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Improving efficiency in the NHS in England: options for system reform

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Background

The financial settlement for the NHS from 2011 onwards will be lean. How lean will not be clear until the intended comprehensive spending review in the autumn of 2010. The NHS Operating Framework 2010/11 advised that primary care trusts (PCTs) should plan for 'real flat' growth in revenue allocations in 2011/12 and 2012/13 and reduced capital allocations.[1] Official NHS sources suggest the gap between supply and demand will reach £15–20bn by the end of 2013/14. Achieving cash releasing efficiency savings on this scale will be a severe challenge.

Considerable central efforts have been made to support providers to make efficiencies. For example, through the Quality Improvement and Innovation Programme (QIPP) initiative at the Department of Health (DH), and through the work of the NHS Institute for Innovation and Improvement, for example in the 'productive ward' series. Locally, better information systems in particular on costs, for example through service line reporting and patient-level costing in foundation trusts, are allowing much better scrutiny of the costs of care delivered by managers and, crucially, clinicians.[2] There has also been improvement in financial management locally by PCTs and trusts as reported by the Audit Commission.[3] The NHS is in a better state than ever to identify where efficiencies can be made and to identify large variations in practice.

Yet there is evidence to suggest that there is significant room for progress. Productivity, for example, has declined over the last decade in part due to large increases in the numbers of staff without concomitant rises in outputs; there continue to be large and unaccountable variations in clinical practice; there have been significant rises in emergency admissions to hospital for patients with conditions amenable to primary care and for admissions with zero length of stay[4]; there has been no real shift in care from hospital to community settings whether because of more effective prevention of ill health or substitution of care; and suboptimal care across provider and budgetary boundaries continues to cause avoidable cost through duplication and preventable ill health. Measures to assess the quality of care are still underdeveloped and for most managers and boards of NHS institutions, quality comes second to balancing budgets. This means that the NHS now enters an era of significant budgetary challenge without routine measures of assessing the impact on quality of care of cutbacks and, for many providers, without detailed information on costs.

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This paper outlines some options available to the DH in the short to medium term. They fall in three broad areas: 'system reform' level (that is external to NHS organisations such as introducing more competition, and altering the national tariff); at the level of NHS commissioners and providers (that is internal to NHS organisations such as improving leadership, information and local incentives); and at the professional or individual level (for example, by improving intrinsic motivation towards shared goals). The focus of this article is mainly on what can be done at national level by the DH, the new NHS board, or the proposed new economic regulator to improve efficiency and reduce costs.

National options to improve efficiency

Targets and performance management

Targets with tight performance management by strategic health authorities (SHAs) and sanctions for those commissioners breaching annual budgets are by far the strongest tools available centrally to control expenditure in the NHS. For example, requiring general practice (GP) commissioning consortia to 'top slice' needed efficiency savings from budgets at the beginning of the year is an effective, albeit blunt, tool. But how targets and performance management will apply to the new GP commissioning consortia is currently unclear.

The coalition government can also reduce administrative costs in the NHS on the bodies it can directly control, hence its action to reduce the number of PCTs and SHAs, and grant-in-aid to arms length bodies, such as the Care Quality Commission.

Tariff

The control of the national tariff price is probably the second most powerful lever open to the DH (or the proposed economic regulator which will assume this function) to keep NHS expenditure down. As the Audit Commission recently noted in a paper analysing productivity in the NHS 'it is a much more secure strategy to set a low tariff than rely on PCTs to cap activity'.[5] In 2010/11 the uplift in the tariff will be zero and will be a maximum of zero in the following three years according to the NHS Operating Framework 2010/11. Reducing regulated prices (national tariffs) is a blunt way of forcing efficiencies because evidence from econometric studies suggests that if the tariff reduces to below the marginal cost of care in a provider, the quality of care reduces in a competitive environment.[6] This is likely in the NHS as there are inadequate measures of quality in place with which to monitor the care given by providers.

The national tariff can also be used to provide disincentives for local providers to provide certain types of care. For example, the tariff for emergency admissions over the planned volume contracted with the local PCT commissioner is 30% of that for an emergency admission within the volume planned. It is intended that the tariff will also now cover the 30-day period post-discharge, to encourage hospitals to reduce readmissions. An area to review is the high tariff price for short-stay emergency admissions.

Allowing closures or reconfigurations of hospitals and other services

Over the last 30 years the number of beds in NHS hospitals has reduced by 30% – similar to international trends. In the last 20 years there have been countless reconfigurations and a marked reduction in the number of facilities. These changes have been driven by new technologies, changes in clinical practice as medicine evolves, the need to make efficiencies because of funding constraints, better information uncovering differences in quality of care and thus the need to concentrate highly specialist care in larger centres. Hospital and service closures are clearly highly contentious and politicised decisions. In today's financial climate a different order of political leadership will be required – local and national – to allow the local decisions needed in the short term.

Monitor quality and therefore value

It is critical that over the next five years cuts are not made blind of the effect on quality. The new quality accounts for NHS trusts should help, but underlining their importance alongside the financial accounts will require high and persistent pressure from the DH, National Commissioning Board, Monitor (in the case of foundation trusts) and local GP commissioners to encourage the boards of providers to focus at least as much on quality as costs.[7]

There is now more focus on quality, for example through the new quality observatories in each SHA, and in the 'Better care, better value' indicators developed by the NHS Institute. Quality accounts are also being piloted for primary and community services in two SHAs. But as the measures of outcomes of care remain relatively underdeveloped, in the face of significant budget cuts it will be very important to make more use of existing local systems to monitor patient feedback on care received. This should be an urgent concern of the proposed NHS board and GP commissioning consortia.

Cut staffing and freeze pay

The NHS employs 1.3 million people and the pay bill in the NHS is approximately 40% of all costs rising to approximately 70–80% in acute NHS trusts. Most non-medical staff are on contracts agreed through Agenda for Change, which increases staff costs in real terms by 1.5% per annum due to annual increments in salaries which equate to approximately £420 million per year.[8] The three-year pay deals agreed under these contracts expire in 2011 when they can be renegotiated, and the deal is likely to be much tougher and yield significant savings because of the large number of staff on these contracts. The government has recently announced for 2010/11 a wage freeze for senior NHS managers, most consultants, general practitioners (GPs) and dentists with a minority of GPs and dentists employed directly by the NHS receiving modest rises of 1–2%.

Significant inflation of the salaries of GPs occurred since the new national General Medical Services contract was introduced in 2004. It is highly likely that these national contracts will be reviewed again to require greater productivity, and payments to practices held down over the next few years. The pros and cons of national contracts for general practices must surely come under scrutiny in future for other reasons, for example to try to remove potential obstacles to the development of more integrated cost-effective care.

The cost of NHS pensions was approximately £12.5bn in 2009/10 with employers' contributions set at 14% of pay.[9] It is unlikely that pension benefits in the short term will alter for existing staff, so the scope for significant reductions in pension costs is small.

Costs of prescription drugs

Prescription drugs account for about 12% of PCT expenditure or £7.5bn. Branded drugs account for 80% of spend and 20% of volume, and generic the remaining 20% of spend but 80% of volume. Nationally the prices of branded prescription drugs are negotiated every five years between the DH and the pharmaceutical industry under the pharmaceutical price regulation scheme (PPRS) resulting in a voluntary agreement between DH and the industry. The last PPRS came into effect in January 2009 and included for the first time support for innovation and uptake of clinically and cost-effective medicines which together are designed to reduce the costs of prescribing in the NHS by 5% by 2014. In a review of the PPRS in 2007, the Office of Fair Trading recommended the DH take much more active steps to develop value-based pricing, particularly for drugs that create the biggest revenues globally – those used for conditions that are chronic and non fatal. This should be pursued.

Procurement

The DH has been active in a number of ways to help increase efficiency within the NHS in back office functions, information technology (IT), use of property and procurement of supplies. Some of the recommendations of the Operational Efficiency Review commissioned by the Treasury have fed into directives and guidance.[10] *Smarter government* emphasised the setting of benchmark comparisons for back office functions, and signalled significant reductions in spending on IT, external

consultancy support, and communications and marketing, which in turn are requirements set out in the NHS Operating Framework 2010/11.[11]

However, as the National Audit Office and Audit Commission pointed out in their recent review of collaborative procurement across the public sector, public bodies are still conducting 'expensive procurement exercises rather than using existing framework agreements to buy standard commodities such as stationery, computer equipment and travel services'.[12] As a result, wide variations in the prices paid by the public sector for key commodities were found. A key recommendation was that the Office for Government Contracts (OGC) should develop a consistent across-government approach for all spending by the public sector on procurement. This should be implemented.

Reduction of central budgets

This option is already taking place, although central budgets (eg for expenditure on the DH) are a small proportion of overall NHS spend.

Strengthening commissioning

NHS commissioners clearly have an important role through the contracting mechanism to encourage greater efficiency among providers, in particular hospitals. Yet as noted above, both PCTs and practice-based commissioning groups, and their predecessors, GP fundholding and total purchasing pilots, have been unable significantly to restrain demand for hospital care, in particular emergency admissions.[13–14] PCT commissioning, and practice-based commissioning, are widely assessed as being weak.[15–16] It is unlikely that national attempts to upskill commissioners, for example through world-class commissioning assurance process, can by themselves result in significant change in the efficiency and quality of clinical care in the short to medium term. Many PCTs (and future GP commissioning consortia) are too underdeveloped and small to attract the management, analytical and clinical expertise needed. They will need to evolve into larger entities, perhaps initially by sharing back office functions and other business services. This will take time and investment in management.

Information, guidance and support

The DH funds the development of a huge amount of information on how to improve efficiency and boost quality, for example in its own work through the Quality, Innovation, Productivity and Prevention (QIPP) initiative, and in funding the work of the National Institute for Health and Clinical Excellence (NICE) and the NHS Institute and the Public Health Observatories. Consequently there is no shortage of guidance available, for example the productive ward series and information about lean management processes available from the NHS Institute.[17]

Similarly the DH has invested, somewhat unsuccessfully to date, in developing an NHS information infrastructure that allows transfer of clinical information across providers, reducing the potential for waste. These systems will be critical for providers, and commissioners, to use to make challenging savings in the future and preserve quality. While these efforts should continue, the more pressing issue is how to encourage people (especially clinicians) to use information, in particular the wealth of information that is currently collected and available. The focus of centrally driven reform over the short to medium term must be on developing incentives to this end.

Incentives

The incentives in the NHS arising from bearing down on tariff prices, from a stringent financial settlement and from central performance management, have been outlined above. These could be characterised as 'push' incentives. Here, less direct incentives that might help to improve efficiency are briefly discussed – these could be called 'pull' incentives, ie they encourage intrinsic motivation within providers to drive change.

There are not enough incentives at institutional level for providers to seek ways to reduce avoidable activity appropriately – neither from the tariff nor from performance management via commissioners or SHAs. Clearly allowing no growth in, or reducing, the national tariff to a point at, or below, marginal costs will encourage activity to be reduced, but this is a crude method since it bears no relation to need or quality of care. A new approach in reform is needed, which encourages clinicians, doctors in particular, to manage budgets covering care outside and inside hospital, to give positive incentives to hospitals for helping people stay well and out of hospital, and puts clinicians in a more central role (as envisaged in Darzi's *Next Stage Review*) in deciding and justifying decisions on major service changes.

Integrated care. Because of this, there is much talk of vertically and horizontally integrated healthcare.[18–23] As yet the evidence of impact of integrated care on efficiency is underdeveloped but it is promising enough for the DH to allow more radical forms to evolve, and to give 'permission' and moral support for the local risks to be taken for evolution to occur. Integrated care may be achieved through a variety of arrangements. No one model is likely to fit everywhere in England and a plurality of approaches should be championed. Similar initiatives to integrate health and social care show early promise (Torbay, Isle of Wight), for example by helping to stem the rise in emergency care for older people by supporting them more effectively at home.[4,19] Again these could be encouraged more widely if they work.

Competition. Encouraging competition between providers for NHS-funded clinical care has for some years been DH policy. Econometric studies suggest that in a market with regulated prices above the marginal costs of providing treatments, competition increases quality.[6] Two early studies in England are suggestive of the same finding.[24,25] But many of these studies examine competition for elective care. As noted above the biggest efficiency gains are likely in the treatment of frail older

people, and those with multiple long-term conditions, for whom integrated care holds more promise. Integrated care has clinical collaboration at its heart.

The current policy of free choice of provider for patients may conflict with the aims of integrated care to consolidate vertically to achieve efficiency and quality gains. This aspect of policy needs to be more clearly thought through.[20,21,26] In particular, given the biggest external stimulus to increase efficiency in the next few years will be an economic one, a key question for the DH is to what extent should efforts be diverted to increase competition locally?

Limiting the benefits available on the NHS or requiring co-payments by patients

The NHS Constitution begins to outline the benefits that are guaranteed on the NHS, although at present these relate more to levels of service (such as waiting times) rather than clinical treatments. NICE is an institution which helps define the cost effectiveness of treatments and thus what may or may not be recommended as being funded by the NHS. The role of the proposed NHS board is yet to be made clear, but one aspect could be to make more clearly the healthcare benefits that are NHS funded, and thus what must be paid for privately.

Yet defining the clinical benefits more explicitly in this way would be highly controversial. First, there is no purely objective and uncontentious method of defining a package. Second, the founding principle of the NHS is to offer comprehensive care which is free at the point of use – this principle is strongly supported by the British public. Third, with obvious evidence of waste in the NHS, it may be highly inappropriate to cut back on benefits available in this way until other ways of increasing efficiency have been exhausted.

Similarly increasing co-payments in the NHS would also be controversial.[27] The main arguments against are that co-payments are often highly regressive, costly to collect, and deter appropriate, as well as inappropriate, demand. If appropriate demand is deterred, then greater costs may be incurred later, not to mention significant ill health. The rationale has been that it would be far more effective to apply co-payments first to *physicians* who are mainly responsible for decisions about treatment and associated costs, in other words to develop disincentives for inappropriate treatment, and incentives for appropriate and preventive care.

Improving self-management and public health

Significant efforts have been made over the past 20 years by DH to encourage self-management and invest in public health. These should obviously continue, although the 'payback' in the short to medium term for the investment will need more careful assessment than has been the case to date to justify the costs.

Conclusion

This paper outlines some of the major approaches open to the DH, and in future the proposed NHS Commissioning Board and new economic regulator, in helping to secure greater efficiencies in care. While there are a number of options, the scale of what is now needed requires fundamental reform, in particular to reduce avoidable ill health and dependency on the NHS.

The focus of reform now and in the medium to longer term should be how to reduce avoidable costs to the NHS particularly from chronic disease and in particular those of older frail people. This can only be achieved by eliminating the barriers to care that currently exist which lead to uncoordinated care, duplication, reactive rather than proactive care, and dependency on hospital care. In short, better integration of care is needed across primary and secondary care, between NHS and social care, and between NHS, social care and self-care. To achieve the efficiencies needed, reforms in the NHS should concentrate on achieving this above all else, and testing its impact.

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