

- 1.1 The Acts of Parliament which founded the National Health Service (NHS) set out a vision of: “a comprehensive health service designed to secure improvement in the physical and mental health of the people ... and the prevention, diagnosis and treatment of illness”¹. In the half century since, the NHS has established itself as the public service most valued by the people of the UK.
- 1.2 To meet its original vision in future, and to justify the value which people attach to it, the health service requires radical reform.
- 1.3 In July 2000, the Government published the NHS Plan². It defined the core values on which the NHS in England should be based in future and many of the detailed changes needed to “universalise the best”, closing both the unacceptable gaps in performance within the UK and the considerable gaps in performance between the UK and other developed countries. The Plan set out the core principles for the NHS and a framework for delivering these principles over the next decade. Many ambitious goals have been defined.
- 1.4 A commitment to a sustained increase in NHS spending was made in March 2000 to underpin the programme of reform.
- 1.5 Against this background, in March 2001, the Chancellor of the Exchequer commissioned this Review to examine future health trends and the resources required over the next two decades to close the gaps in performance and to deliver the NHS Plan and the vision of the original Acts. The Review’s Terms of Reference are set out in Box 1.1
- 1.6 This is the first time in the history of the NHS that the Government has commissioned such a long-term assessment of the resources required to fund the health service. Making a long-term projection of this kind is, of course, fraught with uncertainty, but there are good reasons for attempting it.
- 1.7 Many decisions about resources need to be made for the long term; for example, the number of people to be trained, the skills they will require, the types of buildings likely to be needed and the information and communication technologies upon which the efficient operation of the system will depend. The whole system, including prevention, diagnosis and treatment, rehabilitation and long-term care must be seen from the perspective of the individual patient, with appropriate structures in place to produce sensible incentives and to direct resources efficiently.

¹ National Health Service Act (England and Wales) 1946, National Health Service Act (Scotland) 1947, Health Services (Northern Ireland) Act 1948.

² Department of Health (2000), The NHS Plan - A plan for investment, a plan for reform, Cmd 4818-1, The Stationery Office, London. The Devolved Administrations produced similar Plans.

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.

- 1.8 It is hoped that this Review will help to contribute towards greater stability in the funding and delivery of health care over the next 20 years. While total health spending has risen on average by 3.9 per cent a year in real terms over the past 40 years, annual changes in real terms have varied substantially – from reductions, to an increase of over 10 per cent. Such instability in funding acts as a serious barrier to long-term planning. Taking a long-term view should also provide the opportunity for more effective management of the health service. Good management requires clarity about the long-term, strategic direction of the service coupled with flexibility to respond decisively and appropriately to changes as they occur.
- 1.9 The Review should also contribute towards greater transparency and better understanding of the costs of providing people with the health service they expect. Filling the serious current gaps in data and research that the Review has identified and which are discussed in Annex A will also help in this respect. Together these should assist in the development of necessary processes to expand public involvement in the difficult issues which are certain to emerge as the next 20 years unfold.

SCOPE OF THE REVIEW

- 1.10 The Chancellor has asked the Review to assess the long-term resource requirements for the health service in the UK. The starting point is the set of principles, for England, established in the NHS Plan and developed in subsequent National Service Frameworks (NSFs).
- 1.11 The Review's Terms of Reference encompass financial and other resources. In making its assessments it has considered both together, in order to verify that the health service has sufficient capacity, particularly in terms of its workforce, to spend its financial resources wisely.

- 1.12 The Review has considered the resource requirements for a publicly funded, comprehensive and high quality health service. Although the Terms of Reference relate to health care, it is clear that social care is inextricably linked to health care. They must be considered together. The Review has therefore attempted to identify and draw out some of the key relationships between the two and, as a first step, sets out illustrative projections of resource requirements for social care for adults (especially older people) based on the present position adjusted for changes in the population and in the level of ill health. However, with the time and resources available, it has not been possible to develop social care projections in the same amount of detail as the projections for health care. Further work is required as part of a ‘whole systems’ approach to analysing and modelling health and social care.
- 1.13 Public funds are used to commission services not only from the NHS and local authorities but also from private and voluntary organisations. The Review has made no judgement about the relative merits of different forms of public and private delivery; the resource estimates make no assumption about the public/private mix in the delivery of services in 20 years’ time.
- 1.14 The Review’s Terms of Reference cover the whole of the UK and its resource estimates are presented on this basis, although information and time constraints mean that detailed modelling work has been carried out using data related to England. The Review would like to have considered in more detail how the health trends it has identified may differ between different parts of the UK, but again data and time constraints prevented this. This is discussed further in Chapter 4 and Annex A.

APPROACH OF THE REVIEW

Interim Report

- 1.15 The Review published its Interim Report³ in November 2001. The Overview chapter of that Report is attached as Annex C. The Interim Report outlined the Review's three stage approach:
- Stage one: to understand what patients and the public are likely to expect from a comprehensive, high quality service available on the basis of clinical need and not ability to pay in 20 years' time;
 - Stage two: to map the likely changes in health care needs, technology and medical advance, workforce, pay and productivity; and
 - Stage three: to assess how these changes will affect the resources required to meet patient and public expectations.
- 1.16 The Interim Report considered the first two stages, after assessing how the NHS is performing and where at present it is falling well short of expectations. It sought to identify the key trends which will drive health needs and the resource requirements of meeting them over the next two decades:
- rising patient and public expectations;
 - delivering a 'world-class', high quality service;
 - changing health needs of the population (including demography);
 - technological development and medical advance; and
 - use of the workforce and other productivity changes.
- 1.17 It also set out the factors expected to influence these trends. For example, changes in the number of older people and changes in inequalities among the wider population will impact on health needs.
- 1.18 The Interim Report considered whether the method of financing the NHS was itself a potential driver of total cost. It concluded that the current method by which health care is financed through general taxation is both a fair and efficient one, with no evidence that any alternative financing method to the UK's would deliver a given level of health care at a lower cost to the economy. Indeed, other systems were likely to prove more costly. So continuation of a system of funding broadly similar to that at present was not, in itself, a factor leading to additional resource pressures over the next two decades.
- 1.19 The Interim Report recognised that the UK's overall economic performance was likely to be an important influence on the total resources devoted to health services. The strength of a country's economy tends to be an important determinant of its health spending: countries with a higher GDP (Gross Domestic Product) per capita typically spend more on health care both in absolute terms and as a share of their total income. A relatively stable macroeconomic environment and satisfactory growth will be crucial in

³ Wanless D (2001), Securing our Future Health: Taking a Long-Term View - Interim Report November 2001.
www.hm-treasury.gov.uk/wanless

delivering a high quality health service. The Review assumes that the Government's estimate of the long-term trend rate for GDP growth is achieved.

- 1.20 The Interim Report also outlined the benefits to the economy and society of a high quality health service. For example, research has shown that if average life expectancy could be increased by five years (i.e. to Japanese levels) then GDP in the UK could be between £3 billion and £5 billion a year higher⁴, while it has been estimated that workplace absence cost British business nearly £11 billion in 2000⁵. Indeed, such economic and social benefits were at the heart of the objectives in founding the NHS. Individuals, employers and the Government stood to benefit from the improved levels of national health arising from curing sickness and preventing disease, and were therefore all deemed to have a stake in delivering them. This is still the case today.
- 1.21 The Interim Report did not attempt to estimate the resources required for the health service over the next two decades. Its aim was to set out analysis and views as a basis for widespread consultation.

Consultation

- 1.22 The Review has undertaken a wide range of discussions on the Interim Report throughout the UK. Formal consultation events have been 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. Over 400 people from the NHS and social care organisations, patient groups, academic and private sector organisations have attended meetings held to discuss the Interim Report.
- 1.23 The Review has also visited a number of other countries to discuss the challenges facing their health care systems and the approaches which they adopt to long-term resource planning. In addition to visits to Australia, Canada and the US in advance of the publication of the Interim Report, the Review has visited France, Germany and Sweden and held discussions with those involved in the planning and delivery of health care in the Netherlands. The Review also commissioned a report⁶ from the European Observatory on Health Care Systems to examine the trends and challenges facing the health care systems in eight countries (including the UK). This is being published alongside this Final Report and is available on the Review's website.
- 1.24 In addition, over 130 written consultation responses were received. The individuals and organisations who submitted responses are listed in Annex B. The responses have been analysed and the feedback used to inform the preparation of this Final Report.

⁴ Bloom D and Canning D (2000) Health and Wealth of Nations Science, 18 February; 287: 1207-1209.

⁵ Confederation of British Industry (2001), Pulling Together, May 2001.

⁶ Dixon A and Mossialos E (eds) (2002), Health care systems in eight countries: trends and challenges, European Observatory on Health Care Systems, April 2002.

1.25 The Interim Report was widely welcomed and its findings have been generally endorsed, particularly:

- the identification of the main drivers of health spending;
- the overview of the current position of health services and health outcomes in the UK;
- the analysis of patient and public expectations;
- the main trends affecting high quality health care;
- the discussion of the future workforce and productivity issues; and
- the data on variations in health and health care within the UK.

1.26 People have largely agreed with the Interim Report's findings that:

- 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.

1.27 Two further points were made strongly in the consultation responses, and have been given greater prominence in this Final Report:

- **health promotion:** 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, the Institute for Applied Health and Social Policy 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". 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. In response to these comments, the Review has modelled a range of scenarios to explore the possible impact of reduced activity arising from improved public health; and

- **social care:** further sustained investment in social care is vital because of the current difficulties faced by the social care sector. Help the Aged, for example, felt that the Interim Report had under-stated 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. SCOPE said that structural changes were required to develop an integrated health and social care system. Respondents outlined current problems in the social care sector, such as the closure of nursing and social care homes and the continued difficulties with the transfer of patients from hospital to nursing and residential care.

The Review has taken on board these comments by outlining a view of how a more integrated 'whole systems' approach to health and social care could function. The scenarios outlined in Chapter 3 vary in how well this approach is implemented.

- 1.28 A few respondents addressed the method of financing health care, with some suggesting that alternative methods of financing should be considered. For example, BUPA argued that the Government should encourage additional voluntary spending. REFORM said that countries with mixed funding systems are better funded and achieve better outcomes. Respondents argued that the current funding mechanism through taxation was responsible for a lack of resources and dynamism within the NHS. This was particularly because of the way budgets had been set over many years, the absence of appropriate incentives and the inability to reward efficiency and allow individuals to express choices. Chapter 6 discusses the main mechanisms for financing health care and the comments made in consultation.
- 1.29 Some people argued that 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. Chapter 6 discusses issues about delivery and the effective use of resources.

Final Report

- 1.30 This Final Report assesses the resources required for the health service over the next two decades - the third stage of the Review's approach - based on the trends and analysis set out in the Interim Report and consideration of the views received in consultation.
- 1.31 There are inevitably many large uncertainties, which the Review has had to accept and incorporate into its estimates. In order to make clear how these have been dealt with, while ensuring that the resource estimates deliver a "publicly funded, comprehensive, high quality service available on the basis of clinical need and not ability to pay", the Final Report sets out:
- a description of its view of **the health service in 2022** (Chapter 2) based on the trends in rising patient and public expectations and what a high quality service might mean; and

- **scenarios** (Chapter 3) to account for a range of possible variations in the changing health needs of the population; technological development and medical advance; and use of the workforce and other productivity gains. These factors will determine the resources required to deliver a high quality service. The scenarios impact in two ways. First, through changing the demand for health care and, second, through changing the cost and configuration of the supply of health care. To illustrate the uncertainty involved, the Review has adopted three scenarios, each combining the trends in a way designed to present a coherent whole and a plausible picture of the future.

MODELLING RESOURCE REQUIREMENTS

- 1.32 The Review has produced its assessment of required resources by developing a detailed model of NHS expenditure incorporating the trends and factors identified. Table 1.1 summarises how these trends and factors fit within the Review's approach outlined above and how they feed into its financial model. The Review has also produced projections covering around 60 per cent of personal social services (PSS) expenditure, on the basis of the present position adjusted for population changes in the level of ill health⁷.
- 1.33 Developing a model of the resources required for health and social care over the next 20 years is a complex task. Aside from the challenges arising from the uncertainties of such a long period and the constraints of data, the size and complexity of, and the interrelationship between, the health and social care sectors present a major challenge. For example, health care accounts for the largest portion of public expenditure after social security, with total UK NHS spending expected to be around £68 billion this year.
- 1.34 The Review's analysis of current expenditure on publicly-funded health and social care provides a breakdown by type of activity: for example, elective inpatient admissions, GP visits, district nurse visits, screening, health promotion and stays in residential homes. Approximately 60 per cent of all current health spending has been further broken down by age and sex of the patient and, where possible, by disease group. This breakdown has allowed two approaches to modelling resource requirements: a life-course approach that uses the age breakdown and a disease-based approach.

⁷ PSS expenditure considered in this Review excludes care for children and families and asylum seekers, much of which is not – strictly speaking – health-related. It includes social care for adults with mental health, learning disability and physical disability needs. A detailed model of long-term care for the over 65s has been provided by the Personal Social Services Research Unit at the London School of Economics and Political Science – this includes both NHS and PSS funded long-term care.

Table I.I: Drivers of health need and cost over the next 20 years

		Type of trend	Factor in model
The health service in 2022		Patient and public expectations	Fast access: reduced waiting times
			Safe and high quality treatment: improved clinical governance
			Better accommodation
		Delivering high quality	CHD Renal National Service Framework (NSF) areas Cancer Diabetes Mental health Extending the NSFs to other areas
Scenarios	Impacting on demand	Changing health needs	Demography Life expectancy Proximity to death
			Health status Health needs in old age Impact of health promotion and disease prevention
			Likelihood of seeking care for a given level of need
	Impacting on supply	Technological development and medical advance	Technology and medical advance, including ICT
		Use of the workforce and productivity	Pay and prices Productivity

1.35 Creating the Review's baseline has involved combining data from a wide range of sources. The majority of the data have been drawn from official Department of Health sources, such as the Hospital Episodes Statistics (HES) database. Other data, for example GP visits, have been drawn from surveys. The Personal Social Services Research Unit (PSSRU) at the London School of Economics has provided the baseline data and projections of long-term care for those aged over 65.

1.36 The Review's modelling has involved four stages:

- projecting expenditure to reflect demographic change, but assuming that age-specific use of care and the quality of care remain constant;
- assessing changes, over and above those implied by demographic change, in the type, level and cost of care that will be required to deal with some of the key disease areas over the next 20 years. The Review has analysed in detail the resource implications of meeting the quality standards set out in the NSFs for coronary heart disease (CHD), cancer, renal disease, mental health and diabetes. Together these disease areas account for around 16 per cent of current health service spending. The Review has then examined the possible cost implications of extending these quality standards to other disease groups by extrapolating on the basis of the resource implications of the five for which these detailed plans exist and by making assumptions about the pace of introduction of future NSFs;
- assessing changes in the age-specific use of different types of care from birth to death over the next 20 years. These result from changes in health status due to health promotion and/or wider changes in education and income levels; and from changes in demand for a given level of need related to public expectations about health status which are partly driven by public awareness about health; and
- incorporating the impact of certain key drivers of health care expenditure that apply to all disease categories and ages. These drivers include factors related to the public's expectations for the health service such as improving access to care, better clinical governance and more comfortable accommodation. Other factors such as technological change and potential productivity gains are included here.

Care has been taken in both combining data sources and in the modelling to avoid double-counting of any effects.

1.37 A more detailed summary of the Review's modelling approach is set out in Chapter 4.

STRUCTURE OF THE REPORT

1.38 The remainder of the Report is structured as follows:

- **Chapter 2** describes the Review's vision of the health service in 20 years' time;
- **Chapter 3** outlines how each of the scenarios considered is expected to impact on this view;
- **Chapter 4** sets out a detailed summary of the Review's modelling approach;
- **Chapter 5** presents the Review's estimates of the resources required over the next 20 years under each of the scenarios;
- **Chapter 6** makes a number of observations about the effective use of resources; and
- **Chapter 7** draws together the conclusions and recommendations made.

