

## EXPECTATIONS FOR THE HEALTH SERVICE

The NHS is a national institution that the overwhelming majority of the British public wants to preserve. A universal and comprehensive service that is “there for you when you need it” and contributes to the social well being of the country.

A significant quality gap exists at the moment. Patients are concerned about:

- quick, flexible access to treatment;
- long, empathetic relationships with health professionals; and
- information to make joint, informed decisions.

In 20 years’ time patients will:

- be better informed;
- be more educated;
- not have enough time to get things done;
- be more affluent;
- be less deferential to authority and professionals;
- have more to compare the health service against; and
- will want more control and more choice, rejecting ‘one size fits all’ services.

In the future the public will expect the NHS to provide:

- a universal and fair service that contributes to social solidarity;
- safe, high quality treatment;
- fast access, ‘waiting, but only within reason’;
- an integrated, joined up system;
- comfortable accommodation services; and
- services that are designed around patient’s individual needs.

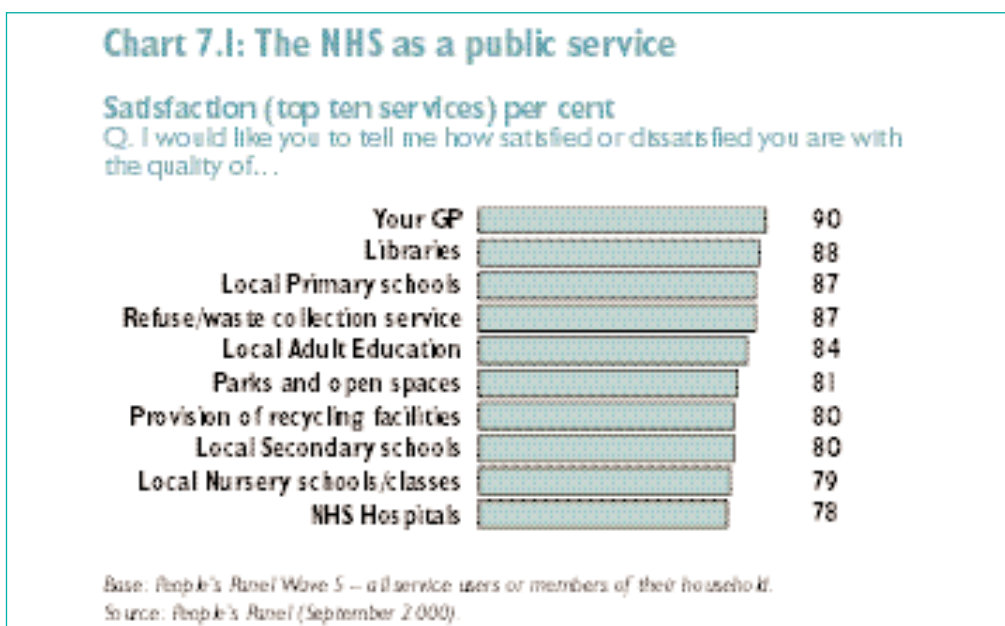
## 7 EXPECTATIONS FOR THE HEALTH SERVICE

### Introduction

- 7.1 Since its inception, the NHS has striven to deliver good quality comprehensive health care including preventive and follow-up services, in addition to treating disease and illness. Views on what constitutes high quality, comprehensive health care differ. High quality from the *professional* perspective includes adherence to professional standards, guaranteeing technical competencies, achieving desired clinical outcomes and rolling back the frontiers of medical knowledge. Quality from a *management* perspective incorporates factors such as the efficient use of resources, complying with organisational standards, identifying and managing risks, and driving service improvement<sup>1</sup>. These are all important attributes for a health care system.
- 7.2 Any attempt to secure a high quality, comprehensive health service must start with the expectations of the people it serves: the public and patients. This Review has tried to develop a broad perspective on what a high quality service might look like in future. The Review has considered the thoughts and aspirations, as reported, of the UK public and has given these expectations a central role in examining the future resource implications.

### The NHS and the public: what do we know?

- 7.3 There is strong evidence of public support for the NHS. Much of the recent research presents a consistent picture of perceptions of the NHS. The picture that emerges is of a national institution that many people continue to hold dear and which, they still believe, performs better than other public services.

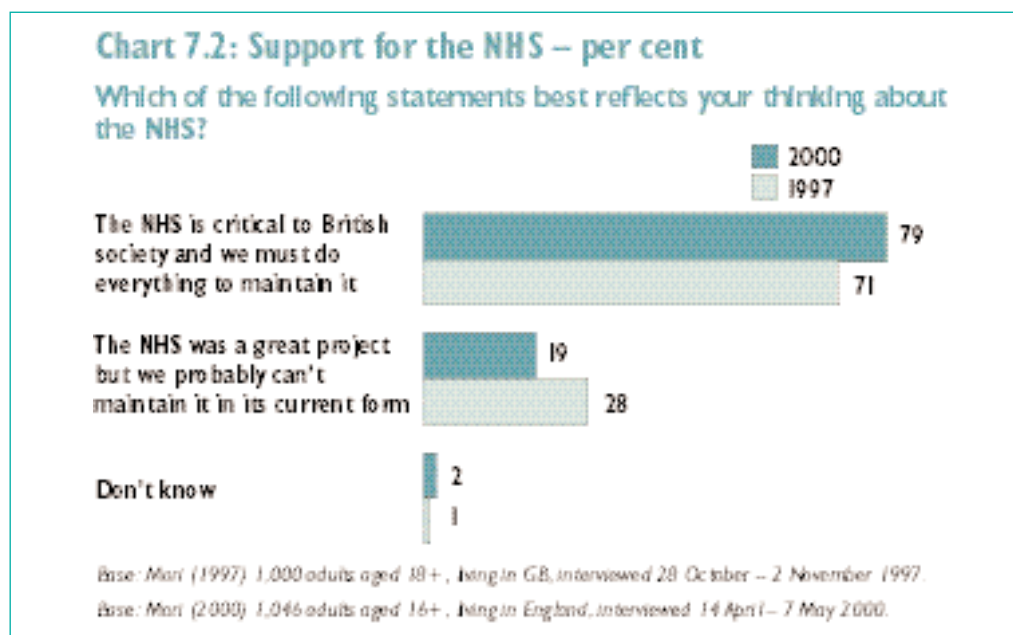


<sup>1</sup> Coulter A (2001) "Improving Quality of Health Care in the United States and United Kingdom: Strategies for Change and Action" Paper presented to the conference on Patient Engagement, June 22-24, 2001, Penny Hill Park, Bagshot.

## EXPECTATIONS FOR THE HEALTH SERVICE 7

7.4 The NHS emerges as a cherished institution that promotes social cohesiveness. People recognise that there are important benefits to society as a whole from a healthy population. They place a high value on the universal access to health care that the NHS provides. The NHS's ethos of treatment based on need, rather than ability to pay, is seen as an important part of a just and fair society. The evidence shows that:

- four in five think that the NHS is critical to British society and must be maintained – this represents an increase of 8 per cent since 1997 (see Chart 7.2); and
- three-quarters of the British public want to retain a universal health service. The British Social Attitudes Survey (BSAS) reveals that over seven in ten oppose a two-tier health service, a figure that has been constant over the 1990s.



7.5 Research from BSAS shows that although public satisfaction with the NHS has varied over the past 20 years, there are some remarkably consistent trends<sup>2</sup>. The key findings include:

- recent users and patients are more satisfied than the general public;
- younger age groups are consistently less satisfied than the elderly;
- people are most satisfied with GP services;
- satisfaction levels for hospital inpatient services are lower;

<sup>2</sup> Muligan J and Appleby J (2001) *The NHS and Labour's battle for public opinion* in Park, A, Curtis, J, Thompson, K, Jarvis, L and Bromley, C (2001), (ed.) *British Social Attitudes: 18th Report*, Sage, London

## 7 EXPECTATIONS FOR THE HEALTH SERVICE

- for hospital care, patients are satisfied with the staff friendliness and the quality of care provided;
- the main areas for improvement are waiting times to see a consultant, waiting for routine operations and waiting time in A&E; and
- the quality of treatment is a concern for just under a third of patients, but is increasing.

These findings are corroborated by a range of other studies<sup>3</sup>.

7.6 However there is a growing acceptance that years of under funding have taken their toll:

- two in three adults view the NHS as under funded and under pressure<sup>4</sup>; and
- the NHS is seen as a key priority for extra spending, particularly among the elderly.

7.7 The BSAS research also confirms that the public is deeply attached to the NHS, and keen to uphold the notions of a comprehensive service free at the point of use. In particular:

- the reported willingness to pay more tax to fund 'a better' NHS has increased over the 1990s rising to 58 per cent in 1999;
- the public are heavily against making the NHS available only to those on lower incomes; and
- only 8 per cent favour charges for visits to the GP; 17 per cent for home visits and 25 per cent for hospital meals.

### A universal and fair service

7.8 The public recognises that spreading individual health risks and resources across society makes for a more effective and equitable system. A National Health Service can ensure that more resources can be devoted to health promotion, prevention and disease management and to reduce inequality and provide health care for the vulnerable members of society.

---

<sup>3</sup> See for example: Airey C, Bruster S, Calderwood L, Erens B, Pitson L, Prior G, Richards N (2001) *National Survey of NHS Patients, Coronary Heart Disease 1999: Summary of Key Findings*, London, Department of Health; Coulter A (2001) "Patients and the NHS" *Wellards NHS Handbook*, Wadhurst: JMH Publishing; Mulligan J (2000) What do the public think? *Health Care UK*, King's Fund, Winter 2000; 12-17; Mulligan J and Appleby J (2001) "The NHS and Labour's battle for public opinion" in Park, A., Curtis, J., Thompson, K., Jarvis, L. and Bromley, C. (2001) (ed.) *British Social Attitudes: 18th Report* Sage, London; Department of Health (1998) *A First Class Service: quality in the new NHS*, London: HMSO.

<sup>4</sup> MORI (2000) "Public Attitudes and Perceptions of the NHS" *Survey Report*, May, unpublished.

## EXPECTATIONS FOR THE 7 HEALTH SERVICE

7.9 Ill-health represents a large burden on the UK economy. On average the UK economy loses around two million working days a week due to sickness absence. These absence levels amount to about 2 per cent of all scheduled working days.

7.10 Sickness is a hidden social tax on business and society which undermines competitiveness and reduces productivity. Ill health impacts on the economy in a number of ways:

- 47,000 working years for men alone are lost every year due to coronary heart disease, and the total lost to all diseases is almost a quarter of a million working years a year;
- the Confederation of British Industry (CBI) estimates that temporary sickness absence costs business over £10 billion a year;
- ill health involves a major loss of productivity potential. 15 per cent of jobless people cite back pain alone as a reason for not working. Back pain accounts for 119 million days of certified incapacity and consumes 12 million GP consultations and 800,000 in-patient days of hospital care a year; and
- there are 2,894,000 people of working age receiving long term sick and disabled benefits. This represents 8¼ per cent of the working age population. The benefits costs are £12 billion a year for those not in work<sup>5</sup>.

7.11 A responsive world class NHS, by providing fast and convenient services would contribute to UK performance in terms of improved health<sup>6</sup>. GDP per head grows faster in countries with longer life expectancy. A recent study found that every additional five years of life expectancy increases the annual growth rate for GDP per head by 0.3-0.5 per cent. This is equivalent to an extra £3-5 billion of GDP in 2001<sup>7</sup>.

7.12 However while the NHS contributes to public health and provides protection against ill health, a recurring criticism is that it is not responsive to people's needs and expectations<sup>8</sup>. Delivering a high quality service over the next 20 years means meeting the public and patients' individual needs and expectations.

---

<sup>5</sup> Department of Work and Pensions, May 2001.

<sup>6</sup> Although not necessarily in getting people back to work, see Normand C (1998) "Ten popular health economic fallacies" *Journal of Public Health Medicine*, 20, 2:129-132.

<sup>7</sup> See Bloom D E and Canning D (2000) "The Health and Wealth of Nations" *Science*, February 18; 287: 1207-1209.

<sup>8</sup> WHO (2000), *The World Health Report 2000, Health Systems: Improving Performance*, World Health Organisation.

## 7 EXPECTATIONS FOR THE HEALTH SERVICE

### Quality and the NHS

- 7.13 The Review commissioned two pieces of primary research to explore patient perspectives on quality in the NHS:
- The Institute for Public Policy Research (IPPR) ran a series of focus groups to explore the influences on patient expectations and examine the public's perception of a high quality service and the current NHS quality gap (see Appendix); and
  - McKinsey and Company examined how patient expectations might change over the next two decades<sup>9</sup>. They looked at trends in other industries and other health care systems and how they are likely to impact on patient and public aspirations for the health service.
- 7.14 The IPPR research showed that the public has high expectations of what the NHS could and should deliver. While the NHS is given some leeway, it is expected to keep up with the generic standards of quality associated with other services.
- 7.15 People compared the NHS against the quality of service they received from many major high street organisations which provide a range of services that are generally tailored, responsive and flexible, and offer excellent value for money. Generally high street services were seen as efficient and joined-up, reliable and providing good levels of communication and information, in contrast to the NHS.
- 7.16 Getting to hospitals or to the GP's surgery can often be a struggle. Hospitals and GPs' surgeries are sometimes poorly served by public transport and car parking is often expensive and in short supply. Receiving treatment on large, mixed-sex wards, having dirty sheets or inedible food, or receiving different or conflicting views from health care professionals can all contribute to negative perceptions.
- 7.17 Overall the public felt that the NHS offered a comprehensive, yet inconsistent service; good in parts but not in others. The key messages from the IPPR research are that:
- many felt that the staff, clinical and primary care services, and emergency treatment and intensive care, were of high quality;
  - the NHS was viewed as providing a poor quality service in terms of care of the elderly, access to A&E and other acute services, its integrated follow-up care, and in terms of its hotel services and health care environments;

---

<sup>9</sup> McKinsey & Company (2001) Expectations of the 2020 UK healthcare system. Health Trends Review: Proceedings of a conference held at the Barbican Centre, London on 18 and 19 October 2001, HM Treasury, November 2001.

## EXPECTATIONS FOR THE HEALTH SERVICE 7

- patients describe their experiences in the NHS too often as frustrating, time consuming, inefficient and, occasionally, frightening;
- the public feel that clinical services and outcomes are not as good as they ought to be when compared to similar countries, in particular for Coronary Heart Disease (CHD), Cancer, Stroke, Mental Health and Diabetes; and
- variations in quality were linked to the recognition that the service is under strain and lacks the capacity to deal effectively with the number of people reliant on it.

### The quality gap

7.18 The IPPR research (summarised in Table 7.1) identifies a high quality service as one:

- where patients can gain access to health care;
- which is responsive and empathic;
- has good communication;
- provides clear information;
- provides appropriate treatment, relief of symptoms; and
- which delivers improvements in health.

7.19 Comparing the NHS today with these standards, some of the biggest quality gaps appear to be around the 'hard' quality factors of providing an efficient, flexible and accessible service:

- patients want quicker, more flexible access to treatment;
- they want longer, good quality relationships with health professionals; and
- they want to be better informed.

7.20 Where the NHS currently excels is as a comprehensive service for everybody; the public values this and wants to maintain it.

7.21 It may be free at the point of access but the public know that the NHS is not free. People have a strong sense that they pay for the health service through taxes and their own 'hard-earned' money. Whilst people recognise that the NHS is a public service, and not a high street bank or supermarket, they increasingly expect the same quality standards to be in place not least in terms of uniform service expectations and responsiveness.

**Table 7.1: The elements of a high quality service**

What makes a high quality service?	How does this relate to the NHS?	What makes a poor quality service?	How does this relate to the NHS?
<p><b>Efficient and joined up.</b> A speedy service where you're seen promptly, where appointments are kept and limits are set for how long you're likely to wait. Efficient management leads to co-ordinated and effective links between different areas of the health service, avoids waste and gives value for money.</p>	<p>"At my GPs I can get an appointment on the same day"                      "My daughter got straight into a hospital bed because the doctor had phoned ahead and had a bed waiting for her at hospital"                      "When my son broke his arm, we went to A&amp;E and he was prioritised over many others there"</p>	<p><b>Failure to deliver and inefficiency.</b> Waiting, cancelling and postponing appointments, poor communication between different parts of the service and unnecessary bureaucracy.</p>	<p>"At my GPs you often have to wait a week for an appointment. What if you are really ill?"                      "I was given an appointment time but still ended up having to wait for 3 hours"                      "I had to wait around for ages because there was a delay in passing records between hospitals"</p>
<p><b>Reliable and consistent: the ability to deliver and meet expectations.</b> Having the staff, facilities and buildings to meet demand (which leads to a desire to see more nurses, more doctors, more beds, more equipment, and more hospitals). The service has the knowledge, equipment and resources to meet demand.</p>	<p>"We had good support from the same midwife before and after the birth of our son"                      "I've had good on-going experience over 19 years with my daughter who has downs syndrome"                      "I had heart trouble about seven or eight years ago and I got checked in and I was straight through. Absolutely no messing. I had all the symptoms of a heart attack and I just went straight through"</p>	<p><b>The service messes you about and doesn't do what it says it will.</b> The service doesn't do the job it's meant to do. There is too much trial and error. Staff are incompetent, unprofessional and unaccountable and don't know what they're talking about.</p>	<p>"My dad was due to go in for an operation and had geared himself up for it and then he was told on the morning that it had to be put back a couple of months"                      "My husband was called in twice for an operation that was then postponed"                      "My daughter was misdiagnosed 3 times before they discovered she had bowel cancer"</p>
<p><b>Communication and information.</b> Staff keep you informed, are honest and sensitive in their communication, offer explanations and can communicate effectively with you in your language. Staff communicate with each other.</p>	<p>"When I had my operation they explained what was going to happen and gave an opportunity for questions"                      "I mean my GP if you go to him he will draw you a diagram and say 'Oh this and this, that's what's wrong, and that's what you want'                      "I mean people don't mind waiting, as long as they are told what is going on"</p>	<p><b>Poor communication and information.</b> Information, when you get it, is inaccurate and inappropriate</p>	<p>"I was waiting around, nobody told me what was going on, I felt like I'd been forgotten"                      "The phone is always engaged when you try and book an appointment or get information from the GPs"</p>
<p><b>Treat you like an individual.</b> Staff have the 'human touch': have time to spend with patients, are caring and understanding, respectful and courteous, look after you as an individual, are responsive to your questions and don't discriminate according to age or disability.</p>	<p>"My wife was allowed to stay in for the week following birth of first child to build her confidence"                      "When I had my operation they explained what was going to happen and gave an opportunity for questions"</p>	<p><b>Lack of personal service and poor communication</b></p>	<p>"I couldn't get to the person at the hospital who I wanted to see and had seen before because they said I had to be referred by my GP"                      "I was told by the surgeon that I should be grateful that he was doing the operation on my father when I made a complaint about him not keeping to the original schedule"</p>
<p><b>Responsive and flexible.</b> You can access services and health professionals easily, when you want to. There is an attempt to accommodate your needs rather than you always having to fit in with the service</p>	<p>"They provided a family room when the whole family was visiting my gran after a stroke"                      "You just walk in there and you go 'can I see Doctor so and so?' And they say 'oh he is a bit busy. He will probably be half an hour' I have never waited any more than twenty minutes"</p>	<p><b>Unresponsive and inflexible.</b> Complicated systems to negotiate, lack of faith in your own judgement, unwillingness to respond to requests.</p>	<p>"My GP twice refused to come out and see my daughter. She ended up going into A&amp;E and stayed in hospital for a week"                      "I had to keep phoning them up to hassle them in order to get the results back from a test"</p>
<p><b>Comfort; feeling at ease.</b> Good food, well-kept and hygienic wards and buildings, Modern hospitals and health centres. Good follow-up care. A good working environment and well-paid staff.</p>	<p>"Nothing was an effort for the staff"                      "The staff went out of their way to help, one nurse stayed beyond her shift to see my son through the worst bit after he'd had a car crash"                      "You need to feel comfortable in every aspect you might be there for. Whether you are waiting to see someone over a problem or if you are waiting for an operation or whatever"</p>	<p><b>Another number, poor staff attitude.</b> Staff talk down to you and don't consider you as another human being.</p>	<p>"Having had a miscarriage I was left on a trolley beside the maternity ward"                      "I went to my GP quite worried about what was wrong with me but the staff were uncaring and told me to come back in two weeks"                      "When my grandfather was admitted to hospital he went missing while the staff just stood around chatting"                      "I was made to feel as if I was being difficult"</p>

# EXPECTATIONS FOR THE HEALTH SERVICE 7

## Future expectations

7.22 Meeting public expectations is the key challenge facing many health care systems. A recent comparison of hospital care in five countries shows that there are significant groups of people voicing concerns about the quality of their countries' health care. Despite this being a problem for many developed countries, the UK had the highest level of patient dissatisfaction (see Table 7.2)<sup>10</sup>.

**Table 7.2: Dimension scores – problem ratings as reported by patients on specific aspects of hospital care 1998-2000**

Dimension of care	Germany	Sweden	Switzerland	UK	US
Information and education	20.4	23.4	16.7	28.7	25.2
Co-ordination of care	17.2	*	13.1	21.9	21.7
Physical comfort	6.7	4.0	2.6	8.3	10.1
Emotional support	21.9	26.0	14.7	27.1	26.8
Respect for patients' preferences	17.9	21.2	15.6	30.7	19.9
Involvement of family and friends	16.6	14.6	11.5	27.5	19.3
Continuity and transition	40.6	40.2	30.0	45.1	28.4

Source: Coulter and Cleary (2001); Picker Institute adult inpatient surveys.

Rates are based on aggregate scores, where 0=best and 100=worst. Rates were adjusted for age and sex.

\* Not included in Swedish surveys.

7.23 Broader trends in society mean that expectations are not standing still and health care systems must respond.

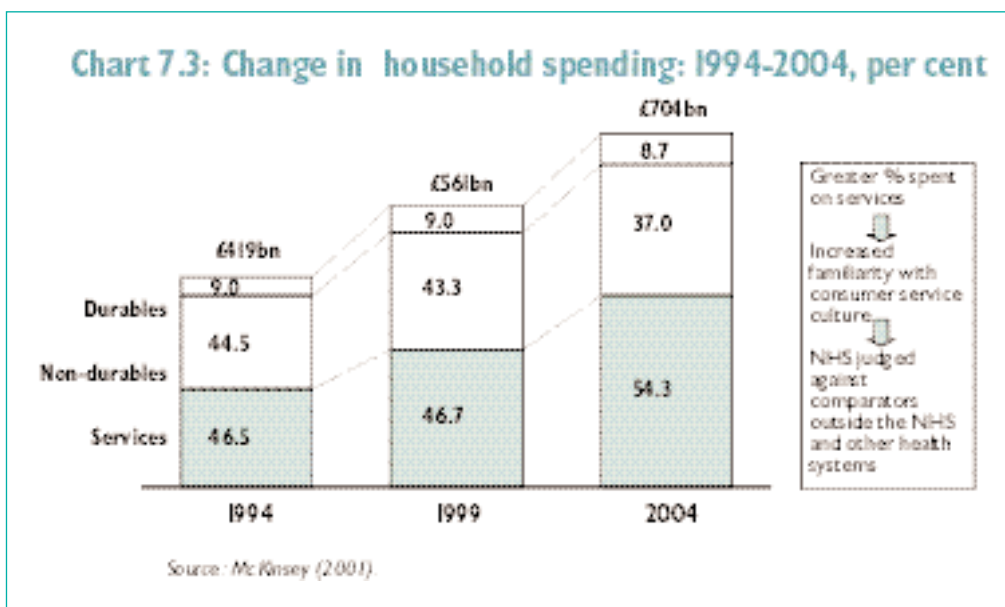
7.24 There are several generic trends that are contributing to the rising expectations placed on the NHS:

- globally, there is widespread evidence of a greater desire for choice as well as increased tailoring of services, especially in more individualised western societies;
- people in the UK now have more than 66 per cent higher disposable income than in 1986 and the expansion in higher education has fuelled rising expectations (see Chart 7.3);
- the continually growing emphasis on high skill, knowledge focused, flexible career paths will impact on health and social services; both in terms of adapting to accommodate these changing lifestyles and meeting the needs these pressures generate, such as increased expectation of increased information and involvement around decision-making;

<sup>10</sup> Coulter A and Cleary P D (2001), Patients' experiences with hospital care in five countries, *Health Affairs* 20(3), 244-52.

## 7 EXPECTATIONS FOR THE HEALTH SERVICE

- changing patterns of work will continue to affect the family, especially the position of women as carers;
- the fact that more people are working and that people are working for longer has meant that people are demanding more accessible and convenient services, available 24 hours a day, seven days a week<sup>11</sup>; and
- there has been a reduction in deferential attitudes and people are increasingly likely to use their 'voice' to complain if they receive poor services. This trend is being felt by health care professionals; complaints to the GMC have risen by 400 per cent since 1995 and GPs are 13 times more likely to face litigation than 10 years ago.



### 7.25 Medical trends also raise expectations:

- medical advances are continually increasing the range of treatments that are available. Increasing success rates have increased people's expectation of being in good health as they get older;
- the number of conditions being officially classified as illnesses continues to grow. Recent additions include: Post Traumatic Stress Disorder (PTSD); Myalgic Encephalomyelitis (ME) and whole classes of workplace illness such as Repetitive Strain Injury (RSI). The number of recognised International Classification of Diseases (ICD) conditions increased from 1178 in 1979 to 2033 in 1993;

<sup>11</sup> Cabinet Office (2000), *Delivery of Public Services, 24 Hours a Day, Seven Days a week (24x7)*, People's Panel, The Stationery Office, London; Cabinet Office (2000), *Open all hours?*, Results from the People's Panel, Issue 5, The Stationery Office, London.

## EXPECTATIONS FOR THE HEALTH SERVICE 7

- people are taking a more active interest in their own health. There has been a rapid expansion in health clubs with an annual forecast growth of 11 per cent in fitness club spend in the UK between 2000 and 2003.
- patients are taking greater responsibility for their health and this is likely to increase in the future as the population ages and acute diseases are transformed into chronic conditions<sup>12</sup>; and
- patients increasingly want access to a wide range of treatments and services beyond the traditional boundaries of the NHS. Spending on alternative treatments such as herbal and homeopathic medicines is growing and is forecast to increase in real terms by 5 per cent a year over the next five years.

7.26 These trends are also driving changes in the roles and responsibilities of patients, the public and health care professionals;

- there is evidence of increased patient co-ordination, action and influence. Paternalistic models of medical authority are increasingly being challenged. Either individually, or collectively via patient groups, people are demanding more influence over what happens to them and the nature of the services they receive;
- similarly ethical attitudes are changing, particularly in relation to technological developments. Some very difficult issues will need to be faced over the next few years;
- there is an increasing intolerance of discrimination on the basis of race, religion, gender or age; and
- many governments are responding to these challenges by increasing the rights of patients and many health care professionals are recognising the need to redefine their relationship with the public<sup>13</sup>.

---

<sup>12</sup> Self-care interventions can have a positive impact on health. See for example Cooper J (2001), *Partnerships for Successful Self-Management, The Living with Long-term Illness (Lill) Project Report*, Long-term Medical Conditions Alliance, London; Illman J (2000), *The expert patient*, Association of British Pharmaceutical Industries, London; Wilson J (1999), "Acknowledging the expertise of patients and their organisations", *British Medical Journal*, 7212, 18 Sept; Department of Health (2001) *The Expert Patient : A New Approach to Chronic Disease Management for the 21st Century*, The Stationery Office, London.

<sup>13</sup> See Smith R (2001), "Why are doctors so unhappy?" *British Medical Journal*; 322:1073-1074, 5 May.

## 7 EXPECTATIONS FOR THE HEALTH SERVICE

7.27 The rapid increase in the amount of information technology is changing relationships. Health and social services are coming under growing pressure to provide more and better information. People increasingly have access to a much wider range of information from a range of different sources. Some of the key trends include:

- more travel and globalisation. People are increasingly making comparisons outside the NHS and looking to other health systems;
- Internet usage is forecast to increase from 16.1 million adults in the UK to 24 million in 2004 (almost four in ten of the population). Over 60 per cent of UK internet users have used it for health-related issues (compared to 47 per cent in the US);
- currently, there are around 10,000 health information websites and the number of new health websites in the EU is increasing by 300 per month. Increasingly these sites contain procedure comparisons and protocols, resulting in better informed patients arriving at the GP's surgery more likely to question the decisions of health care practitioners and the quality of the treatment they receive; and
- commercial and competitive pressures, such as the rapid increase in direct to consumer (DTC) marketing in the US. There is growing pressure to introduce this in Europe to allow drug companies to publicise new drugs and technologies.

### Patient expectations in the future

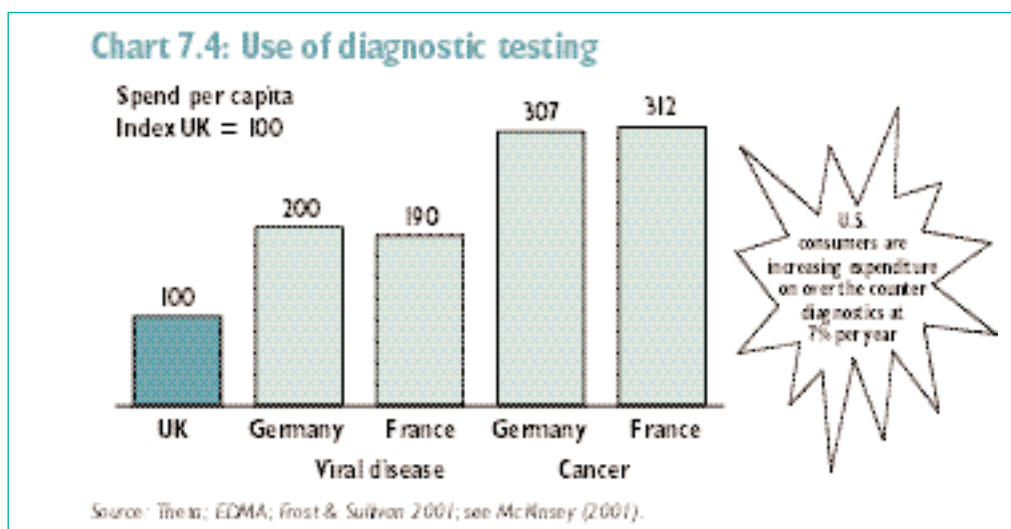
7.28 This Review, in making resource estimates, will assume these drivers translate into challenging expectations. McKinseys analysed these trends, as well as the experience of other industries and systems, to predict patient expectations in the future. This work suggests that over the next two decades patients will expect improvements across five broad areas of quality. These are:

- safe, high quality treatment;
- fast access, 'waiting within reason';
- an integrated, joined up system;
- comfortable accommodation services; and
- a patient-centred service.

## EXPECTATIONS FOR THE 7 HEALTH SERVICE

### Safe, high quality clinical treatment

- 7.29 The safety of the UK health care system is likely to come under increasing scrutiny as information about clinical quality increases. Across many health care systems, the clinical quality of the health care provided has been the focus of heightened attention.
- 7.30 There will always be risks involved in medicine but safe systems reduce the likelihood that somebody will be harmed by medical interventions. Nevertheless there is an increasing awareness of adverse events (such as rates of hospital acquired infections) and underuse and overuse of services.
- 7.31 Wide variations in health care practice continue. The UK lags behind the rest of Europe and the US in the use of the latest technology for diagnostics and communication (see Chart 7.4). The practice of health care is struggling to keep up with the science of health care to ensure evidence-based practice is spread consistently throughout the system.
- 7.32 People will expect that clinical quality will continue to improve; probably at a faster rate than in the past. They will expect a safe, effective and equitable service that is among those providing the best outcomes in the world (see Table 7.3). They will want:
- the best treatment outcomes, with minimum variability of success;
  - the rapid uptake of the newest technology for prevention, diagnosis and communication;
  - greater emphasis on pro-activity by GPs, with focus on lifestyle, prevention, screening and lifestyle;
  - clinicians and other staff 'at their best'; and
  - accurate and helpful information on service performance<sup>14</sup>.



<sup>14</sup> See for example the recent impact of Dr Foster in making accessible to the public information on variations in service provision and outcomes, [www.drfooster.co.uk](http://www.drfooster.co.uk).

## 7 EXPECTATIONS FOR THE HEALTH SERVICE

**Table 7.3: A safe, high quality service**

What?	NHS reality	Comparators	Expectation
The best in treatment with minimal variability of success	Behind on many dimensions	Europe and U.S. have higher 5year cancer survival	To be with the leaders
<ul style="list-style-type: none"> <li>• Uptake of new treatments</li> <li>• Application of best approaches</li> <li>• The best clinicians</li> </ul>	<p>Slow uptake</p> <p>Slower uptake of new technology e.g., laparoscopy vs U.S.</p> <p>Little or no audit data available</p>	<p>Twice as much in Germany, 3 times in France</p> <p>Increasing number of sites providing physician information</p>	<p>A leader</p> <p>Quick, not slow</p> <p>'Somebody capable'</p>
Availability of newest technology for prevention, diagnosis and communication	Lags behind other countries	Use of in-vitro testing for diagnosis of cancer is three times that in the U.K., for viral disease twice	Diagnostics technology available for use in the GP surgery, making the diagnosis quicker and waits shorter
<b>Pro-activity by GPs</b>			
<ul style="list-style-type: none"> <li>• Routine checks</li> <li>• Screening tests</li> <li>• Health advice</li> </ul>	<p>'Only what I go with'</p> <p>Limited to National Screening Programmes</p> <p>Low level of consumer demand</p>	<p>'Patients want regular screening and check-ups for all'</p> <p>US: 73 per cent of visits involved blood pressure check</p> <p>In US, 14 per cent of visits to doctor for diet education, 10 per cent exercise advice</p>	<p>'More than I came for', and option for routine checks</p> <p>Available for a range of conditions, including genomic technology</p> <p>Structured health advice</p>
<b>Quality Clinical staff</b>			
<ul style="list-style-type: none"> <li>• Time spent with physician</li> <li>• Staff updated CME</li> <li>• Motivation and interest</li> </ul>	<p>Mean time with GP: 9 mins</p> <p>Often ad hoc</p> <p>Poor morale Staff shortages Onerous on-call rotas</p>	<p>US, mean time with GP: 18 mins</p>	<p>Option for more time</p> <p>Highly trained staff regularly updated</p> <p>Alert and willing</p>

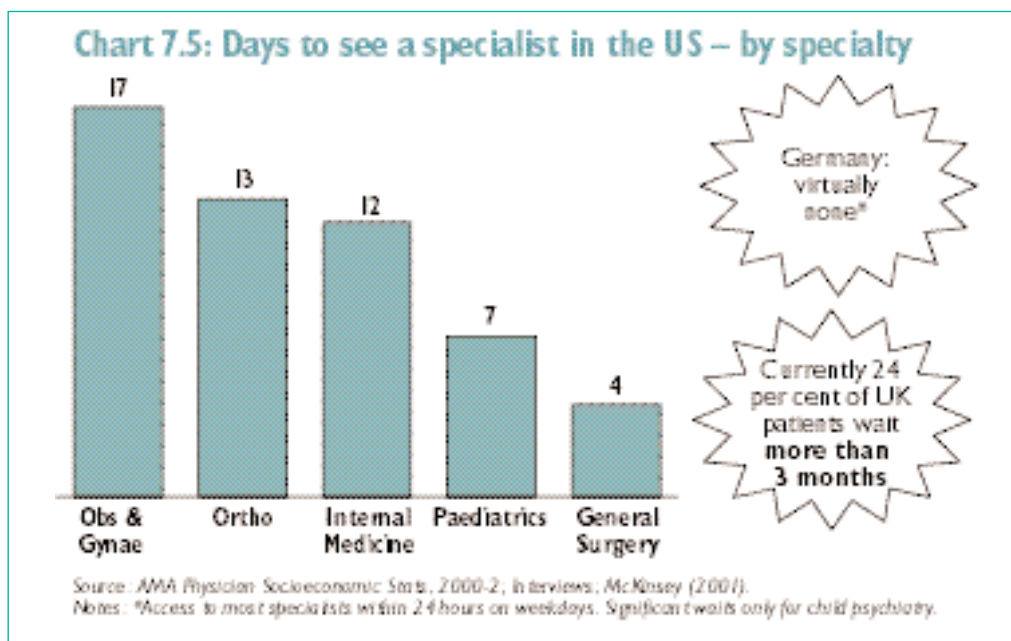
Source: McKinsey (2001).

## EXPECTATIONS FOR THE HEALTH SERVICE 7

### 'Waiting within reason'

7.33 One of the main reasons for dissatisfaction with the NHS at the moment is speed of access<sup>15</sup>. Both the private sector and other comparable health care systems are seen as more responsive to their patients:

- waits in the UK for outpatient treatments are long compared to other key comparator countries (see Chart 7.5);
- at 30 September 2001 there were over one million people waiting for admission to hospital. 43,900 patients had been waiting for over 12 months. 208 English residents were reported as having waited for longer than 18 months for treatment<sup>16</sup>; and
- in the quarter ending 30 September 2001, 78 per cent of patients were seen within 13 weeks, and 96 per cent within 26 weeks, of referral by their GP<sup>16</sup>.



7.34 In the future, people will expect a prompt service with greatly reduced waiting times. They will only be prepared to 'wait with reason'. Where at the moment people wait months McKinseys suggest 'in the future read days or weeks'; where they currently wait weeks, 'read hours or days' and for hours, 'read minutes'.

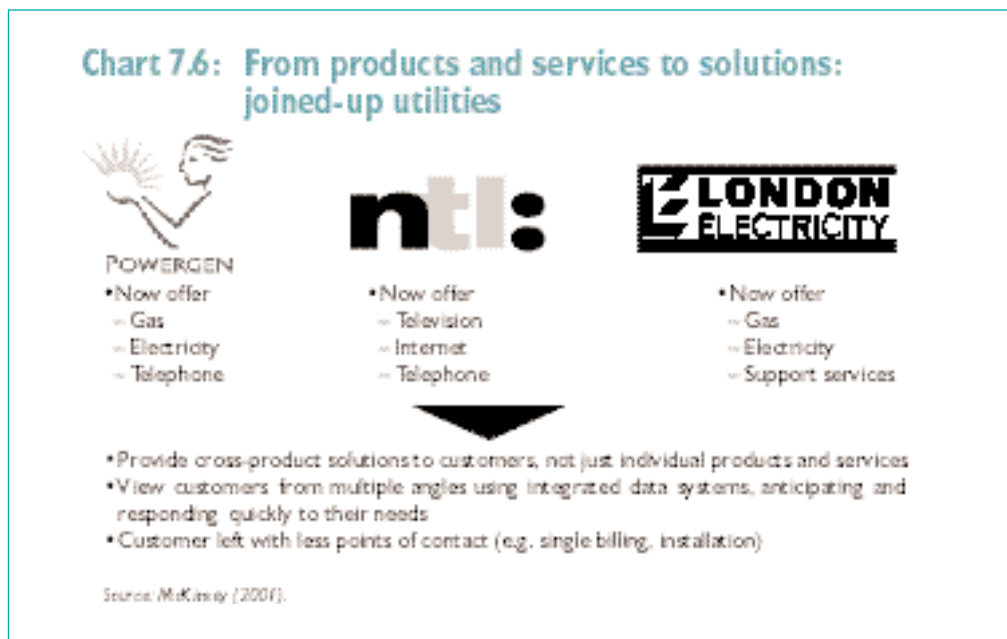
<sup>15</sup> Muligan J and Appleby J (2001), The NHS and Labour's battle for public opinion, in Park A Curtis J, Thompson K, Jarvis L and Bromley C (2001) (ed), *British Social Attitudes: 18th Report*, Sage, London.

<sup>16</sup> Department of Health.

## 7 EXPECTATIONS FOR THE HEALTH SERVICE

### An integrated, joined up system

- 7.35 A safe system is also an integrated, joined-up system. An integrated health system would have effective links between both hospital departments and hospitals and primary care. It would also improve the links between the health service and other services such as social care. These wider links with other agencies will become increasingly important as the population ages<sup>17</sup>.
- 7.36 Too many patients feel they now have to battle with the service in order to get what they want out of it:
- getting past the 'difficult' receptionist in their local GP's surgery;
  - struggling to understand the complicated language doctors use to explain conditions and treatments; and
  - feeling they are constantly having to pester people to get the information or help they need.
- 7.37 People will, increasingly, expect an integrated system that looks after patients' needs providing an efficient hassle free service. Innovations such as the Electronic Health Record will fuel such expectations; patients are likely to be less accepting of requests for repetitive information or communication weaknesses (see Chart 7.6).



<sup>17</sup> See Donelan K, Blendon R J, Schoen C, Binns K, Osborn R, Davis K (2000), The elderly in five nations: the importance of universal coverage, *Health Affairs* 19(3) 226-35.

## EXPECTATIONS FOR THE HEALTH SERVICE 7

### Comfortable accommodation services

- 7.38 In terms of 'quality', other countries and the private sector also score highly in offering a more pleasant environment; the 'home comforts'. The accommodation services available abroad and in private health care are seen to far exceed those available in the NHS. At the moment the NHS is caricatured by bland food, served up in outdated 'Nightingale' wards, with eight patients in a bay in an open ward, with little access to entertainment or communication. In some cases, patients are still having to stay in mixed sex wards.
- 7.39 In the future, patients will reasonably expect comfortable accommodation services; neither 'the Ritz' nor 'a youth hostel'. They will expect:
- healthy food and a comfortable environment. BUPA for example spends double what the NHS spends on food, while, on average, the public spends nearly 40 per cent more than the NHS per day; this is expected to increase to 50 per cent by 2005;
  - a single or double room which is clean and bright and, if necessary, will accommodate a companion to stay, especially with children. For example, at the moment German and French hospitals have a maximum of four beds per room and most US hospitals have two beds per room; and
  - accessible health care settings and not 'old dilapidated Victorian buildings'.
- 7.40 These are minimum standards that, in 20 years, this Review will assume all patients should be receiving from the NHS. However, there is clearly a lot of scope for variations around this minimum. Some people may prefer private rooms or more facilities. The extent of choice and payment for non-clinical services above the minimum is an issue that may need to be addressed in the future.

### A patient-centred service

- 7.41 To meet patient and public expectations, the NHS must provide patients with better information and greater involvement in decisions about their health care<sup>18</sup>. The Picker Institute reports that the most common problems patients report at the moment are that<sup>19</sup>:

---

<sup>18</sup> Cleary P D, Edgman-Levitan S (1997), Health care quality: incorporating consumer perspectives. *JAMA* 278, 1608-12; Cleary P D, Edgman-Levitan S, Walker J D, Gerteis M, Delbanco T L (1993), Using patient reports to improve medical care: a preliminary report from 10 hospitals. *Quality Management in Health Care* 2, 31-38; General Medical Council (1999), *Seeking patients' consent: the ethical considerations*. London, General Medical Council.

<sup>19</sup> See Coulter A (2001), Improving Quality of Health Care in the United States and United Kingdom: Strategies for Change and Action Paper presented to the conference on Patient Engagement, June 22-24, 2001, Penny Hill Park, Bagshot; Coulter A (2001), Patients and the NHS *Wellards NHS Handbook*, Wadhurst: JMH Publishing; Coulter A (2001), Medicine and the media, *Oxford Textbook of Primary Medical Care*, Oxford; Coulter A (2001), The Future in Edwards A and Elwyn G (eds), *Evidence-based patient choice*, Oxford University Press; and [www.pickereurope.org](http://www.pickereurope.org).

## 7 EXPECTATIONS FOR THE HEALTH SERVICE

- there is not enough involvement in decisions;
- there is no one to talk to about anxieties and concerns;
- tests and treatments are not clearly explained;
- insufficient information is provided for family and friends; and
- there is insufficient information about recovery.

7.42 Patients do not all have the same requirements and the NHS must design systems and services accordingly. Increased choice and involvement are not at present key priorities for the public, but the evidence suggests that they are likely to become increasingly important in the future.

7.43 The public is likely to want clinicians to take account of their preferences and to involve them in the choice of treatment and management of their condition. The health service is likely to move beyond informed consent to actively promoting informed choice.

7.44 Many people want to play a part in their own care. They want the NHS to help them do so. Better education, and access to much more information mean that people are less likely to accept a passive role as recipients of health care. They want to be involved not just with their own health but increasingly over how health care is provided.

7.45 There is some choice in the NHS at the moment. Currently patients can choose:

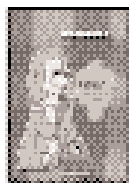
- which GP provides their primary care;
- whether or not to accept recommended treatments (the right of consent);
- how they access advice, though a GP, walk-in centres, NHS Direct via the phone or online;
- what sort of maternity services to use;
- appointment times and booked admissions, i.e. choose when you have your treatment;
- which consultant to meet with or to have a second opinion; and
- some choice on which hospital they are sent to, in discussion with their GP as 'gatekeeper' to secondary care.

# EXPECTATIONS FOR THE HEALTH SERVICE 7

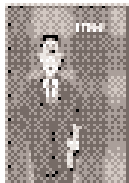
7.46 However in the UK patients' choice is currently limited in practice by:

- supply limitations – when there is a waiting list, the hospital decides if and when a patient receives treatment. Supply constraints also mean that choice is unlikely to exert much pressure on efficiency or innovation; and
- lack of knowledge and information – making patients unable to choose between alternatives.

7.47 McKinsey research suggests that, while patients' expectations for choice and involvement will increase, different patients will want different things from the NHS. McKinsey's identified six different groupings of patients which go beyond traditional socio-economic classifications. These are:



- *Dependers*: depends on contact for reassurance
  - *Anxious seekers*: motivated by fear of ill health
- } high users



- *Stoics*: unconcerned, mostly avoid health care
  - *Avoiders*: in denial until major symptoms appear
- } medium users

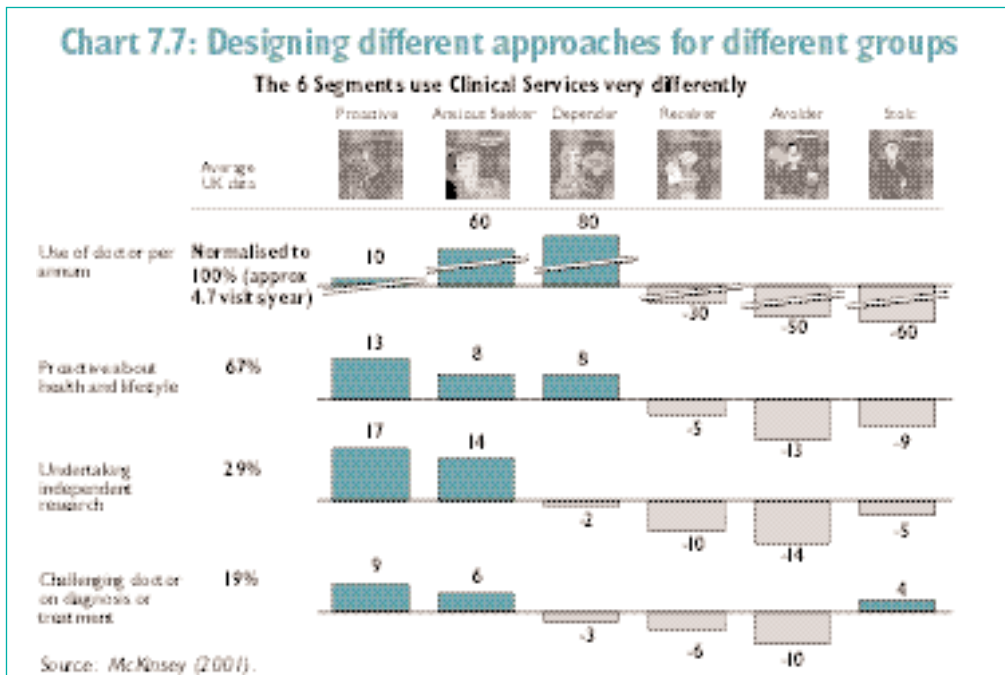


- *Proactive*: realistic, strong personal control
  - *Receivers*: trusting and passive
- } low users



## 7 EXPECTATIONS FOR THE HEALTH SERVICE

7.48 These groups place different demands on the NHS (see Chart 7.7). The trends affecting patient expectations will impact on these patient groups in different ways. The NHS will need to respond differently to different types of patients. Helping patients at risk of a disease to adjust their lifestyle will be very different for proactive groups that for avoiders.



### Conclusions

7.49 Discussion with patients and the public continues to confirm the high support people have for the NHS and its values. The ethos of the NHS – care based on need – commands universal support. Over the next two decades, despite the move to a more consumerist society, patients and the public will continue to expect the health service to provide equitable and fair access to treatment.

7.50 But there are likely to be significant changes in the public and patients' expectations for the health service. In the future, when they access the NHS, patients will expect the health service to deliver high standards, in terms of:

- safe, high quality treatment from a world class service;
- fast access, 'waiting within reason';
- integrated, joined up care;
- comfortable accommodation services; and
- care tailored to their personal needs; a patient-centred service.

# EXPECTATIONS FOR THE HEALTH SERVICE 7

## 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?

## Appendix: IPPR research

A total of six focus groups were conducted in August 2001, structured according to the following specifications.

Location	Age	Details
Leeds	18-24	Young singles
Midlands	18-24	Young singles
South East	30-45	Young families
Leeds	30-45	Young families
South East	50-65	Empty nesters – parents whose children have left home
Midlands	50-65	Empty nesters – parents whose children have left home

All groups were mixed gender but respondents were all from social class ABC1 reflecting our concern with looking at the frontier of patient expectations and its likely evolution over time. Each focus group lasted an hour and a half and was facilitated by an experienced qualitative researcher from IPPR.

The focus group research is published on the website [www.hm-treasury.gov.uk](http://www.hm-treasury.gov.uk).



Delivering a high quality service means implementing world class standards. Over the next 10 years, the commitments in the NHS Plan and the National Service Frameworks (NSFs) to modernise and deliver a patient centred service begin the process of 'catch up' with other health care systems:

- the Review has focused on five disease areas: cancer, coronary heart disease (CHD), cancer, mental health, diabetes and renal disease. Together these cover around 10 per cent of NHS expenditure;
- implementing the NSFs would reduce cancer deaths by a fifth and save 20,000 lives a year from CHD;
- preliminary estimates suggest that delivering best practice might add between 3.5 per cent and 13 per cent a year to the cost of treating these diseases; and
- one of the major components of the cost of implementing the NSFs is the cost of statins to reduce cholesterol for those at risk of CHD. Statins have been found to be cost-effective for those at risk with CHD. If all the 6 million people at risk from CHD are treated this could add up to £2 billion a year to health service spending. Statins represent an example of the medicalisation of risk.

Implementing these standards will mean:

- creating space for clinicians to devote around 10 per cent of their time to professional development and clinical governance activities;
- improving the safety of the NHS by ensuring that people get quick access to the service by significantly reducing waiting times;
- investing in information and communication technology (ICT). The current ICT infrastructure is limited and acts as a major constraint on more effective and efficient ways of working;
- delivering a modernised capital stock and around 100 new hospitals by 2010; and
- ensuring that patients increasingly act as co-workers with health care professionals, taking more responsibility for aspects of their health and health care. This will be supported by technological developments which will allow better information and more self-monitoring.

The Review will need to assess whether these areas are the main cost drivers and whether the estimates of their impact on resources are robust.

## 8 DELIVERING HIGH QUALITY

### Introduction

- 8.1 In the future, patients, the public and the Government will expect a high quality health service free at the point of use and available on the basis of clinical need. The NHS Plan sets out a range of targets and programmes for the NHS over the next 10 years for improving quality and ‘catching up’ with other health care systems.
- 8.2 Many of the initiatives set out in the NHS Plan will help to meet future patient expectations. Their cost implications need to be carefully assessed. The Review proposes to produce costings for each of the components of a high quality service identified, setting out the costs of ‘universalising the best’.
- 8.3 The purpose of this chapter is to set out the many commitments already made for the NHS, which will be a starting point for the Review’s resource estimates. It outlines some of the key assumptions and initial estimates that will underpin the costing of the elements of ‘universalising the best’ to enable the NHS to meet the future patient expectations outlined in the previous chapter. These estimates are preliminary. The Review will need to give further consideration to their robustness.

### A high quality, joined up system

- 8.4 There are two aspects to a high quality, joined up service:
- the setting of standards and associated infrastructure requirements across the whole health care system; and
  - the delivery mechanisms needed to ensure the achievement of those standards.
- 8.5 The task of costing these two elements can build on the quality framework outlined in the NHS Plan:
- NSFs and the Cancer Plan set out common standards for the NHS to achieve over a period of 10 years<sup>1</sup>. The aim is to reduce inequalities and improve the coverage of well proven, cost effective interventions approved by the National Institute for Clinical Excellence (NICE); and

---

<sup>1</sup> The US National Institute of Health recently undertook a major review of the US health care system in the 21st century, *Crossing the Quality Chasm*, and endorsed the approach of setting clear benchmark standards for quality in the most important disease areas. It identified 15 conditions that account for most of the US’s expenditure on health.

<sup>2</sup> Scally G and Donaldson L (1998), *Clinical governance and the drive for quality improvement in the new NHS in England*, *British Medical Journal* 4 July: 61-65.

## DELIVERING HIGH QUALITY 8

- clinical governance provides a “framework through which NHS organisations are accountable for continually improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish.”<sup>2</sup>

8.6 Taken together the NHS plan, the NSFs and clinical governance provide the opportunity to develop a high quality health care system which embodies a patient-centred, no blame, open and questioning learning culture, driven by excellent leadership, and promoting an ethos where staff are valued and supported as they form partnerships with patients.

### Delivering a world class service

8.7 The NSFs provide a useful ‘bottom-up’ approach for estimating the expenditure required to ‘catch up’ to world class standards. The NSFs set standards for prevention, diagnosis and treatment, describe service models and explain how these standards will be delivered and progress monitored. NSFs span traditional organisational boundaries, bridging both primary and secondary care.

8.8 The standards set out in the NSFs take into account:

- evidence of effectiveness and cost effectiveness of interventions to prevent and treat patients;
- evidence about current clinical practice and how to improve the delivery and quality of services;
- current variations in practice and service provision;
- the potential impact of changes on individuals and on the population as a whole; and
- the potential to improve services, equity and health.

8.9 The NSFs specify modest goals in terms of treatment thresholds and do not anticipate how best practice is likely to evolve over the next 20 years. They are primarily a means of disseminating current best practice over a 10 year period and do not take into account technological advances and future patient expectations.

8.10 The Review proposes to estimate the expenditure implications of ‘catching up’ and providing high quality care, taking into account technological advances and future patient expectations in five disease areas:

- CHD;
- cancer;

## 8 DELIVERING HIGH QUALITY

- mental health;
- diabetes; and
- renal disease.

8.11 These have been chosen as priority areas because of the importance of the disease, the availability of interventions of proven cost effectiveness and amenability to monitoring<sup>3</sup>. The purpose of studying these five disease areas is to form a 'bottom up' estimate of the expenditure, for each, required to deliver a world class health service.

8.12 The Review has assessed the coverage of these NSFs in terms of three measures of the burden of disease - mortality, morbidity and expenditure. The NSFs cover around 40 to 70 per cent of mortality depending on age. There are gaps in the younger age group, which relate to injury and poisoning, and in the older age group, which relate to respiratory conditions.

8.13 Assessing the NSFs' coverage of morbidity is more difficult, but estimates suggest that coverage extends to around 12 per cent. The main gaps are musculoskeletal, genito-urinary, skin, digestive, respiratory, eye and ear diagnosis (see Table 8.1).

**Table 8.1: National Service Frameworks – coverage of morbidity (per cent)**

NSF	Disability	Consulting behaviour
CHD	4.1	2.4
CHD – heart failure	2.2	3.6
Cancer	1.1	3.5
Mental health	3.2	0.6
Mental health–suicide	0.0	1.0
Diabetes	1.2	1.0
Renal	0.5	0.1
<b>Total</b>	<b>12.3</b>	<b>12.2</b>

8.14 Table 8.2 shows that the NSFs account for around 10 per cent of expenditure across hospitals, community provision, primary care and pharmaceuticals - ranging from 15.2 per cent of the pharmaceutical sector to 6.1 per cent of community care.

<sup>3</sup> For example the Review does not intend to cost up the NSF for older people as this would involve double counting. Most of the relevant programmes that will benefit older people come from activities not covered in the NSF, such as general targets on waiting times and improvements in the funding of long term care which are costed separately and not by client group. Similarly intermediate care will be dealt with as part of improving rehabilitation. The evidence base for estimating the evolution of the NSF for Children is currently not robust enough for the purposes of this Review.

**Table 8.2: National Service Frameworks, coverage of expenditure by sector (per cent)**

	Hospital	Primary care	Pharmaceutical	Community care
CHD	2.4	2.4	9.0	0.9
CHD – heart failure	1.6	3.6	0.0	0.0
Cancer	6.3	3.5	2.9	0.9
Mental health	2.0	0.6	0.6	3.0
Diabetes	0.6	1.0	2.7	1.1
Renal	0.4	0.1	0.0	0.2
<b>Total</b>	<b>13.3</b>	<b>11.2</b>	<b>15.2</b>	<b>6.1</b>

*Source: Department of Health.*

8.15 The Review will work with these disease areas to produce a range of scenarios centred on the evolution of high quality service standards over the next 10 years. This bottom-up methodology will:

- assess how the changes in demography and morbidity outlined in Chapter 9 might affect this pattern of clinical need;
- identify the quality standards likely to be expected in the UK in the future;
- understand how some of the changes in technology outlined in Chapter 10 might change the volume and mix of resources required to deliver this quality of care and what level of uncertainty exists; and
- examine whether there are any trends affecting the health service which will have a differential effect on health service spending which is outside these main conditions.

8.16 The Department of Health in England has made provisional estimates of the expenditure required to deliver a world class service in the five areas identified above, building on work for the NSFs and the Cancer Plan. Preliminary analysis suggests that providing a world class service ('universalising the best') might add between 3.5 per cent and 13 per cent a year to the cost for these disease areas. These diseases account for one in ten of all health spending. As a result these figures cannot be considered representative of the likely costs of providing a world class service across all disease areas. The following sections discuss the five main disease areas in greater detail.

## 8 DELIVERING HIGH QUALITY

### Coronary heart disease (CHD)

8.17 CHD is common, frequently fatal and largely preventable:

- the burden of CHD is higher, and has fallen by less, in the UK than in many other countries;
- CHD kills more than 110,000 people a year in England, of who more than 41,000 are under the age of 75;
- more than 1.4 million people in the UK suffer from angina and about 300,000 people have a heart attack each year; and
- CHD accounts for around 3 per cent of all hospital admissions in England.

8.18 The NSF for CHD sets out standards for every stage of CHD:

- primary prevention;
- treatment of heart attacks and other coronary syndromes;
- treatment of angina by drug therapy and revascularisation;
- secondary prevention;
- cardiac rehabilitation; and
- heart failure<sup>4</sup>.

8.19 Procedure rates for revascularisation are lower than in comparator countries but the feasible rate of expansion over the next few years is restricted by the numbers of cardiothoracic surgeons currently in training.

8.20 Considerable expenditure is required for faster and more accurate diagnosis and faster access to treatment - notably rapid access chest pain clinics which meet patients' expectations for prompt diagnosis of symptoms, and faster ambulance response times to emergency calls.

8.21 It has been estimated that implementing the NSF for CHD will save around 20,000 lives a year. The majority of these lives saved are from the timely administering of appropriate drugs and technologies such as:

- ACE inhibitors (6,200), aspirins (1,300) and beta-blockers (1,500) in heart attack victims; and
- the prescribing of statins (5,600) in primary and secondary prevention.

---

<sup>4</sup> Examples of the CHD standards and goals are: (a) people thought to be suffering from heart attack should receive thrombolysis within 60 minutes of calling for professional help; (b) everyone meeting the NSF criteria for angiography and revascularisation is identified and treated within three months to the standard set out in the NSF.

8.22 Over the next 10 years, the implementation of NICE recommendations will be a major driver of expenditure - estimated at around £500 million a year by 2010 – reflecting the growing numbers of effective but expensive technologies. Revascularisation is also likely to cost around £500 million a year by 2010.

8.23 However, the main cost driver for CHD in the future is likely to be associated with drug therapy for those at risk of CHD. Statins and subsequent technologies will change the nature of how CHD is tackled, shifting the focus of treatment to those at risk of CHD, rather than those presenting with symptoms:

- the cost per life year saved for statins is £4,000 for secondary prevention, i.e. those who have had a heart attack, and £8,000 for primary prevention, i.e. those highly likely to have a heart attack;
- prescribing statins costs over £350 a year per person. Currently there are approximately one million people receiving statins;
- initial NSF estimates of expenditure assumed that therapy would be confined to people under the age of 70, but there is no reason to believe that therapy should be withdrawn at that age or not offered to older patients; and
- the NSF suggests secondary prevention plus primary prevention for those at high risk of CHD over the next 10 years. The numbers who could benefit are substantial. There are around 1.4 million people in England with CHD and another six million at high risk. This represents around a third of those people over 45 years of age.

8.24 Such assumptions would mean that prescribing statins to those at risk from CHD would cost nearly £2 billion a year by 2010, even before the cost and impact on primary care in terms of managing and monitoring those at risk is taken into account.

8.25 The expenditure estimates assume a 10 per cent offset to statin expenditure reflecting the reduced need for treatment for both primary and secondary prevention. They assume that everyone prescribed statins complies with their treatment plan. This is unrealistic. Research suggests that compliance rates after five years for those agreeing to treatment are approximately 70 per cent. Moreover several statin patents expire before 2010 and competition from generics could develop, reducing these estimates.

## 8 DELIVERING HIGH QUALITY

### Cancer

8.26 The UK's cancer survival rates are among the worst in Europe (see chapter 5):

- in 1999, there were 133,000 deaths from cancer in England and Wales (excluding non-melanoma skin cancer and non-malignant neoplasms);
- deaths from cancer represent 26 per cent of all male deaths and 22 per cent of all female deaths; and
- the Government has pledged that by 2010 it will cut the cancer death rate by one fifth in people under 75.

8.27 Lung cancer, breast cancer, bowel cancer and prostate cancer are the major cancers in the UK and worldwide and will continue to dominate the fight against cancer in 2020 (see Table 8.3).

**Table 8.3: The evolution of the incidence of cancer in the UK**

Now	Number of cases per year (1997)	2020
Lung	38,870	Prostate
Breast	38,270	Breast
Bowel	34,310	Bowel
Prostate	21,770	Lung
Bladder	12,730	Stomach
Stomach	10,480	Bladder
Non-Hodgkin Lymphoma	8,310	Non-Hodgkin
Oesophagus	7,010	Oesophagus
Ovary	6,820	Melanoma
Pancreas	6,710	Leukaemia

*Source: Cancer Research Campaign.*

8.28 The Cancer Plan specifically sets out, by 2006, to match England with the best European standards in response to evidence of poorer survival and unacceptable waits for diagnosis and treatment. The NHS Cancer Plan aims to tackle key areas including:

- ensuring that by 2005 nobody waits more than two months from urgent referral for suspected cancer to the beginning of treatment;
- extending breast screening, cervical screening and piloting a new programme for colorectal screening, with a commitment to introduce other screening programmes as and when research demonstrates that they are clinically cost effective;
- employing 1,000 extra cancer specialists by 2006;
- investing in palliative care to better support cancer patients in the community; and
- tackling health inequalities by reducing adult smoking, particularly among manual workers.

- 8.29 Substantial additional investment and expansion of treatment are required to meet these goals. The main expenditure drivers are additional treatments and the modernisation and expansion of diagnostic equipment and facilities.
- 8.30 The Department of Health has estimated that to deliver these standards by 2006 will require spending of an additional £1 billion a year spread equally across screening, treatment and equipment. This costing covers the full use of currently proven technologies and, in a few instances, anticipates the successful outcome of current research.
- 8.31 In other areas such as equipment, the costing aims to match the standards seen in Europe, but taking into account over-capacity in some European countries. These Department of Health estimates represent the cost to get up to these European standards. The costs of 'keep-up' are likely to be substantially less.

### Kidney (renal) failure

- 8.32 End stage renal failure (ESRF) is fatal in a few months if not treated<sup>5</sup>:
- in England in 1998, 48 per cent of patients had a functioning transplant, 32 per cent were on haemodialysis and 20 per cent were on peritoneal dialysis;
  - the number of patients in England being treated for ESRF has risen by 35 per cent over five years;
  - Renal Replacements Therapy (RRT) consumes almost 2 per cent of the NHS budget, and this is set to rise. The incidence of ESRF increases with age; and
  - the percentage of patients over 65 years of age beginning treatment in the UK rose from 37 per cent in 1992 to 47 per cent in 1998.
- 8.33 England has low acceptance rates for renal dialysis compared with most other major European countries (see Table 8.4).

**Table 8.4: Renal dialysis acceptance rates**

Germany	Netherlands	Spain	Italy	France	UK
162	81	120	130	111	87

*Notes: Per million of the population.*

*Source: Department of Health estimates. Based on 1998 data from a number of sources and collated for the Kidney Alliance.*

<sup>5</sup> Renal Replacement Therapy (RRT) consists of kidney transplantation or dialysis, in which either the patient is connected to a machine which removes toxins from the blood (haemodialysis), usually in hospital, or dialysis fluid is introduced into the peritoneal cavity (peritoneal dialysis). Most patients move between treatments at different stages of their disease.

## 8 DELIVERING HIGH QUALITY

- 8.34 Calculation of the target acceptance rate required to match the best in Europe requires account to be taken of different risk factor profiles across countries. Work to inform the forthcoming renal NSF will be costed on the basis of a target acceptance rate of 145 acceptances per million by 2011.
- 8.35 The difference in the UK's performance in transplant rates is less marked. As shown in Table 8.5, it is well behind that of Spain but not very different from other countries.

**Table 8.5: Kidney transplant rates**

Germany	Netherlands	Spain	Italy	France	UK
30	29	45	24	28	25

Notes: Per million of the population.

Source: Department of Health estimates. Based on 1998 data from a number of sources and collated for the Kidney Alliance.

- 8.36 UK rates may be increased following a Transplant Action Plan now in preparation. The Department of Health has estimated that additional spending of around £400 million a year on renal disease will be needed in 10 years' time in order to meet world class standards and implement the NSF<sup>6</sup>. The estimates take into account several technological improvements in haemodialysis and developments in primary and palliative care which are likely to be the major cost drivers by the time the Renal NSF is fully implemented.

### Mental health

- 8.37 Mental health is the 'Cinderella service' of the NHS. For far too long, mental health has been stigmatised and starved of resources and national attention. However, mental health problems are increasing and likely to be more important in the future:
- at any one time, around one in six adults has a mental health problem such as anxiety or depression, although less than 1 per cent of the population suffers from severe mental illness; and
  - suicide is now the second most common cause of death in those under the age of 35. There are over 4,000 deaths from suicide in England each year.
- 8.38 Such under-funding and neglect is currently being addressed. Mental health was one of the first NSFs and is one of the four priority areas in *Our Healthier Nation*, which sets a target of reducing the suicide rate by 20 per cent by 2010.

<sup>6</sup> Such estimates do not include increases in the transplant rate, which in any case are unlikely to exceed a few hundred a year compared with 20,000 or so on dialysis.

## DELIVERING HIGH QUALITY 8

- 8.39 Most people with mental health problems are cared for by their GP and the primary care team, and this is what they prefer. Generally, for every 100 individuals consulting their GP with a mental health problem, nine will be referred to specialist services for assessment and advice, or for treatment.
- 8.40 Estimates of the costs resulting from implementing a world class mental health care service will cover adults and the elderly, but not children or adolescents:
- the estimates will encompass technological, demographic and medical trends; and
  - demographic trends such as the size and age distribution of the population will be a key driver on the demand for mental health services.
- 8.41 The Department of Health has provided initial estimates which suggest that delivering a world class service would require increasing spending by £3.2 billion a year on:
- preventive interventions based in primary care or in the community;
  - the increased uptake of drugs such as atypical antipsychotics;
  - increasing the number of staff - including 30,000 mental health nurses, 15,000 new primary care workers, 15,000 support workers and 2,000 psychiatrists; and
  - making good past under-spending on capital.
- 8.42 Although the severely mentally ill consume a high level of resources per person, the numbers involved are small compared to those with minor or moderate mental illness, and the major growth will be in the costs of treating mental illness in primary care.
- 8.43 There will be offsetting savings due to a reduction in the costs of mental illness and crime.
- MIND estimate the total costs of mental illness at £37.2 billion a year. Of this, £11.8 billion is lost employment. In 1995 over 91 million working days were lost as a result of mental illness;
  - 30 per cent of employees experience mental health problems and at any given time 5 per cent are experiencing major depression; and
  - Home Office estimates put the overall cost of crime at £58 billion per year with a significant proportion being committed by people with mental illness. Some 90 per cent of young offenders and 90 per cent of prisoners have mental health problems.

## 8 DELIVERING HIGH QUALITY

- 8.44 It is difficult to estimate the exact value of the potential savings, but it does not seem unreasonable to assume that there might be a 5 per cent reduction in the costs of mental illness and a 2 per cent reduction in the costs of crime as a result of the proposed changes, giving a net saving across government as a whole of some £3.1 billion a year.
- 8.45 These service improvements are expected to bring benefits in the form of reduced crime and time off work, contributing to social cohesiveness.

### Diabetes

- 8.46 An estimated 3.2 per cent of the adult population in England, around 1.3 million people, have diagnosed diabetes. It is a group of chronic disorders which involve a raised level of blood glucose. The two most common types are:
- *Type 1* diabetes mellitus, which results from an absolute deficiency of insulin and more commonly detected before the age of 30; and
  - *Type 2* diabetes mellitus, which results from a relative deficiency of, or insensitivity to, insulin and which is more commonly diagnosed in people aged over 40.
- 8.47 Type 1 diabetes is treated by insulin injections. Type 2 diabetes is normally treated by diet or tablets (but may also require insulin).<sup>7</sup> Health care costs are around £1-1.25 billion a year, or 2.7-3.4 per cent of NHS expenditure in England, with most of the costs arising from the long-term complications resulting from diabetes not being properly managed.<sup>8</sup>
- 8.48 The NSF standards for diabetes capture the current evidence base, and implementing the NSF fully would deliver a world class service. The UK Prospective Diabetes Study (*UKPDS*) published in September 1998 showed that better blood glucose and blood pressure control in Type 2 diabetes reduces risk of complications. The diabetes NSF is based on:
- evidence that the onset of Type 2 diabetes can be delayed if not prevented;
  - evidence that tight control of blood glucose and blood pressure increase life expectancy and the quality of life in both Type 1 and Type 2 diabetes;
  - evidence that supported self-care improves outcomes;

---

<sup>7</sup> Around 15 per cent have Type 1 and 85 per cent have Type 2. Prevalence is increasing particularly for Type 2.

<sup>8</sup> Department of Health estimates.

- new therapies and improvements in existing therapies; and
- better understanding that the support of people with diabetes has to go beyond the traditional medical model, reinforced by the emergence of the Diabetes Specialist Nurse.

8.49 Incidence is difficult to predict in diabetes, especially since a world class service would be expected to impact on the incidence of diabetes and its complications. The Review will take into account the increasing incidence of supported self care for the management of Type 2 diabetes and its complications, in line with the trend increase of 3 per cent a year in diagnosed disease.

8.50 The estimated annual cost of the diabetes NSF when fully implemented is around £750 million, with the main costs drivers being programmes to manage major diabetes complications and increase optimal glucose control.

8.51 Nevertheless such NSFs are only one part of delivering a high quality joined up system. The management task for the health service of achieving all of these standards and objectives, even with additional resources, is immense.

### Clinical governance

8.52 The current programme to improve clinical governance in the NHS is the central element of a framework designed to deliver a high quality service. It encompasses safe staff, safe practice and a safe environment and builds on the NSFs.

8.53 The costs associated with poor service should not be ignored as they are significant:<sup>9</sup>

- research suggests that an estimated 850,000 (with a range of 300,000 to 1.4 million) adverse events occur each year in the NHS hospitals, costing £2 billion in additional hospital days. Around a half of these direct costs are avoidable;
- the costs to the NHS of hospital acquired infections has been estimated at nearly £1 billion a year. Around 15 per cent of cases are preventable;
- this is in addition to the estimated £400 million a year cost of clinical negligence litigation; and
- legal costs frequently exceed the amount that the claimant actually receives. Many of the cases of litigation show potentially avoidable causes.

---

<sup>9</sup> Department of Health (2000), *An organisation with a memory*, The Stationery Office, London.

## 8 DELIVERING HIGH QUALITY

8.54 In high quality services, all staff are engaged in quality improvement activities. In the airline industry, for example, pilots typically devote 15 per cent of their time to such quality improvement work on activities such as:

- team training;
- route checking;
- simulation exercises;
- safety training;
- customer service training;
- near miss and adverse incident analysis;
- briefing and debriefing on all flights;
- communication skills and conflict resolution; and
- appraisal.

8.55 Clinical governance is the delivery mechanism which supports the different elements of the quality agenda. Clinical governance is an umbrella term, under which sit a collection of existing and newly developed structures and processes that provide support to the NHS in reviewing the quality of its services and planning ways of working towards future improvement. At the heart of this approach is the clinical team.

8.56 The principal cost drivers associated with clinical governance will be the amount of protected time that is devoted to clinical governance activities. Estimates suggest that<sup>10</sup>:

- medical staff in hospital Trusts and in primary care currently devote approximately 5 per cent of their time to clinical governance activities, principally clinical audit and professional development;
- nursing staff in hospital Trusts and primary care currently devote around 2 per cent of their time to clinical governance activities; and
- similarly, other professional staff currently devote 2 per cent of their time to clinical governance activities.

8.57 From these starting assumptions, the Review will assess the cost implications of all staff devoting 10 per cent of their time to clinical governance and quality improvement activity by 2010-11. These calculations will include all those employed in primary and secondary care, including technical, scientific and administrative staff.

---

<sup>10</sup> Department of Health estimates.

## DELIVERING HIGH QUALITY 8

- 8.58 It is anticipated that clinical governance will need to be operating for five years before the financial benefits of improving the systems of clinical governance are realised. These potential financial benefits may mean a reduction in the rate of growth of some costs rather than an actual fall.
- 8.59 The Review also proposes to estimate the 'price of non-conformance', i.e. the cost to an organisation such as the NHS of not producing the goods or services to the required standard at the first attempt:
- it is widely accepted that the price of non-conformance in many industries falls in the range 25-40 per cent of operating costs;
  - service industries tend to be at the higher end of this range while sophisticated manufacturing industries feature at the bottom of the range; and
  - the British arm of the US-based consultants Crosby Associates have collected data on the price of non-conformance in NHS hospitals. This ranges from 23 per cent to 38 per cent, with an average of 32 per cent. This figure is rising, in part, due to the increased cost of litigation.
- 8.60 For the forecasting exercise, the Review will assume that after five years of the introduction of clinical governance the price of non-conformance will start to reduce. The NHS would be considered world class if this figure could be reduced to 25 per cent of operating costs. The Review proposes to investigate what savings the NHS would realise from year-on-year improvement in the cost of non-conformance up to this threshold.

### New technology

- 8.61 Information systems to support the improvement of service quality will need to be a major feature of the changing health service over the next 10 years. Health care is to a large extent a knowledge-based service industry. Modern e-solutions are enabling the introduction of new knowledge management systems to transform such industries.
- 8.62 The NHS should be part of this general trend. In particular:
- e-health is an essential element in building a patient-focused NHS;
  - e-infrastructure is needed to underpin key elements of the NHS Plan (e.g. booking of appointments and clinical networks);
  - people expect the NHS to keep up to date; and
  - it could alter fundamentally the relationship between patient and professional.

## 8 DELIVERING HIGH QUALITY

8.63 There is a range of new technologies with potential applications to health care:

- the Internet is a rich source of information (albeit unregulated and not always accurate) which can be used interactively and anonymously for patients and professionals;
- digital TV has the potential to provide health information programmes to the public, via dedicated health channels/programmes, or health links from other programmes. Digital TV can also be used for internet and e-mail and is moving rapidly towards greater interactivity;
- PDAs (Personal Digital Assistants) are small, portable computers which could be used by health professionals on the move;
- WAP (Wireless Application Protocol) phones provide some mobile internet access for health care professionals at locations which are convenient for the patient;
- call centres provide telephone access convenient for most users; and
- telemedicine has the potential for medical consultations to be carried out remotely via e-technology, e.g. video links and foetal monitoring by telephone or computer.

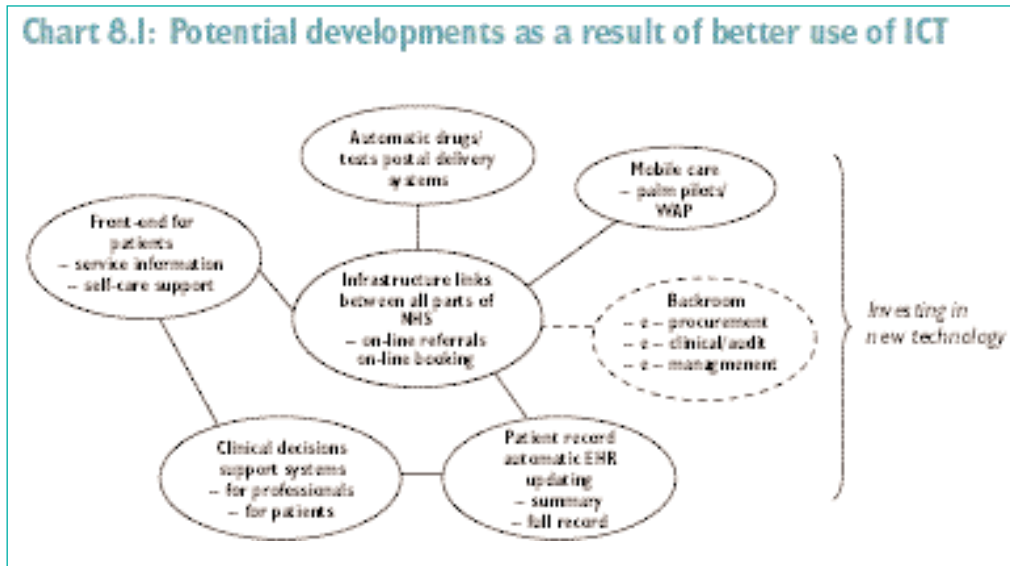
8.64 But as Chapter 10 highlights in greater detail, there has been serious under investment in information technology to support clinical activity in the NHS.

8.65 Improving the quality of information and use of information and communication technology is fundamental to the concept of integrated care, considering the needs of patients rather than institutions. It offers the prospect of developing a 'whole system' approach, breaking down traditional care boundaries and delivering an interconnected care system. It could also contribute significantly to improving the efficiency of care:

- many other organisations have made substantial savings, mostly by replacing costly face-to-face interactions by low cost electronic ones; and
- savings could be made in business to business transactions (both within the NHS and between the NHS and suppliers) as well as NHS to patient transactions.

## DELIVERING HIGH QUALITY 8

- 8.66 Investing in ICT could also have a significant impact on the quality of care through tangible improvements such as ensuring patient notes and test results are always available and identifying malpractice via quality control systems (see Chart 8.1).



### 'Waiting within reason'

- 8.67 The picture of future patient expectations outlined in Chapter 7 suggests that patients will want faster access to health care and to spend longer with health care professionals. A widely recognised facet of any high quality service relates to its ability to provide fast, flexible access to treatment. Some patients have a dangerously advanced stage of disease by the time they are treated.
- 8.68 The NHS Plan makes a commitment that by 2005 the maximum waiting time for inpatient treatment will be cut from the current eighteen months to six months and the maximum waiting time for a routine outpatient appointment will be reduced from over six months at present to three months. Traditional waiting lists will also be replaced with booking systems. The NHS Plan also states that by 2005 each patient will be able to see a GP within 48 hours. In the future, patients will expect only to 'wait within reason'. Some of the modelling assumptions which will be used in the Review are outlined in Table 8.6.

## 8 DELIVERING HIGH QUALITY

**Table 8.6: 'Waiting within reason'**

What?	NHS reality	Comparators	Expectation
First GP appointment	25% of patients wait more than 4 days	Germany and France: on the same day	A reasonable appointment according to need "Sooner if kids involved"
Seen by a specialist	24% of patients wait more than 3 months	In the USA: it is usual to see a specialist within 21 days; in Germany it take usually 24 hours, and in France it takes around 7 days	Days not months
Wait for inpatient admission after clinic and Wales	Average wait of 4.3 months in England by patients insisting	Most delays in Germany are caused upon treatment in a specific hospital France: maximum wait 4 weeks	Days or weeks, not months
A&E – wait for a doctor – Wait for admission	Hours Hours	US: some hospitals have a maximum wait of 30 minutes. Average of 49 minutes In Germany, all A&E patients are seen within minutes of arrival	Minutes not hours

Source: McKinsey (2001).

8.69 Vastly improving waiting times will have a knock on effect and is likely to result in extra activity. A feedback loop of unmet demand will have to be modelled.

### Comfortable accommodation services

8.70 Accommodation services in the NHS are variable and the patient environment has typically been neglected:

- much of the NHS estate is in need of modernisation. NHS 'backlog' maintenance is currently in excess of £3 billion;
- 29 per cent of the NHS estate pre-dates 1948. Many NHS hospitals pre-date the formation of the NHS and are ill-suited to modern medicine. The NHS Plan aims to complete 100 new hospital schemes by 2010;
- the NHS currently provides around 300 million meals a year and the total current spend on food is estimated to be around £500 million a year;
- current information suggests that around 50 per cent of people prefer single rooms, with around 40 per cent preferring multi-bed bays. At the moment the NHS rarely provides in more than 20 per cent single rooms in its hospitals; and

## DELIVERING HIGH QUALITY 8

- over the next 20 years, the number of people preferring greater privacy while in hospital is likely to rise. The reasons given are almost all social rather than clinical - some people prefer privacy, while some want company.

8.71 The main cost drivers in providing comfortable hotel services are likely to be:

- new hospitals and the modernisation of the NHS estate;
- reducing room sizes to four or fewer; and
- improving the quality of hospital food.

### *New hospitals and modernising the estate*

8.72 NHS assets have not always been replaced when necessary. In many instances, this means that health care is being provided in old buildings and by out of date equipment. Some old buildings have been well maintained and are still suitable for the delivery of high quality services. In general, however, a high quality health service would replace or substantially refit buildings at the end of their asset lives, which has been traditionally assumed to be around 60 years in the health service. Provisional Department of Health estimates suggest that if this had happened over the past 60 years, capital charges paid by the NHS would now be around £435 million a year higher than they are currently.

### *Reducing room sizes to four or fewer*

8.73 The Review expects that the number of patients preferring single rooms will increase over the next 20 years and will assume that the majority of beds in newly-built hospitals will be in single en-suite rooms. There are likely to be significant capital costs associated with reducing room sizes to four or fewer, whether in new buildings or refurbishments (although the use of single rooms may mean that supporting space, e.g. consulting rooms, nurses stations, etc. will no longer be needed or will be significantly reduced). There may be other costs associated with this because of a need for more nurses. Higher numbers of en-suite rooms will require more support staff due to higher maintenance and cleaning.

### *Improving the quality of hospital food*

8.74 The Review proposes to assume that patients will expect increased choice in both the type of food and when they receive it. People will still typically want a main meal in the evening, with a lighter midday meal, and with access to snacks through the day. However, it is probably to anticipate that patients (and staff) will increasingly expect a meal to be provided whenever they need it.

## 8 DELIVERING HIGH QUALITY

### A patient-centred service

8.75 In addition to wider societal changes, the growth in information about health and health care providers will increase the pressure for greater choice and a more patient-centred service.

8.76 Research conducted by the Picker Institute suggests that patients' top priorities for a patient-centred service are:<sup>11</sup>

- confidence and trust in doctors and nurses;
- clear explanations of conditions and treatment;
- the opportunity to talk to doctors;
- information about medication;
- involvement in decisions about care; and
- staff who understand anxieties and fears.

8.77 Moreover, there are likely to be positive effects of informing and involving patients such as:

- better and more efficient adherence to treatments;
- more low-risk treatments;
- better chronic disease management; and
- less psychological distress.

#### *Self care*

8.78 The NHS Plan states that “the frontline in health care is the home” and a key component of its vision is self care. Most health care takes place with people looking after themselves and their families in their own homes:

- it has been estimated that self care accounts for as much as 80 to 90 per cent of all care that people need; and
- self care is particularly relevant for people with chronic conditions. One in three people in the UK live with a long-term condition and the trends outlined by this Review suggest that this figure is set to rise.

---

<sup>11</sup> See Coulter A (2001), *Improving Quality of Health Care in the United States and United Kingdom: Strategies for Change and Action Paper* presented to the conference on Patient Engagement, June 22-24, 2001, Penny Hill Park, Bagshot; Coulter A (2001), *Wellards NHS Handbook*, Wadhurst: JMH Publishing; Coulter A (2001), *Oxford Textbook of Primary Medical Care*, Oxford; Coulter A (2001), *The Future in* Edwards A and Elwyn G (eds), *Evidence-based patient choice*, Oxford University Press; and [www.pickereurope.org](http://www.pickereurope.org).

**Table 8.7: Examples of self care support programmes**

Self care support	Purpose and example	Benefits
Health Professional-led clinic	Providing medication management information, e.g. diabetes and asthma clinics	Reduction in drug intake
Professionally led self-management group	Providing skills training in condition management, e.g. skills training for people with ulcerating colitis	Improved health status, better use of care services and better communication with care professionals
Lay led self-management courses	Providing skills training in condition management	Improved health status, better use of care services and better communication with care professionals
Information and symptom management day	Provide disease specific information e.g. MS Society 'This is your Life' project	Increased confidence in dealing with condition, better use of services reduction in specialist visits better use of medication
Lifestyle change programmes	Provide guidelines to prevent strokes, e.g. Hull and East Riding Health Action Zone (HAZ), post-TIA stroke prevention programme	Prevention of stroke for patients who have had a stroke or TIA
Multi-professional partnership programmes	Reduce teenage pregnancy, e.g. North Staffordshire HAZ programme	Increase in self-esteem, partnerships between teenagers, community, schools
Multi-media touch screen booths	Provide audio-visual health information for minority ethnic groups, e.g. Sheffield, Leicester and Nottingham HAZ	Ease of access to information, overcomes problems associated with written information
Audio-visual media-led programmes	Provide health information, e.g. Bradford HAZ drama series	Reach messages of importance to minority groups, enhance social worth of community
Community pharmacy projects	Promote self care of minor ailments	Speedier access to treatment advice, reduction in GP consultations, reduction in prescribing cost and volume, improved supply of over the counter medicines
Back to work projects	Help people with Multiple Sclerosis (MS) get back into employment or hold on to current job, e.g. MS Society Employment Project	Greater confidence in applying for work, skills to manage condition, maintain financial independence
Facilitated self help groups	Share experiences of older people, e.g. Tower Hamlets Diabetes story-telling project	Improved diet and management of diabetes, increased understanding of condition, effective use of medication, reduction in GP visits
Patient support networks and groups	Provide support and disease specific information, e.g. expert patient networks organised by British Liver Trust, Diabetes UK	Reduced isolation, improved ability to deal with condition, more self-confidence
Internet linked information and support networks	Enhance communications between people with disabilities and services, e.g. Swindon communications project	Improved access to information, more choice and control over own lives, more inclusive life in society, training in IT skills

Source: Department of Health.

## 8 DELIVERING HIGH QUALITY

8.79 Evidence suggests that people do not<sup>12</sup>:

- visit GPs when they have sustained access to more informal support networks;
- use mainstream services if they have been trained to take care of some of their long-standing problems; and
- take drugs if they have knowledge or the confidence in managing their conditions in other ways<sup>13</sup>.

8.80 Promoting self care means that people make more appropriate use of health care services. A range of studies indicate self care programmes can reduce:

- GP visits by as much as 46 per cent;
- hospitalisation rates by 50 per cent; and
- outpatient visits by 17 per cent.

8.81 Initial Department of Health estimates suggest that investing in around £200 per person with a long-term condition results in savings and quantifiable benefits of double that amount as a result of fewer GP visits, decreases in hospital admissions and A&E visits, and a reduction in the number of prescriptions and the drugs bill. Taking possible costs on special measures to manage risks into account, the net benefits are estimated at £150 per person.

8.82 Such estimates do not factor in other additional non-quantifiable benefits such as:

- better communication between patients and care professionals;
- better use of health and medical information;
- improvement in clinical outcomes, such as reduction in pain, reduction in disabilities;
- better symptom management;
- increase in self-confidence in managing own health;
- reduction in anxiety and depression;
- reduction in days off work; and
- significant improvement in quality of life.

---

<sup>12</sup> Cooper J (2001), *Partnerships for Successful Self-Management, The living with long-term illness (lil) Project Report*, Long-term Medical Conditions Alliance, London; Illman J (2000), *The expert patient*, Association of British Pharmaceutical Industries, London; Wilson, J (1999), Acknowledging the expertise of patients and their organisations, *British Medical Journal*, 7212, 18 Sept; Department of Health (2001), *The Expert Patient : A new approach to chronic disease management for the 21st century*, The Stationery Office, London.

<sup>13</sup> It is widely accepted that as many as 50 per cent of filled prescriptions are either not complied with or not found necessary by patients. Self care support in the pharmacy sector can lead to a better relationship between the prescriber and the patient; there would be greater respect for values and views of both; the patient would 'select' the medication and be responsible for that choice.

### *Choice and tailoring*

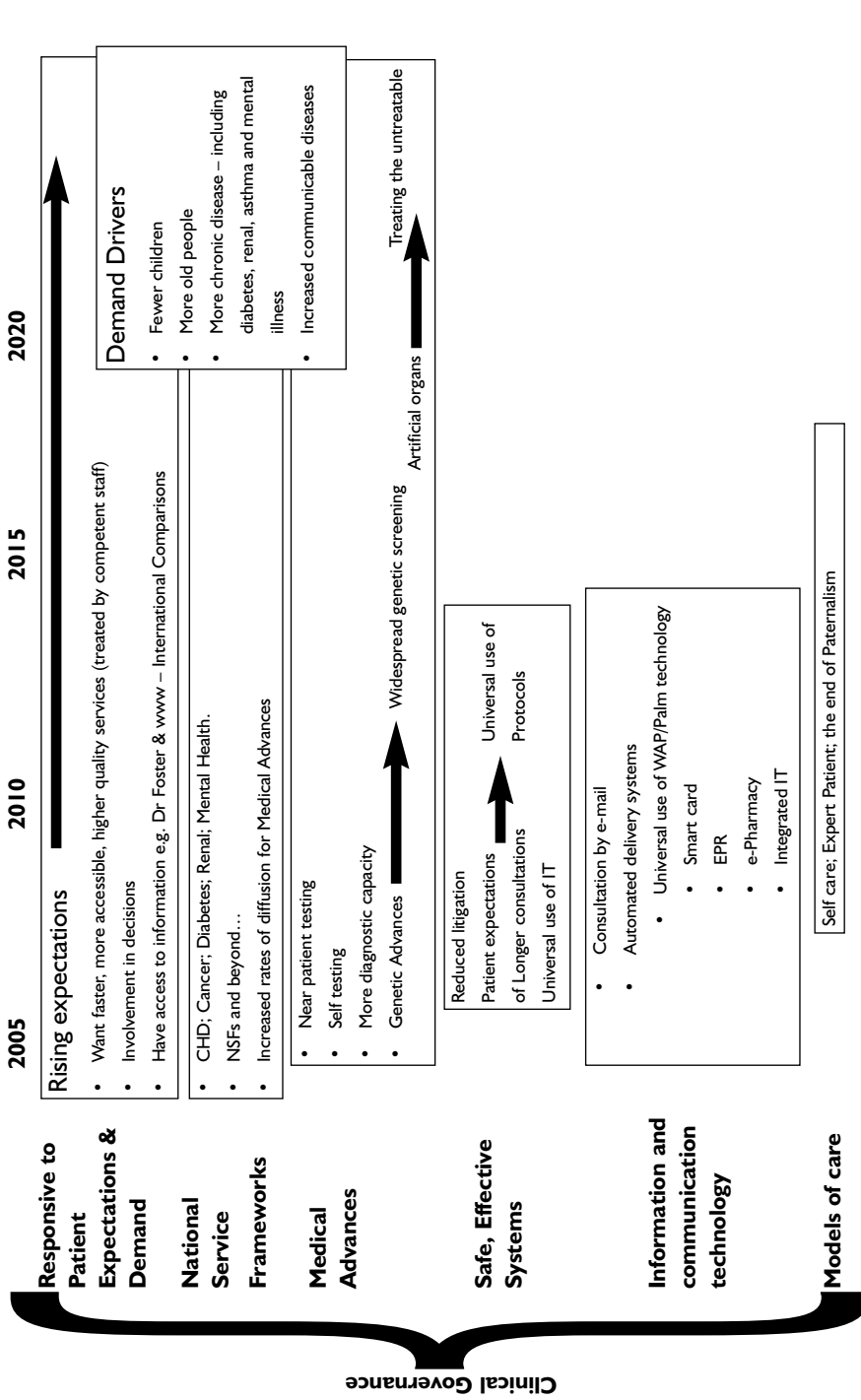
8.83 Existing choices are often implicit rather than explicit, or vague rather than clear. Developing choice in the service will involve:

- providing good quality information about both the providers and the content of care - an essential pre-requisite for enabling real choices;
- developing outcomes and performance data to provide the opportunity to be more radical and specific in the choices made available to patients regarding providers;
- increasing capacity within the service; and
- ensuring that expanding choice does not increase inequity of access to health and health care.

8.84 The Review will assess increasing responsiveness by examining:

- extending choice in primary care;
- enhancing choice in secondary care; and
- increasing the availability and usefulness of information to patients regarding treatment and care.

**Chart 8.2: Delivering high quality**



## Conclusions

8.85 The NSFs and NICE have already begun to set clear national standards for important conditions such as CHD and mental health and for the use of specific treatments e.g. taxanes for breast cancer and Relenza for influenza. These standards, together with effective clinical governance and backed up by better patient-focused methods of monitoring, are designed to raise quality and reduce inequality. Chart 8.2 provides an outline of the components of delivering a high quality service over the next 20 years.

8.86 Over the next 10 years, the main spending pressures are likely to come from more rapid diffusion of existing technologies as the NSFs are implemented, radical improvements in waiting times and a more effective clinical governance system.

### Questions for consultation

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?

