The BOW GROUP

Target Paper

‘Equity and Excellence: Liberating the NHS’ – Opportunities and Challenges

The Bow Group Health Policy Committee

(Stuart Carroll and Gary Jones)

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The Bow Group was founded in February 1951 as an association of Conservative graduates, set up by a number of students who wanted to carry on discussing policy and ideas after they had left university. They were also concerned by the monopoly which socialist ideas had in intellectual university circles. It originally met at Bow, East London, from which it takes its name.

Geoffrey Howe, William Rees-Mogg and Norman St John Stevas were among those attending the first meeting. From the start, the Group attracted top-flight graduates and quickly drew the attention of a number of government ministers, notably Harold Macmillan. In the intervening time, Michael Howard, Norman Lamont and Peter Lilley have all held the Bow Group chairmanship. Christopher Bland, the current Chairman of BT, was Bow Group chairman in 1969. In the recent General Election five recent members of the Bow Group Council were elected to the Commons.

Since its foundation the Bow Group has been a great source of policy ideas, and many of its papers have had a direct influence on government policy and the life of the nation. Although it has no corporate view, it has at times been associated with views both of left and right - always within the broad beliefs of the Conservative Party. The Bow Group (BG) has four clear objectives:

To contribute to the formation of Conservative Party policy

To publish members' work and policy committee research

To arrange meetings, debates and conferences

To stimulate and promote fresh thinking in the Conservative Party

Recent publications include (all available at www.bowgroup.org):

The Case for Energy Crops: How Developing Countries can Help Themselves & Boost UK Energy Security
Tony Lodge (BG Transport & Energy Committee) **July 2010**

The Enterprise Nation? Developing Northern Ireland into an Enterprise Zone
Ross Carroll with a foreword by Lord Trimble (BG Economics Committee) **April 2010**

The Quality and Outcomes Framework – What Type of Quality and Which Outcomes?
Gary Jones, Stuart Carroll and Jennifer White (BG Health Committee) **February 2010**

The Right Track – Delivering the Conservatives' Vision for High Speed Rail
Tony Lodge with a foreword by Lord Heseltine (BG Transport & Energy Committee) **January 2010**

"People Power: Reforming QUANGOs" – Is this Applicable to Health Agencies?
Stuart Carroll and Nick Hoile (BG Health Committee) including contributions from Sir Andrew Dillon, Dr. Richard Barker and Dr. Bill Moyes **November 2009**

More for Less: Cutting Public Spending, Protecting Public Services
The Rt. Hon John Redwood MP and Carl Thomson (BG Economics Committee) **November 2009**

Doing Veterans Justice: Conversations with the Forgotten Fighters
Ross Carroll, Stuart Carroll and Julien Rey (BG Health Committee) including contributions from Simon Weston OBE and Captain Surgeon Morgan O'Connell **June 2009**

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A Report by the Health Policy Committee of the Bow Group (18th August 2010)

Stuart Carroll[1] and Gary Jones[2]

Bow Group Health Policy Committee

The Health Policy Committee is committed to researching and analysing the issues and challenges facing the NHS and wider healthcare sector as a result of Government policies. The Committee regularly meets to discuss new research projects and how it can support viable, sustainable and effective policies to improve the provision and delivery of healthcare services.

Chairman – Stuart Carroll

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Executive Summary

- On 12th July 2010, the Secretary of State for Health, Andrew Lansley MP, announced the publication of the Government's flagship Health White Paper, *'Equity and Excellence: Liberating the NHS'*.

- This White Paper outlines a vision of an NHS where GPs are the commissioners of care; where there is competition between providers within a regulated framework; and where patients are empowered through an "information revolution" and can make educated decisions and informed choices about their own care.

- Many of the concepts in the White Paper have been proposed and, to some extent, advanced by the previous Labour Government, yet it still represents the most radical Government Health White Paper since the creation of the NHS in 1948.

- Whilst the White Paper signals relatively few changes in the patient facing end of the health service, the proposals to introduce GP consortia to carry out the bulk of NHS commissioning constitutes a radical and bold step. These courageous plans have great potential to bring primary care closer to patients with a stronger focus on prevention. However, the smooth and effective implementation of this policy will be necessarily dependent on the removal of a number of practical barriers. These include the perceived problems of accountability, patient engagement, service quality and estate management.

- A substantial part of the White Paper is dedicated to outlining how the improvement of healthcare outcomes for all will be the primary purpose of the NHS. A new NHS Outcomes Framework will be the main mechanism for driving up quality and promoting equity and excellence across all services, and will provide an indication of the overall performance of the system within an international context. Whilst it is encouraging that the framework is focused on outcomes, it will be crucial that this framework is not too prescriptive and still allows local consortia to innovate.

- The White Paper makes direct reference to the Government's big idea to place public health and prevention at the centre of the new NHS. To this extent, the Government has pledged to create a new Public Health Service with a White Paper on public health promised later this year. These are promising proposals, which will need to be fully backed and funded should the NHS revolution be fully and properly implemented – something that is much needed to safeguard the future health of the nation and financial sustainability of the NHS itself.

- The White Paper is right to emphasise and prioritise the need to make savings where possible, and reform the culture of the NHS to allow for a more effective and efficient healthcare system. However, the White Paper is not so clear on where precisely the pledged £20 billion will be saved and is even less clear on what constitutes the promised 45% cuts in "management costs". Although we know that PCTs and SHAs

are under “death sentence” and will soon be wiped off the NHS organogram, promises to “clear backroom staff”, “cut bureaucracy” and “make efficiency savings” confer a degree of vacuity that does raise important questions about how the theory will be mapped into practice.

- A key underlying theme throughout the White Paper is the important issue of innovation and value – or what can be understood as such. For the NHS to optimise scarce resource and investment decisions, a more rounded and considered definition of value and innovation is needed that transcends the narrow confines of the common Whitehall “race to the bottom line”. This is essential to making long-term decisions that accrue optimal returns for the NHS.

- If fortune favours the brave, then this White Paper is certainly along the right lines and scores extremely high marks out of 10. These courageous plans have great potential to bring primary care closer to patients with a stronger focus on prevention. However, the smooth and effective implementation of this policy will be necessarily dependent on the removal of a number of practical barriers and strong leadership across the 1.4 million people making up the NHS. The key for the Coalition Government will be to flesh out these plans over the coming months in order to overcome identified obstacles and deliver a health system which is truly patient-centric achieving outcomes that are amongst the best in the world.

1. Introduction

On 12th July 2010, the Secretary of State for Health, Andrew Lansley MP, announced the publication of the Government's flagship Health White Paper, *'Equity and Excellence: Liberating the NHS'*[3]. The 57 page document outlines a vision of an NHS where GPs are the commissioners of care; where there is competition between providers within a regulated framework; and where patients are empowered through an "information revolution" and can make educated decisions and informed choices about their own care. While some of these concepts have been proposed and, to some extent, advanced by the previous Labour Government, the new White Paper marks an ambitious and radical attempt to fully implement these revolutionary principles in a synchronised and far-reaching manner.

This new NHS is to be governed by a tripartite regulatory system, with the Care Quality Commission (CQC) governing quality and safety; Monitor widening its remit as the economic regulator; and the new national NHS Commissioning Board to support GPs in their new commissioning role by providing guidance. There are also important precursor proposals pertaining to public health; the abolition and downsizing of QUANGOS; the concepts of value, innovation and productivity; and the importance of quality and outcomes to facilitate better patient experiences and patient health outcomes.

The changes outlined in the White Paper, many of which are long-term in nature and subject to consultation, are not likely to immediately change the way in which patients use the NHS. Indeed, early analysis would suggest relatively few major changes in the customer facing end of the health service with care, in most cases, still free at the point of use. The Government's forthcoming proposals on public health will be all-important is this regard. Furthermore, it should be acknowledged that some of the ideas contained within the White Paper are redolent of the previous administration's plans for health policy. For example, the Labour Party manifesto also contained plans for all hospitals to become Foundation Trusts and provide support for the independent sector.

However, for those who work in and around the NHS these proposals are genuinely radical and fundamentally reformist. Indeed, it could be argued that this is the most revolutionary Government White Paper since the creation of the NHS in 1948. This is not least the case given the central plank of the Government's NHS proposals: to place GPs, as commissioners, in control of approximately £80 billion of the overall NHS budget against the backdrop of 45% cuts in "management costs" and the abolition of the 152 Primary Care Trusts (PCTs) and 10 Strategic Health Authorities (SHAs) in England.

If fortune favours the brave, then this White Paper is certainly along the right lines. It is the purpose of this short research paper to explore and examine the vision outlined in the White

[3] The White Paper can be downloaded by accessing the following link: http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_117352.pdf, Accessed August 2010.

Paper and those proposals most important and interesting to "liberating the NHS" and advancing the equity and excellence the Government has pledged itself to deliver.

2. Overview of Main Proposals in the White Paper

The main proposals contained within the White Paper can be summarised as follows.

2.1. Changing the structure of the NHS

In an attempt to cut bureaucracy and devolve responsibility for commissioning to local GPs, PCTs and SHAs are to be abolished across the lifetime of the current Parliament. New organisations will emerge including around 500 local General Practice Commissioning Consortia, the national NHS Commissioning Board and Healthwatch. The CQC will act as the 'quality regulator' and Monitor will act as the 'economic regulator' albeit details on the latter are somewhat sketchy. In addition, a review of arms-length bodies is underway, with the Health Protection Agency (HPA) the first major causality.

2.2. Changing the culture of the NHS

The Government has pledged to change the culture of the NHS. A fundamental part of this culture shift is the move away from the previous Labour Government's obsession with measuring performance through process and targets to instead a culture of measuring performance based on clinical quality and health outcomes. Frontline clinicians and patients will now be in the driving seat rather than NHS managers.

2.3. A patient-centric NHS

Patients and the public will be empowered through transparency of information about service quality and outcomes, shared decision-making with clinicians about their treatment and care; and choice about who will provide their treatment and care. Local Healthwatch is set to have a strong voice and, according to the proposals, will have a strong relationship with local authorities. Patient and public involvement will be the responsibility of local GP commissioners.

2.4. Commissioning

Perhaps the most significant shift in structure and culture is the creation of around 500 GP commissioning consortia that will decide local priorities for buying healthcare within a framework established by the NHS Commissioning Board. According to this new system, the Commissioning Board will be responsible for some regional and national specialised services.

2.5. New roles for Local Authorities

Local authorities will take responsibility for public health, including appointing directors of public health. However, GPs commissioning powers will include some public health work. Details on public health issues and a new public health service will be addressed in a further white paper in the autumn. Councils will be given new roles, through Health and Well-being Boards, with responsibility for:

- Joining up healthcare, social care and health improvement
- Promoting integration and partnership
- Leading on assessing local needs
- Building partnerships for service change and priorities.

2.6. GP contract

The White Paper confirms plans to scrap GP boundaries and renegotiate the Quality and Outcomes Framework (QOF). Earlier indications suggest that these proposals are unpopular with some GPs and will therefore require the Government to astutely negotiate with the BMA.

2.7. NHS staff

The White Paper gives all NHS Trusts the right to negotiate pay for their staff. This is a significant reform that will inevitably be unpopular with trade unionist organisations.

In the following sections, we focus specifically on five key areas that feature prominently across the White Paper. These include:

1) **The GP commissioning revolution;**
2) **Quality and outcomes;**
3) **Public health and prevention;**
4) **Efficiency savings and QUANGOs; and,**
5) **Value and innovation.**

Each area is examined in accordance with other Government pledges and pronouncements made in relation to the NHS.

3. The GP Commissioning Revolution

The most significant and ambitious proposals set out in the White Paper are plans that will see the creation of GP Consortia to take on the role of GP commissioning. Consortia will take over commissioning for the majority of NHS services, including elective hospital care and rehabilitative care, urgent and emergency care, most community health services, and mental health and learning disability services. Importantly, the consortia will not purchase primary medical services, which will instead be the responsibility of the NHS Commissioning Board. The Board will also assume responsibility for purchasing dentistry, community pharmacy and primary ophthalmic services, as well as national and regional specialised services, maternity services and prison health services, but all with the help of GP consortia to ensure appropriate input at the local level.

It is widely considered that PCT commissioning has been a disappointment in recent years and has failed to deliver its potential. In April 2010, the cross party Health Select Committee

published its report on commissioning[4]. The Committee found that while there are some good examples of PCT commissioning, many PCTS believe they are working effectively "although the evidence would suggest otherwise." The report argued that PCTs are not commissioning effectively enough and that they lack the "clinical knowledge" to challenge hospitals over the provision of services. The report also criticised the World Class Commissioning (WCC) initiative citing that, while it is too early to judge the success of WCC, there were serious concerns about the capacity of PCTs to make the necessary changes.

It is clear that enhanced GP commissioning could play a key role in improving clinical standards and productivity in the NHS. The Government's proposals, although in some quarters controversial, could introduce a new perspective that is closer to patients and a stronger focus on prevention. However, a number of practical barriers will need to be overcome if this policy is to effectively work. These include the perceived problems of *accountability*, *patient engagement*, *service quality* and *estate management*.

3.1. Accountability

The Government has attempted to assure the public that the new GP consortia will guarantee accountability for the management of large amounts of public funds. This is crucial given that the existing £80 billion annual budget currently held by PCTs and SHAs will be handed directly over to GPs. However, the White Paper does not clearly set out the nuts and bolts of the proposed framework. Further detail is needed should the Government be successful in reassuring the public that the vast majority of NHS money is being spent efficiently and effectively.

In addition, it is not clear how GPs will share the risks and rewards of their enhanced roles. It is likely that many GPs will anticipate benefiting financially from the new model as they acquire new responsibilities. It will be essential that the Government sets out a clear framework to ensure that robust rules on transparency and accountability so that everyone involved – GPs, PCTs, hospitals, contracted companies – know exactly where they stand, and most importantly, are directly accountable to patients.

3.2. Patient engagement

One of the most positive aspects of the White Paper is its patient-centric feel and intent. Indeed, Andrew Lansley has said himself that "no decision about me, without me" is the very essence of the Government's approach. Patients should have more choice, and to this end the White Paper has promised to scrap "top-down targets" in favour of measuring standards and performance through collecting information on patient health outcomes. The new NHS will be required to provide information based on key indicators such as hospital acquired infection

[4] The Health Select Committee report into commissioning can be downloaded by accessing the following link: http://www.publications.parliament.uk/pa/cm200910/cmselect/cmhealth/268/268i.pdf, Accessed August 2010.

and MRSA rates, whilst ensuring patients through the use of Patient Reported Outcome Measures (PROMS) are asked about the quality of their care.

Although these proposed reforms are overwhelming positive – and will go a long way to put the patient at the very heart of the NHS – it is not overly clear how patients will make their voice heard under the new GP consortia arrangements. Due to the scrapping of practice boundaries, patients will be able to "vote with their feet" by choosing their local GP. Patients are even able to move out of their local area to neighbouring consortia that may have a track record of success or more experience in a particular disease area. However, some patients will want to stay local and there is no obvious mechanism for patients feeding back concerns to their local consortia to drive up standards.

Under the proposals, Local Involvement Networks (LINks) will now become local HealthWatch organisations. Local HealthWatch will aim to ensure that the views and feedback of patients and carers are an integral part of local commissioning across health and social care. It will be funded by and be accountable to local authorities. If the local HealthWatch is not performing, the local council will have the responsibility to put in place better arrangements. Health and wellbeing boards will also be set up to promote integration and partnership working between the NHS, social care, public health and other local services and improve democratic accountability.

However, these proposals could be boosted by ensuring that the new position of Director of Public Health in local authorities are appointed "Local Commissioning Champions" and work alongside Local HealthWatch and health and wellbeing boards in their local area to ensure patients input is actively sought. It will be crucial that Local HealthWatch works effectively with local authorities. By involving Directors of Public Health, the implementation of these proposals will be significantly aided.

3.3. *Service quality*

With an increased number of commissioning bodies, there is a greater likelihood of different approaches to the prioritisation of treatments and funding decisions. Furthermore, this is likely to result in a postcode lottery with some consortia being more successful than others. In theory, with the new ability of patients to register with GPs away from their home territory, this should result in patients choosing the best practices and in turn help drive up standards.

However, not all patients will be able to afford to move GPs and there is a danger that patients in deprived areas may be limited to their local consortium. It is a positive step that the GP Commissioning Board is to be held responsible for health inequalities and it will be crucial for the new Board to ensure that the performance of consortia in the most deprived areas is carefully monitored to facilitate better patient health outcomes.

In a previous piece of research, the Bow Group found that the GP Contract has led to a great variation in the number of GPs and registered patients in deprived areas where access to GP

services is limited. For example, some areas of the country only have around 40 GPs per 100,000 eligible patients, whereas other areas have well over double this number[5]. It should be evident that addressing this disparity is fundamental to tackling health inequalities and ensuring all patients have decent access to local healthcare services.

In addition, many GPs lack the expertise to commission some care services especially when it comes to certain conditions, and their proposed new powers could lead to a disparity in provision. It is widely considered that some GPs currently lack the specialist mental health knowledge and training to understand the complexities of mental health commissioning. For example, the mental health charity Rethink found that only 31% of GPs felt equipped to take on the role of commissioning mental health services[6]. The Government needs to take another look at the implications of their proposals for mental health and consider whether commissioning mental health services should be under the remit of the NHS Commissioning Board.

3.4. Estate management

Previous Government policy has implied that whoever retains responsibility for commissioning should be in charge of estate management of the NHS estate. With GPs becoming responsible for commissioning, this begs the important question "who will manage the estate?" The NHS's property portfolio is the largest in Europe and had an estimated value of £36 billion in 2008[7] and in times when great efficiency savings are needed, this area is likely to be evermore important in the future.

PCTs currently own community hospitals, clinics, some walk-in centres, and some GP surgeries. In light of their "death sentence", PCTs will likely find it harder to manage their properties as the best staff move to other organisations in what runs the risk of a PCT staff mass exodus. The Government should urgently seek to work with local authorities to ensure that adequate provisions are in place. It may be that in some areas the local authority takes control. However, in others areas more creative solutions might be needed using local infrastructure that is already in place.

4. Quality and Outcomes

A substantial part of the White Paper is dedicated to outlining how the improvement of healthcare outcomes for all will be the primary purpose of the NHS. At a national level, the government believes that the focus and accountability should, as far as possible, be centered on the health and clinical outcomes. Locally, the structures and processes of care will need to be monitored, but focusing on these too heavily at a national level can lead to a distortion of

[5] Hansard, 4 September 2006, Col. 2096WA

[6] White Paper to hand mental health commissioning to GPs; but most don't have necessary expertise, Rethink Press Release http://www.rethink.org/how_we_can_help/news_and_media/press_releases/white_paper_to_hand.html July 2010, Accessed August 2010.

[7] Good Corporate Citizenship Website http://www.corporatecitizen.nhs.uk/pages/buildings.html, Accessed August 2010.

clinical priorities and risks creating a whole system of accountability that it is more concerned with the means rather than the result – an accountability system that has lost sight of the purpose of the NHS.

A new NHS Outcomes Framework will be the main mechanism for driving up quality and promoting equity and excellence across all services, and will provide an indication of the overall performance of the system within an international context. It will include a focused set of national outcome goals determined by the Secretary of State, against which the NHS Commissioning Board will be held to account, alongside overall improvements in the NHS.

The NHS Outcomes Framework should be credited for its focus on outcomes. It is clear that the primary focus of any healthcare system should be placed on improving patient health outcomes and patient experiences. Linking performance review – and associated rewards and penalties – to the outcomes that are of most important to patients, which is in turn fundamental to ensuring patient accountability and restoring professional discretion over how to treat patient needs.

However, it will be crucial that this framework is not too prescriptive and still allows local consortiums to innovate. In its recent evaluation of the QOF, the Bow Group found that central planning can be an ineffective and flawed way of fostering a system that allows for the prioritisation of local healthcare imperatives. Evidence shows that one of the central flaws of the QOF was that targets were set at the national and central level not allowing local areas to priorities their own local needs. It would be deeply regrettable if the Government were to transfer this flawed way of thinking to the new NHS framework. The new framework must support the delicate balance of providing national leadership, but also allowing local consortiums to innovate.

5. Public health and prevention

The Government's big vision for health policy is to promote public health and shift the NHS away from curative to preventative healthcare. This is most notably exemplified by the commitment to create a new Public Health Service "...to integrate and streamline existing health improvement and protection bodies function, including an increased emphasis on research, analysis and evaluation".[8]

A separate White Paper on public health will be published later this year outlining the details of this core idea. With this in mind, *'Equity and Excellence: Liberating the NHS'* is understandably laconic on how this new Public Health Service will look and work, and how it will link with the reformed NHS. However, the Government has provided some insight.

[8] 'Equity and Excellence: Liberating the NHS', pp. 9-10.

5.1. The new health premium

The White Paper reveals that the Department of Health will create a ring-fenced public health budget within which local Directors of Public Health will be responsible for health improvement funds allocated according to relative population health need derived using formula including "health premium". The immediate question, which the forthcoming public health White Paper will need to address, is how this formula will work and what this "health premium" will entail. As with all policies of this kind, the devil will very much be in the detail and until further detail is disclosed the jury remains out.

5.2. Public health: there is no alternative

The Government should be congratulated for seeking to significantly raise the profile of the public health imperative above and beyond existing initiative and policies, which have largely failed to meet their intended objectives. There is no escaping the fact too many people in the UK are living unhealthy, and in some cases life-threatening, lifestyles that is costing British society, the UK economy and the NHS an incalculable amount. A new approach is needed – and needed quickly. The existing curative model has had its day.

Indeed, it is self-evident – or at least it should be – that improving the nation's public health, and in turn the need to shift the NHS towards preventative medicine and personalised healthcare, is fundamental to advancing improved health outcomes; tackling health inequalities now worse than in Victorian times; and shaping a more affordable NHS through the achievement of significant cost-savings. It is also an economic imperative. For the UK economy to recover, productivity needs to be optimised. Reducing productivity losses and indirect costs from ill-health is therefore crucial. Prevention is the only cure

For far too long, the NHS has been a misnomer. The UK does not really have a National *Health* Service, but rather a National *Illness* Service that is disproportionately structured and geared towards an outdated curative and reactive healthcare model. This is the case whether it be in terms of commissioning; the provision of services; the national directives and policy; or the day to day delivery of healthcare.

5.3. Convincing the Treasury

The real acid test will be whether the Government really means it. By that, we mean will the vision for a healthier nation and the ambition to facilitate a genuinely preventative and public health focused National *Health* Service be backed up by sustained funding and Treasury support. There is no doubting that the political argument for public health and prevention has been won. No sane-minded politician or policymaker can sensibly dispute the rationale informing the "better prevent than cure" philosophy.

The real question is whether the Treasury – the NHS's payer – is convinced the economic case, at a time of unprecedented strain on the public purse, has been won and there is scope for sizeable long-term investment to generate acceptable short-term as well as long-term returns. The brutal truth is that the Treasury remains sceptical and, as they say in Westminster, "you cannot beat the Treasury".

To this extent, the argument will need to be consistently, strongly and politically made to ensure the "great vision" of a new NHS is adequately resourced. Without it, the NHS we know will struggle to be saved from it owns financial disintegration and economic meltdown as the costs of curative healthcare reach unaffordable extremes.

6. Efficiency savings and QUANGOs

Against the backdrop of the UK's gargantuan budget deficit and the attendant squeeze on public expenditure, the White Paper outlines its commitment to the Government's ongoing cross-sector efficiency drive: *"The NHS will need to achieve unprecedented efficiency gains, with savings reinvested in front line services, to meet the current financial challenge and the future costs of demographic and technological change".*[9]

Although the Government has pledged to increase health spending in real terms across the lifetime of the Parliament, this does not mean the NHS is immune from having to make efficiency savings and, thus in reality, cuts. Indeed, the White Paper reaffirms the Government's commitment to enforce £20 billion of efficiency savings (approaching 20% of the entire NHS budget), which will be reinvested into the NHS to help fund the real terms spending increases. This target will be achieved by reducing NHS management costs by more than 45% over the next 4 years, and radically simplifying (cutting) the number of NHS QUANGOs following the Government's recently announced review of arms-length bodies.

6.1. How will these savings be achieved?

In a nutshell, the objective of £20 billion savings is ambitious and immediately prompts questions as to how this can be achieved without hitting front line services. Is it realistic and feasible to cut "management costs" by 45% or more in 4 years? And what NHS bodies and QUANGOs can sensibly be cut, downsized or merged to contribute to this ruthless efficiency drive?

It is difficult, if not impossible, to contend the assertion that the NHS could not be leaner, meaner and generally more efficient. After all, there is no escaping the appalling legacy of waste and profligacy of the previous Labour Government in which, regrettably, the NHS was a serial offender. Indeed, as previous research has emphatically shown, much of the Labour spending binge was swallowed up by overly generous and above inflation pay increases; doubtful management expenditure and endless reconfigurations; expensive and low value IT projects; and a byzantine bureaucracy of process-driven performance indicators. For example the NHS currently has around 40,000 managers - one for every ten nurses. Administration alone costs the NHS around £4.5 billion a year - yet the DH has still needed to spend £478 million in the last five years on external consultants. Meanwhile, overall NHS staff numbers reached 1.43 million in 2009, which is a 30% increase since 1999[10].

[9] Equity and Excellence: Liberating the NHS, p. 5.
[10] NHS Information Centre 2010.

It is from this perspective that Andrew Lansley is right to emphasise and prioritise the need to make savings where possible and reform the culture of the NHS to allow for a more effective and efficient healthcare system. This is absolutely critical to the sustainability and affordability of the NHS. However, the real question remains: what will be cut and where will the axe of efficiency actually fall?

The truth of the matter is it is difficult to know. The White Paper is not so clear on where precisely the £20 billion will be saved and even less clear on what constitutes the 45% management costs (cuts). Other Government pronouncements have so far offered little additional insight. Although we know that PCTs and SHAs are under "death sentence" and will soon be wiped off the NHS organogram, promises to "clear backroom staff", "cut bureaucracy" and "make efficiency savings" confer a degree of vacuity that does raise important questions about how the theory will be mapped into practice.

6.2. The role of QIPP

It is likely that Quality, Innovation, Productivity and Prevention (QIPP) – an initiative introduced by the previous Labour Government – will be at the vanguard of the £20 billion efficiency drive. This has already been signalled by Sir David Nicholson, Chief Executive of the NHS, in recent correspondence.

The purpose and rationale informing QIPP is essentially to find ways for the NHS to provide "more for less" emphasising the four domains determining its composition. The initiative is a direct product of the financial challenges confronting the NHS and, in turn, the wider economic climate. It is closely aligned to other NHS initiatives including Commissioning for Quality and Innovation (CQUINN) – a payment framework that makes a proportion of provider income conditional on quality and innovation – and the now well-entrenched Payment by Results (PbR) system of paying healthcare providers using the NHS tariff and currencies that link payment to activity.

Although there is much merit in the principles, arguably axioms, informing the QIPP agenda, its success will be necessarily reliant on local implementation and therefore local leadership. This is pretty much true of all initiatives and policies introduced in an organisation the size of the NHS. In short, QIPP needs to become woven into the DNA of the NHS whereby quality, innovation, productivity and prevention are not merely part of the conscious need to meet yet another NHS initiative, but rather become an intrinsic part of the subconscious ethos informing daily decisions throughout the healthcare system. It is from this premise that there is likely to be a long road ahead across many parts of the NHS.

6.3. Review of arms-length bodies

A central part of the Government's efficiency drive is the recently announced *'Liberating NHS: Report of the Arm's Length Bodies Review'*, which sets out proposals to abolish, downsize or merge existing health QUANGOs over the next 4 years. This review will be used to validate DH plans for a radical simplification of the health agency landscape.

In November 2009, the Bow Group published a report looking into this very matter and found that there was little scope to abolish any of the following health agencies[11]:

1) The National Institute for Health and Clinical Excellence (NICE) – provides national guidance for take up of NHS treatments and interventions.
2) The Care Quality Commission (CQC) – regulates health and adult social care provision in England.
3) The Medicines and product Healthcare Regulatory Agency (MHRA) – regulator providing licences for medicines, medical devices and healthcare interventions.
4) Monitor – assesses, licenses and monitors NHS Foundation Trusts.

The Government agrees and has categorised all the above NHS bodies as being safe. In the case of NICE, the Institute's role will be expanded under White Paper proposals to extend its role in developing quality standards.

Arguably, the most controversial announcement to date is the Government's decision to abolish the Health Protection Agency (HPA) and transfer its functions to the Secretary of State under a new Public Health Service. The roles and responsibilities of the HPA are by no means trivial playing a central role in health protection, as recently witnessed with the swine flu epidemic, and tapping into many other areas of health policy including, for example, vaccination and immunisation policy through analytical and evaluative support to the Joint Committee on Vaccination and Immunisation (JCVI).

Understanding how this transfer of functions will take place, and what will be sacrificed along the way, is all important. For example, in the case of vaccination and immunisation policy, will the new Public Health Service provide the JCVI with infectious disease modelling support and data analysis?[12] Or will the JCVI be integrated into NICE as proposed by the Conservative Party in Opposition?[13]

Although the wider economic climate dictates that the DH has to make its own savings – and the downsizing and abolition of health agencies should naturally form part of this process – the implications of abolition and merging need to be carefully thought through. In the case of HPA, the "age of austerity" does provide a precursor rationale for the Government's decision. However, it is difficult to judge whether this is a sensible and cost-effective thing to do given that the details on the new Public Health Service have yet to be announced. For now, the jury remains out.

[11] "People Power: Reforming QUANGOs" – Is this Applicable to Health Agencies? Stuart Carroll and Nick Hoile (BG Health Committee) including contributions from Sir Andrew Dillon, Dr. Richard Barker and Dr. Bill Moyes November 2009.

[12] Currently, the HPA Modelling Unit provides the JCVI with modelling support for the purposes of economic evaluation of given vaccinations and infectious disease areas.

[13] Conservative Party, 'Improving Access to New Drugs: A Plan to Renew the National Institute for Health and Clinical Excellence', 3rd November 2009.

6.4. Cutting and saving are not always that easy

The White Paper makes a series of lofty promises pertaining to sizeable efficiency savings and weighty cuts to management costs. With all of this, there is an important cautionary note to sound. Throughout the political ages, governments right around the world have consistently pledged to their electorates that they will cut waste, reduce bureaucracy and improve efficiencies. In virtually all cases, governments have failed to do so often finding the practice far more difficult – politically and practically – than the theory. There is a real danger that the same could apply to the NHS particularly given its overarching size.

However, Andrew Lansley has one important thing going for him – the acute economic context and the sharpened financial backdrop. The UK's parlous public finances, and the political will (in some ways legitimised by the election result), mean the Government has absolutely no choice but to cut, make savings and, importantly, reform the way in which Whitehall departments go about their business. The political argument, which in the main is backed by large parts of the public, has been won to allow for Cabinet Ministers to genuinely take on the waste even if this means redundancies and job losses.

The main difficultly will be the practical side. This great efficiency saving and cost cutting exercise will need to be done in a surgical and considered way. Knowing what to cut and when to cut is the essence of the conundrum confronting all Government departments. Allied to this is the need to appreciate the "invest to save" philosophy as cutting alone will not do the job. It is from this perspective that a clear and proper understanding of innovation and value will be seminal to the chances of the Andrew Lansley hitting the £20 billion target.

7. Value and innovation in the "age of austerity"

A key underlying theme throughout the White Paper is the important issue of innovation and value – or what can be understood as such. These two pivotal words, and the implicit concepts therewith, are directly mentioned 13 times across the 57 pages of the White Paper and have featured prominently in all other Government pronouncements pertaining to the NHS. They are also symbiotic with productivity – a perennial problem that continues to undermine performance and true "value for money" across the healthcare system.

7.1. Getting more for less

As discussed in Section 6, despite the Government's pledge to ring-fence the NHS budget and safeguard real term spending increases, this ineluctable economic imperative is now impelled by the need to cut waste and make "efficiency savings" (in the region of £20 billion) in the new "age of austerity". Getting more for less, even in the much cherished NHS, is the new Whitehall strap line, and no Government department is fully exempt. There is no escaping or hiding from this thudding reality. It is from this perspective that understanding what "more for less" – and its various semantical derivatives – actually means, and how this principle (or sentiment) will be applied, is a matter of seminal significance; and not only for Andrew Lansley and his reforming department.

It is also an issue that confers amplified political importance given the forthcoming Treasury Comprehensive Spending Review (CSR) and the Coalition Government's ongoing activities informing the budget deficit reduction plan. Indeed, as traditionally the most powerful Government department in Whitehall, the UK's parlous public finances and eye-watering budget deficit have necessarily ensured that the Treasury has never been more formidable. Moreover, the CSR, with all its intent to punitively apply the literal meaning of "comprehensive" in a line by line microscopic breakdown of departmental balance sheets, indicates the Treasury's determination to not only garner a reputation for omnipotence but likewise omniscience.

The DH therefore has no choice but to pull its weight and, as the Health Secretary has correctly pointed out, must find new and innovative ways to put the NHS on a more economically sustainable and efficient footing. In light of the NHS being designated as a sacred cow, there will be great opportunities for any savings to be re-invested in frontline services to make the health service more preventive and more efficient in the future. The Government's big splash around public health and preventative healthcare is as much the product of today's frosty economic reality as it could ever be about health and clinical imperatives. Inherited and retained initiatives such as QIPP have already given the NHS a sharp taste of what value and innovation can look like.

7.2 What will innovation and value mean in the new NHS?

However, it is an important question to ponder as to what the new Government's definition of innovation and value in the new NHS really means – not the political, rhetorical or platitudinous definition, but the real definition as seen as part of daily procurement and tender decisions moving forward. Is it a sugary euphemism for what has to date been the prevailing Whitehall status quo – ***cost*** and therefore implicitly "a race to the bottom line", cuts and the alternative or option with the lowest price? Or is it actually about ***real economics*** and therefore really looking at the incremental cost (price) relative to the incremental return on the investment (benefit or outcome accrued) and advancing the principle that sometimes you have to invest more to save more?

With the Government's reformist tendencies, it is our hope that within reason it genuinely means the latter – and there is sound reason to be optimistic. For example, the Government's pledge to introduce a system of "value-based pricing" (VBP)[14] for drugs and medicines (and presumably all other healthcare interventions) is noteworthy in this regard. Although there

[14] In various documents and on various occasions, the Government has pledge to introduce a system of value-based pricing (VBP). This has been the central tenet of Andrew Lansley's thinking regarding drug pricing and the existing Pharmaceutical Price Regulation Scheme (PPRS). The Government has committed itself to introduce a VBP system by 2014 when the existing PPRS runs out. The White Paper specifically pledges: "The Government will also reform the way that drug companies are paid for NHS medicines, moving to a system of value-based pricing when the current scheme expires. This will help ensure better access for patients to effective drugs and innovative treatments on the NHS and secure value for money for NHS spending on medicines. As an interim measure, the Department is creating a new Cancer Drug Fund, which will operate from April 2011; this fund will help patients get the cancer drugs their doctors recommend" (White Paper, p. 26). It remains an open question as to what exactly a VBP system will entail. Two key questions remain: 1) how will value be defined? And 2) how will any definition of value being measured, updated and monitored over time?

remains much uncertainty as to how a VBP system would practically work and what it would actually entail, it does raise the real possibility, as far as the drugs budget is concerned, for the principles of dynamic and allocative efficiency to be applied. In a nutshell, drugs conferring high value (however defined) would justify a relatively and incrementally higher price and vice versa. This would mean decision criteria based solely on price, and price alone, would be something of the past as the true definition of economically advantageous is advanced.

Of course, any sensible definition of innovation and value cannot be formulated in isolation to the UK's difficult economic outlook. The countless lines of dark red on the UK PLC balance sheet mean that affordability and therefore cost cannot be sidelined. However, the brutal truth of the matter is that, as historical analysis and experience have plainly demonstrated, in recent times the Whitehall definition of innovation and value has not exactly covered itself in empirical glory. This is particularly the case when it comes to procurement, tendering, virement and budgetary decision-making where any meaningful definition of "value for money" has often been lacking.

Indeed, the trumpeting legacy of arguably one of the greatest white elephants of all time, the ramshackle and dysfunctional maze that is Labour's NHS IT system, is an acute case in point. The NHS National Programme for IT was initially expected to cost £2.3 billion over three years. However, the National Audit Office found that costs had spiralled to £12.4 billion over ten years concluding that "[the IT system] had not demonstrated that the financial value of the benefits exceeds the cost of the Programme."[15] It is little wonder that there is so much waste across Government departments when the applied definition of value and innovation has in too many cases been so bluntly one-dimensional.

To dichotomise public spending decisions, as many politicians and commentators continue to do, in terms of spending on the one hand or cuts on the other is to essentially miss the point. It is not just about ***how much*** you spend, but the ***way*** in which you spend what you have available – and this is the essence of innovation and value. Alas, there is little positive to say about the quality of spending in some parts of the NHS, and this is an area where real improvements must be sought.

7.3. The basic health economic problem

The Government is right to emphasise the need to get more for less, and the White Paper makes encouraging noises in this regard. The basic health economic problem of how to meet infinite healthcare demands with finite resources is now evermore acute amid the current recessionary climate and the UK's eye-watering budget deficit. For the future of the NHS to be affordable and sustainable, innovation and value must be seen as part of the solution rather than part of the problem.

[15] The National Programme for IT in the NHS. National Audit Office, June 2006.

However, innovation and value should not be defined as merely equalling cost or price as this is too simplistic a definition of what true innovation and value can mean. Just as the NHS cannot cut its way to a better future nor can it spend its way to a better future – as 13 years of Labour Government showed. The new era of politics offers much promise and much hope, and with it the opportunity to genuinely revolutionise the way the NHS innovates and values investment decisions moving forward.

Concluding Thoughts

If courage, minerals and boldness are a marker of policy success, *'Equity and Excellence: Liberating the NHS'* would score extremely high marks out of 10 – arguably a very impressive 9. A quick retrospective review of government policy since 1948 suggests there has not been a White Paper as reformist and radical as the current Government's opening offering. For those who feared a meek and mild Government that would do nothing more than tinker and blinker with a discredited status quo, all fears have been allayed by this aspirational document.

However, reformist ambition and radical intent are only one part of the equation. The reality is that the Government must now find a way to make the 4th largest organisation in the world (after the Indian Railways, Chinese Red Army and Wal-Mart), with its 1.4 million employees, accept the proposed reforms and changes, and smoothly pioneer the radical ideas the Government has confidently propounded. As with all things in life, particularly those of a political nature, people and leadership at all levels is imperative. As the implementers, it is NHS people that will ultimately make or break the Government's ambitious NHS vision. By devolving so much power, the fate of Government's central policy will ironically soon be in the hands of others. It is a big question to ponder as to whether the NHS has the internal leadership, stomach and appetite to pull it off.

It is from this perspective that any definition of policy success would increasingly seem to involve little middle ground. To put it bluntly, Andrew Lansley will either be remembered as the great reformer or the great failure. Should it be the former, a future career on the global lecture circuit awaits as health policymakers around the world benchmark and marvel at the UK's great reforms. Should it be the latter, public and political confidence in the NHS will likely be badly shaken as many will question whether the NHS can ever be truly reformed and thereby made to work.

In a nutshell, the stakes are high and arguably have never been higher. For all our sakes, let's hope Mr. Lansley's (and the Government's) legacy is the former. After all, the NHS is just too important for failure to be an option.

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