by the social care sector. Some respondents felt that the Interim Report had understated the contribution of social care and that there was a need to invest in social care staff to deliver higher productivity elsewhere in the system. One response said that “it is essential for there to be substantial investment in social care to support older people, to ensure that the NHS Plan is successfully implemented, and to reduce dependency in older age”.

7 OTHER ISSUES RAISED IN CONSULTATION

- 7.6 Others argued for structural changes to develop an integrated health and social care system. Responses outlined current problems in the social care sector, such as the closure of nursing and social care home and the continued difficulties with the transfer of patients from hospital to nursing and residential care. One respondent referred to the “problems resulting from the allocation of health and social care funding through different mechanisms”.

International comparisons

- 7.7 There were very few comments on the international comparisons presented in the Interim Report, with most respondents who did touch on international comparisons agreeing with the Interim Report’s analysis of the differences in inputs, outputs and outcomes across the group of comparator countries.

Financing health care

- 7.8 Chapter 4 of the Interim Report discussed the financing of health care and considered whether the method of funding the health service is itself a factor determining the resources which will be needed over the next 20 years.
- 7.9 Of those who commented on health care financing, most supported the Review’s conclusion in the Interim Report that the current method by which health care is financed in the UK through general taxation is both fair and efficient. Strong support for a continuation of the current financing system was received from some respondents. For example, one response “supported the broad conclusions of the Review, i.e. that the NHS ... should continue as a tax-funded service”.
- 7.10 However, a few consultation responses questioned the Interim Report’s conclusions. Some claimed a causal link between financing health care predominantly through general taxation and the historic under-investment in the health service. One respondent said that “the UK’s publicly financed health care system has been associated with a significant cumulative under-investment in resources, infrastructure and poor service provision”.

7 OTHER ISSUES RAISED IN CONSULTATION

- 7.11 It was suggested that the UK's method of financing health care hides the real cost of health care, so impacting adversely on patient responsibility and engagement. It was also suggested that, in private or social insurance schemes, where people choose regularly whether to stay with their existing insurer or move to another, they could exert more influence over what is provided, could show their willingness to pay more for better services and could help exert discipline on total spending.
- 7.12 Some private medical insurers and research groups argued that the UK's method of financing restricts patient choice and limits the responsiveness of the service. For example, one said "we maintain that it is imperative properly to investigate the reasons why the NHS fails to respond better to preferences. There are currently few incentives to the system to respond to patients' individual choices and, without building levers into the system to do this, it is unlikely that there will be significant improvement".
- 7.13 A few respondents advocated out-of-pocket payments for clinical services such as visits to a GP or a specialist, while others argued strongly against them. One respondent pointed to problems of affordability of prescription and dental charges among some groups.

Health care organisation and delivery

- 7.14 Some argued that greater decentralisation and a more diverse mix of private, public and 'not-for-profit' providers than currently seen in the UK health service would result in greater efficiency and responsiveness.
- 7.15 One respondent said that "the UK is about the only country that channels the bulk of its healthcare services through a single monolithic state-run structure" and called for "a range of delivery models to suit local circumstances". Another argued that "there is an important role for the private sector in increasing the capacity to deliver NHS services ... for example, the private sector has undoubted expertise in elective surgery, and would be prepared to expand in parts of the country where NHS capacity is stretched".
- 7.16 A few respondents were more guarded about the success of greater decentralisation. For example, one referred to "the inherent contradiction of stated policy to devolve power to front line doctors and nurses and PCTs and yet apparently maintain a uniform national system".

ANNEX A

LIST OF THOSE CONSULTED

A.1 This Annex provides details of the organisations and individuals both in the UK and other countries which the Review met and visited and which responded to the written consultation. A full list of those who attended and spoke at the Health Trends Review Conference is set out on pages 221-224 of the Interim Report.

A.2 Written consultation responses were received from:

NHS

Birmingham Health Authority
East London and The City Health Authority
Essex Local Medical Committees
Greater Glasgow NHS Board
Health Development Agency
Highland NHS Board
NHS Information Authority
North Essex Health Authority
North Staffordshire Health Authority
Northamptonshire NHS Trust
Nottingham City PCT
Nuffield Orthopaedic Centre NHS Trust
Pinderfields and Pontefract Hospitals NHS Trust
South Staffordshire Health Authority
South West Kent PCT
The Ambulance Service Association
Walsall Hospitals NHS Trust
West Hampshire NHS Trust
West Hull PCT
West Sussex Health Authority

Royal Colleges

Academy of Medical Royal Colleges
Faculty of Public Health Medicine
Royal College of General Practitioners
Royal College of Nursing
Royal College of Physicians
Royal College of Physicians and Surgeons of Glasgow
Royal College of Surgeons of Edinburgh

ANNEX A

Academic institutions

Centre for Health Economics, University of York (Diane Dawson, Maria Goddard and Peter C Smith)
Council of Heads of Medical Schools (Professor Robert Boyd)
Institute for Applied Health and Social Policy, King's College London (Dr Perri 6 and Dr Edward Peck)
London School of Economics and Political Science (Professor Walter Holland)
London School of Hygiene & Tropical Medicine (Dr David Metz)
University of Essex (Professor Joan Busfield)
University of Leicester (Professor Richard Baker)
University of Southampton (Professor Dame Jill Macleod Clark)

Professional bodies and organisations

AIM UK
Association of British Insurers
Association of Chartered Certified Accountants
Association of the British Pharmaceutical Industry
British Generic Manufacturers Association
British Health Care Association
British Medical Association
Business Services Association
Confederation of British Industry
Continuing Care Conference
NHS Confederation
Proprietary Association of Great Britain
Royal Pharmaceutical Society of Great Britain
Scottish Specialists in Pharmaceutical Public Health Group
The British Computer Society
The Chartered Institute of Public Finance and Accountancy
The Chartered Society of Physiotherapy
The College of Optometrists
The Society of Chiropractors and Podiatrists
Worshipful Company of Information Technologists

Business and industry

Andstrom Consulting Ltd
Aventis Pasteur MSD
Boots the Chemists
BUPA
Celtic Dimensions
DPP 2000 Ltd
Electronic Data Systems Ltd (EDS)

ANNEX A

Glaxo SmithKline
Haden Young
Inventures
iSOFT Group plc
Lilly UK
Microsoft
Norwich Union
Novo Nordisk
Pharmaceutical Schizophrenia Initiative (PSI)
PPP healthcare
SmartSensor Telemed Ltd
Standard Life Healthcare
Swiss Re Life & Health
Unilever

Trades Unions

UNISON

Patient organisations, charitable and voluntary organisations

Action on Smoking and Health (ASH)
Age Concern
Association of Community Health Councils for England & Wales
(ACHCEW)
Association of Welsh CHCs
Cardiff Community Health Council
Carers UK
Diabetes UK
Gwent CHC
Gwynedd CHC
Help the Aged
National Association of Citizens Advice Bureaux
National Cancer Research Network & BT Health
National Council for Hospice and Specialist Palliative Care Services
National Heart Forum
No Smoking Day
Pharmacy Healthcare Scheme
Royal National Institute for Deaf People
Scope
Smoking Control Network
The British Thoracic Society
The College of Health
The Enhancement Trust
The Healthcare Improvement Network

ANNEX A

The Isabel Medical Charity
The Nuffield Trust
The Stroke Association
UK Public Health Association
YMCA England

Political parties

Crawley Constituency Labour Party

Research groups

GeneWatch UK
Institute for Alternative Futures
REFORM

Devolved Administrations

Northern Ireland Dept of Health, Social Services & Public Safety
Scottish Executive
The National Assembly for Wales

Overseas governments

National Institute of Public Health and the Environment, Netherlands

Individuals

Pam Alford
Frank Arnold
Tom Brooks
Christine Glover
Ian Hopkinson
John Roberts
Malcolm McAlpine
Michael Miller
Michael Place
Rachel Paton
Dr Simon Price
Anna Richell
Anthony Roberts
Dr Dominic Smethurst
Tony Tarrega
Walter Stanners
Rosemary Lever
Dr J Wardrope
Dr Paul Weston-Smith

ANNEX A

Dr JG Whittle

A.3 The Review met with the following UK health organisations, academic institutions, companies, associations and individuals:

Adam Smith Institute
Age Concern
Association of British Pharmaceutical Industries
Baroness Sally Greengross
Beeson Gregory
Boots the Chemist plc
British Medical Association
BT Health
BUPA
Camden and Islington Mental Health NHS Trust
Centre for Policy Studies
CIVITAS
Confederation of British Industry
Crisp Street Health Centre
Diabetes UK
East London and the City Health Authority
European Observatory on Health Care Systems
Guys and St Thomas's NHS Trust
Health Development Agency
Health Unions (Amicus, AUEW, CDNA, SCP, HCSA, TGWU, CSP, BDA, GMB, UNISON, MSF, SOR)
Homerton Hospital
Institute for Fiscal Studies
Prof Sir Richard Sykes, Imperial College London
John Radcliffe Hospital
Judge Institute for Management Studies
King's Fund
Medical Research Council
Medical, management staff and patient groups in Scotland, Wales and Northern Ireland
National Horizon Scanning Centre, University of Birmingham
National Institute for Clinical Excellence (NICE)
Nestor Healthcare
NHS Alliance
NHS Confederation
NHS Northern and Yorkshire
NHS South Eastern Region
NHS West Midlands

ANNEX A

North Durham Health Care NHS Trust
Nuffield Trust Regional meeting, Exeter
Patients' Association
Pinderfields Hospital
Prof Sir Michael Peckham, University College London
Prof Tom Kirkwood, University of Newcastle
Queen Mary & Westfield College (QMWC)
Royal College of General Practitioners
Royal College of Nursing
Royal College of Physicians
Royal College of Surgeons
Royal London Hospital
Social Market Foundation
Standard Life Healthcare
Tomorrow Project
Trades Union Congress

A.4 The Review consulted with the following overseas government departments, organisations and individuals:

Australian Commonwealth of Health and Aged Care
Bundestag Health Committee
Canadian Health Ministry
Centenary of Australian Federation Seminar on Sustainable Health Financing, Canberra (involving UK, Australian and New Zealand representatives)
Dutch Health Ministry
French Ministry of Employment and Solidarity
French Social Security Ministry
German Federal Health Ministry
German National Advisory Group
Health Canada
Mark McClellan, Council of Economic Advisers, White House, Washington DC
Organisation for Economic Cooperation and Development (OECD)
Professor Patricia Danzon, Wharton School, University of Pennsylvania
Queensland Health
Swedish Association of Local Authorities
Swedish Federation of County Councils
Swedish Ministry of Finance
Swedish National Board of Health and Welfare
Urban Institute, Washington DC
US Agency for Healthcare Research and Quality

ANNEX A

US Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration)
US Congressional Budget Office
World Health Organisation

A.5 In addition, the Review also consulted with:

Department of Health and its equivalents in Scotland, Wales and Northern Ireland
European Observatory on Health Care Systems at the London School of Economics and Political Science
Government Actuary's Department
Office for National Statistics
Personal Social Services Research Unit