LETTER TO THE CHANCELLOR OF THE EXCHEQUER

Dear Chancellor

In March 2001 you asked me to undertake a Review of the long-term trends affecting the health service in the UK. My Final Report is attached. It builds on the Interim Report which I presented to you in November 2001.

The Interim Report showed how far the UK has fallen behind other countries in health outcomes. We have achieved less because we have spent very much less and not spent it well. That shows up in significant shortfalls in our capacity to deliver. We all have an interest in improving the position, as individuals, businesses and communities. The health services sector is so large, it should become a vibrant sector of the economy, providing not only a healthy population and workforce, but also itself contributing to employment and national wealth.

My Interim Report, based on wide-ranging academic research, described the key factors likely to have an impact on the resources required to deliver a high quality health service over the next 20 years – the health needs of the population, rising expectations, technology and medical advance and the use of the workforce and other productivity changes.

Consultation

Since its publication, the Review has received 130 written consultation responses and I have held discussions with more than 400 people from a wide range of organisations. I have met with many who work in health and social care, often at the front-line, and undertaken a series of international visits to gain a better understanding of other countries' systems. The Review also commissioned an international comparison of health systems.

There was broad agreement in the consultation exercise that we had identified the most relevant factors, although it did highlight some additional points. In particular, respondents noted the need for stronger links between health and social care and the importance of health promotion and disease prevention. These issues are considered in the Final Report.

Main influences

In line with the Terms of Reference, my Final Report attempts to quantify *"the financial and other resources required to ensure that the NHS can provide a publicly funded, comprehensive, high quality service available on the basis of clinical need and not ability to pay"*.

The main influences on the resources required are:

- **commitments already made to improve the quality of the health service and its consistency.** The NHS Plan and the National Service Frameworks (NSFs) include many promises, especially reducing waiting times and guaranteeing specific treatments;
- **changing patient and public expectations**. Further enhancements to quality beyond those presently planned and provision of greater choice will be demanded by patients. Other countries, against which the UK's performance will increasingly be compared, will continue to improve their health outcomes and levels of care. Improved quality such as shorter waiting times will itself tend to expand demand;
- **advances in medical technologies**, including pharmaceuticals. Trends towards the end of the 20 year period are particularly uncertain as a major expansion of knowledge in, for example, genetics might have significant practical impact;
- **changing health needs of the population**, including demography. Over the next 20 years, the changing age structure of the population is likely to have a more limited impact than many have assumed on health service spending. Health care needs may decline with improvements in public health but people, especially older people, will demand more from the service;
- **prices** for health services resources, including skilled staff, have historically risen faster than the general level of inflation and there seems every reason for this to continue; and
- the level of **productivity improvement** which can be achieved. Productivity in the health service is difficult to measure but there are many reasons to believe that resources can be used more effectively. Current use of information and communication technology (ICT) is extremely poor, changes in the skill mix of staff can go further and there is significant scope for better management (and less bureaucracy). If more decisions were taken in a holistic way, recognising the inter-relationships between many of the resources in the system, the health service would be more effective. For example, better integration of health and social care for older people could reduce 'bed blocking' to low levels and free up expensive hospital beds for many more patients.

The health service in 2022

My Terms of Reference asked me to determine the resources needed for a high quality service. That, therefore, needs definition and Chapter 2 of the Report describes the Review's vision of such a service in 2022. Patients are at its heart, demanding and receiving safe, high quality treatment, fast access and comfortable accommodation services. It is therefore far ahead of the present health service and a huge challenge to deliver.

The Review has assumed that the current NSFs are delivered as planned and the NSF approach is assumed to be extended across other diseases. Waiting times are reduced, first meeting existing targets and then going better to achieve maximum waiting of two weeks. Health care professionals devote a significantly greater proportion of their time to

clinical governance activities, improving both quality and safety, and there is substantial investment in modernising and rebuilding both hospital and primary care buildings.

Scenarios

We have estimated the costs of meeting this vision over the next 20 years, first 'catching up' with best practice and then ensuring that the UK 'keeps up'. The cost estimates have been produced for three alternative scenarios, set out in detail in Chapter 3. Each delivers the high quality vision but in different ways:

- scenario 1: *solid progress* – people become more engaged in relation to their health. Life expectancy rises considerably, health status improves and people have confidence in the primary care system and use it more appropriately. The health service becomes more responsive, with high rates of technology uptake, extensive use of ICT and more efficient use of resources;
- scenario 2: *slow uptake* – there is no change in the level of public engagement. Life expectancy rises, but by the smallest amount in all three scenarios. The health status of the population is constant or deteriorates. The health service is relatively unresponsive with low rates of technology uptake and low productivity; and
- scenario 3: *fully engaged* – levels of public engagement in relation to their health are high. Life expectancy increases go beyond current forecasts, health status improves dramatically and people are confident in the health system and demand high quality care. The health service is responsive with high rates of technology uptake, particularly in relation to disease prevention. Use of resources is more efficient.

Resource estimates

We developed a detailed model of health service expenditure to project the cost of delivering the health service envisaged for 2022 under each of the scenarios. Chapter 4 of the Final Report describes the model and how it has been used to produce the Review's estimates of resource requirements. Many other scenarios are, of course, possible and could result in very different estimates.

The Review's spending estimates for these three scenarios are summarised in the table below. In the current year, total NHS spending in the UK is expected to be around £68 billion. To deliver the high quality service envisaged, the Review projects that this will rise to between £154 billion and £184 billion by 2022-23 (in 2002-03 prices). Across the 20 year period this implies total NHS spending increasing at an average rate of between 4.2 and 5.1 per cent a year in real terms.

It is beyond the scope of this Review to plot a detailed path from where we are now to where we would be aiming in 2022. But, we have looked at the profile of spending in five year blocks. The fastest period of growth is in the early years, reflecting the need to deliver improvements as quickly as sensibly possible. Over the next five years, UK NHS spending on this basis would grow at an average annual real rate of between 7.1 and 7.3 per cent. The range is small because the cost increases are largely driven by objectives already announced and common to all scenarios. The growth rate eases back in the

second five years, although remaining well above the historic average. During the second decade, as an increasing amount of the 'catch up' spending has been undertaken, growth reduces further to between 2.4 per cent a year in *fully engaged* and 3.5 per cent a year in *slow uptake* in the final five years.

The *slow uptake* scenario is the most expensive but it is also the one based around the worst health outcomes. *Fully engaged* is the least expensive but based around the best outcomes. Higher spending inputs do not necessarily imply better health outputs and outcomes.

On the simple assumption that private health expenditure remains constant at its present level of around 1.2 per cent of GDP, total UK health spending would rise to between 10.6 and 12.5 per cent of national income in 20 years' time.

UK health spending summary

		Projections			
	2002-03[1]	2007-08	2012-13	2017-18	2022-23
Total health spending (per cent of money GDP)[2]					
Solid progress	7.7	9.4	10.5	10.9	11.1
Slow uptake	7.7	9.5	11.0	11.9	12.5
Fully engaged	7.7	9.4	10.3	10.6	10.6
Total NHS spending (£ billlion, 2002-03 prices)					
Solid progress	68	96	121	141	161
Slow uptake	68	97	127	155	184
Fully engaged	68	96	119	137	154
Average annual real growth in NHS spending (per cent)[3]					
Solid progress	6.8	7.1	4.7	3.1	2.7
Slow uptake	6.8	7.3	5.6	4.0	3.5
Fully engaged	6.8	7.1	4.4	2.8	2.4

[1] *Estimates.*

[2] *All figures include 1.2 per cent for private sector health spending.*

[3] *Growth figures are annual averages for the five years up to date shown. (Four years for the period to 2002-03).*

The results are very sensitive to the assumptions made about productivity in the model. The sensitivities outlined in Chapter 5 illustrate this clearly. In the *solid progress* scenario, UK health spending is projected to rise to 11.1 per cent of GDP by 2022-23. But if, for example, productivity growth was to be 1 percentage point a year lower than assumed and nothing else changed, the equivalent spending figure would be 13.1 per cent of GDP. Conversely if productivity was to be 1 percentage point a year higher over 20 years, the percentage of GDP devoted to health care, all other things being equal, would be 9.4 per cent by 2022-23. This points to the importance of reform alongside additional investment.

Workforce and capacity

In arriving at resource estimates, we have needed to consider carefully both short-term and long-term capacity issues, particularly in relation to the workforce. To aim for too rapid a rate of activity growth risks hitting capacity constraints and simply driving up costs. However, aiming too low would mean delaying much needed improvements in quality and access.

Some of the projected increase in expenditure required will not impact directly on staff requirements. The projections allow for a substantial and immediate expansion in spending on both ICT and the capital estate. But substantial increases in activity are also needed, for example to implement the NSFs and reduce waiting times. Because it takes time to recruit and train new staff and to change the skill mix among the existing workforce, there is inevitably a short-term limit on the pace at which the service can sensibly expand.

Using a model of the workforce developed with the Department of Health, the Review has assessed the plausibility of our activity projections by comparing the implied workforce demand with projections of workforce supply. Even with planned increases in workforce supply over the next few years, I believe that our projections for UK real terms spending growth of 7.1 to 7.3 per cent a year over the next five years are at the upper end of what should sensibly be spent. Indeed, to be wisely spent, they already represent a very considerable management challenge. The figures incorporate assumptions that the significant workforce expansion planned for the next few years is fully delivered, that ICT spending can be doubled and spent productively and that waiting time and NSF commitments are met.

Beyond the short term, there is scope — if action is taken early — both to increase the numbers and adjust the skill mix of staff further than current plans. This is necessary. The increased activity implied by the projections would result in a substantial increase in demand for health care workers: over the 20 year period, at least two thirds more doctors and up to a third more nurses. Assuming that the existing ambitious plans for expanding the skilled workforce are achieved and that estimates of reductions in average length of stay from the National Beds Inquiry are delivered, then without any other action the model projects a small shortfall of nurses by 2020 but a larger shortfall, around 25,000, of doctors, especially GPs.

We explored the contribution that skill mix changes might make to the potential mismatch between demand and supply over the next 20 years. The estimates in Chapter 5 of the Final Report illustrate how workload might be shifted from doctors to nurse practitioners, and from nurse practitioners to health care assistants (HCAs). That will need to be a significant part of the solution. But there will also need to be an increase in the numbers of doctors and nurses over that already planned. This should be achievable if the current discussions about pay modernisation for GPs, nurses and consultants result in improved recruitment and retention and deliver the flexibility needed for future management of resources.

Social care

My visits, reinforced by many consultation respondents, showed the importance of integrating thinking about health and social care. No review of health care resources would be complete without considering the link between them.

I have, therefore, considered it necessary to go beyond my remit to begin to consider social care; although the Review could not build up detailed projections in the same way as for health care. I recommend that any future reviews should fully integrate modelling and analysis of health and social care. Indeed it is for consideration whether a more immediate study of the trends affecting social care is needed.

As a first step, in the Final Report, I have included projections of personal social services (PSS) spending in England covering spending on the elderly and on adults with mental health problems and physical and learning disabilities. These calculations take account only of the present baseline spend adjusted for population changes and changes in the level of ill health. They show spending rising from £6.4 billion in 2002-03 to between £10.0 billion and £11.0 billion in 2022-23 (in 2002-03 prices). The average annual real growth rate rises over successive periods, from between 2.0 and 2.5 per cent a year in the first five years to between 2.7 and 3.4 per cent a year in the final five years. This confirms the finding in my Interim Report that demographic change and, in particular, the ageing of the population is a more important cost pressure for social care than for health care. These figures do not include estimates of any additional increase in the level of resources required to deliver higher quality in social care or more imaginative planning of the whole of social care. The figures quoted are therefore under-estimates of the additional resources which will be required.

Effective use of resources

Success in achieving a high quality health service will not be guaranteed by spending the amounts of money estimated in this Report. In working through the modelling and absorbing the views expressed in consultation, many issues arose about the way in which resources are currently being used in the health service. Both additional resources and radical reform are vital: neither will succeed without the other.

Chapter 6 of my Final Report sets out a number of observations which I hope will help the debate about how best to use resources. I would differentiate strongly between, on the one hand, issues of local delivery and, on the other, the central role of government in setting standards, regulating health and social care services and establishing those processes which determine how information and money should flow.

As far as standards are concerned:

- in addition to examining newer technologies, the National Institute for Clinical Excellence (NICE), in conjunction with similar bodies in the Devolved Administrations, should examine older technologies and practices which may no longer be appropriate or cost effective;
- the proposed extension of the NSFs to other areas of the NHS is very welcome. NSFs and their equivalents in the Devolved Administrations should be rolled out across the rest of the health service. In future, they should include estimates of the resources – in terms of the staff, equipment and other technologies and subsequent cash needs – necessary for their delivery; and
- a key priority will be to invest effectively in ICT. A major programme will be required to establish the infrastructure and to ensure that common standards are established. Central standards must be set and rigorously applied and the budgets agreed should be ring-fenced and achievements audited.

Evidence-based principles need to be established for public health expenditure decisions. In consultation, the possible benefits of increased investment in health promotion and disease prevention were stressed. As the Review's model illustrates, lifestyle changes such as stopping smoking, increased physical activity and better diet could have a major impact on the required level of health care resources. Given the projected increase in old people

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

The NHS has had many reorganisations over its history, the most recent happening at present with the establishment of 28 Strategic Health Authorities (StHAs) for England. The challenge now must be to ensure that this new structure works effectively and involves a high degree of accountability and public involvement at local level.

The current reorganisation of the NHS is pointed in the direction of decentralisation of delivery to local units. I am convinced that direction is right and that greater local freedom can improve the overall health service significantly. It could develop much further with powerful benefits possible from innovation and experimentation in resource management.

Rigorous and regular independent audit of health spending will be necessary to ensure that all resources are being used efficiently. Incentives for local performance will be necessary but targets should be used with care. The health and social care services are complex and have many objectives which are difficult to aggregate. They do not lend themselves to a small number of targets because of the danger of mis-allocation of resources that would bring. Rather the audit process should examine performance in the round against the wide range of objectives which the central standard-setting process would set.

As the NHS Modernisation Board noted in its recent Annual Report, progress towards the NHS Plan objectives has been variable, and there still remain a number of difficult issues such as waiting times and clinical quality. The balance of health and social care is still skewed too much towards the use of acute hospital beds. More diagnosis and treatment should take place in primary care. There is scope for more self-care. Modernising the NHS needs at least a 10 year programme of change as well as additional resources. Clear signs of progress will be necessary if the health and social services are to command continuing public confidence and support.

The governance of local delivery of health care could usefully include wide community representation, for example, of both patients and the business community. This would be a useful step towards better public engagement, which the Review shows could play a major role in the future stability of the NHS. Better public health programmes as well as the results of independent audits and publicity about local units' performance should help.

On funding, the majority of those expressing views agreed that the current method of funding the NHS through taxation is relatively efficient and equitable. The Interim Report concluded that the current system is both a fair and efficient one. I remain of that view. The need for equity and to avoid any disruptive change while such a huge process of change is already underway seem to me very persuasive arguments. The way in which the resources are raised to fund health and social care will continue to be an issue for consideration in the light of the UK's overall economic performance. The important issues, as far as funding is concerned, will be the long-term sustainability of the sources of funding and the confidence with which those responsible for delivery can plan ahead.

On more minor specific issues raised, my own view is that it would be inappropriate to extend out-of-pocket payments for clinical services but there may be some scope to extend charges for non-clinical services. This would potentially help provide more choice for patients. If non-clinical charges are to be considered, then the policy on exemption

from prescription charges could usefully be examined at the same time, as the policy ought to be more clearly aligned with the principles of the NHS.

A list of all my recommendations is included in Chapter 7 of the Report.

Conclusion

The Review flags the need for a very substantial increase in resources for health and social care. This increase could be moderated if the NHS could achieve better productivity than the Review assumes. If the extension of the NSFs to all disease areas costs less than predicted, the increase would also be reduced. If there were to be more success in implementing public health measures then the long-term costs of health care treatment could be limited.

The resource increase envisaged could also be moderated by delivering high quality as defined over a longer period or if it were to be decided that some of the improvements, when considered in detail, did not provide value for money. Information about all these issues should be gathered more systematically in future.

Your decision to establish this independent Review has been widely welcomed. I believe that there should be a further review in approximately five years time to re-assess the future resource requirements. A future review would benefit from a fuller information base and further research in the areas I have indicated. In particular, health inequalities affect the resource requirement for health and social care but knowledge of how socio-economic need and health need are related is incomplete. This is a major area of uncertainty for the future. Subsequent reviews should be able to draw upon the better information, research findings and international knowledge base which I recommend in Annex A.

I am conscious that a thorough analysis of all the issues in the Devolved Administrations was not possible given the data constraints I have outlined. These constraints too should be addressed and any future review of this kind should examine the regional variations within England.

Finally, I would like to express my thanks to all those who have assisted me. The Advisory Group, listed in the Interim Report, gave expert advice. I am also grateful to all those I met and those who sent responses to us but, most of all, to the superb Review team which supported me led extremely ably, before the Interim Report, by Anita Charlesworth, and after it, by Ian Walker.

Thank you for the opportunity to conduct such a stimulating Review. I have sent copies of this letter and the accompanying report to the Prime Minister and to the Secretary of State for Health.

Yours sincerely,

Derek Wanless

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