Policy Futures for UK Health: Pathfinder

A CONSULTATION DOCUMENT

September 1999

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**In Association with
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**The Judge Institute of Management Studies
University of Cambridge**

Contents

Foreword

Since its inception the Nuffield Trust has identified individuals and subjects which would impact on health and health care policy in the United Kingdom, with notable examples being *Screening in Medical Care* [1], Archie Cochrane's *Effectiveness and Efficiency: Random Reflections on Health Services* [2], Thomas McKeown's *The Role of Medicine: dream, mirage or nemesis?* [3], David Weatherall's *The New Genetics and Clinical Practice [A]* and Alain Enthoven's *Reflections on the Management of the National Health Service* [5].

In keeping with tradition and reflecting the more complex issues in health and health care policy today, the Nuffield Trust established a Policy and Evaluation Advisory Group (PEAG), supported by the appointment of a Nuffield Trust Fellow at the Judge Institute of Management Studies at me University of Cambridge, to provide a research and intelligence capability for the Trust.

The Policy Futures for UK Health Project stems from the work of PEAG. It involves examining the future environment for UK health, with a time horizon of 2015. The first environmental scan has resulted in a series of ten technical papers, which cover the following areas:

1. The Global Context	6. Social Trends
2. The Physical Environment	7. Organisation and Management
3. Demography	8. Workforce
4. Science and Technology	9. Ethics
5. Economy and Finance	10. Public Expectations

Reading across from these ten technical papers, the Pathfinder report is a policy assessment of the forward look to 2015. It asks the question, what should policy do now to take account of these trends and issues - **what should** inform UK health policy, and what are the gaps in health policy now?

Pathfinder represents a distillation of themes and issues from the Policy Futures for UK Health Project 26 issues are assessed within the Pathfinder report. From that overall assessment a set of 6 issues has been drawn up to represent the key areas that need to be addressed by UK health policy in order to deal with the future. The 6 issues on which action is required for the future are:

• People's expectations and financial sustainability
• Demography and ageing
• Information and knowledge management
• Scientific advance and new technology
• Workforce education and training
• System performance and quality (efficiency, effectiveness, economy and equity)

Each of the 6 issues requires new thinking and priority setting in health. This will involve thinking about the health service in a different way. We hope that the Pathfinder report represents a first step in new thinking in terms of making a full assessment of the factors affecting the future of health, helping to decide where UK health wants to be in the world in 2015, and planning policy and priority setting for achieving those long-term goals in health policy.

What the Policy Futures exercise represents is an agenda for health. It promotes the idea that new, innovative, and long-term strategic thinking needs to take place to deal with the issues that will determine the future of health. The agenda for action refers to policy makers, staff in the NHS, patients, consumers of health services, and the public.

The Policy Futures for UK Health Project and the work of PEAG are ongoing. Further reports and publications will appear in subsequent years. The technical papers will also be revisited and different subjects will be tackled. This Pathfinder report is for wide consultation and invited comment. You can email your comments to policvfutures@jims.cam.ac.uk. You can also send your comments to Dr Charlotte Dargie, Nuffield Fellow in

Health Policy. The Judge Institute of Management Studies, Cambridge University, Cambridge, CB2 1AG. You can also find this Pathfinder report along with other technical papers in the Policy Futures series at the Nuffield Trust website: www.nuffieldtrust.org.uk. Please respond with your comments by Friday 19th November 1999.

Finally, the Trust is grateful to the members of the PEAG, to Professor Sandra Dawson and Pam Garside of the Judge Institute of Management Studies and to the authors of the 10 technical papers. A particular **thanks** is due to Dr Charlotte Dargie. Nuffield Trust Fellow at the Judge Institute of Management Studies, the author of the Pathfinder report.

John Wyn Owen. CB
July 1999

References

[1] *Screening in Medical Care: reviewing the evidence* A collection of essays with a preface by Lord Cohen of Birkenhead (Oxford, Oxford University Press for the Nuffield Provincial Hospitals Trust, 1968).

[2] Cochrane, A. L. *Effectiveness and Efficiency: Random Reflections on Health Service* (London, Nuffield Provisional Hospitals Trust, 1971).

[3] McKeown. T. *The Role of Medicine: dream, mirage or nemesis?* (London, Nuffield Provisional Hospitals Trust. 1976).

[4] Weatherall. D. *The New Genetics and Clinical Practice* (London, Nuffield Provisional Hospitals Trust, 1982).

[5] Enthoven. A. C. *Reflections on the Management of the National Health Service: An American looks at incentives to efficiency in health services management in the UK* (London. Nuffield Provincial Hospitals Trust, 19S5).

The full list of publications in the Policy Futures for UK Health Project Technical Series are:

1. K Lee *A Review of Priority Global Health Issues for the UK* (London: The Nuffield Trust, 1999).
2. S Palmer *A Review of Trends in the Natural and Built Environment* (London: The Nuffield Trust, 1999).
3. C Dargie *Analysing Trends and Policy Issues in Births. Deaths and Diseases for the UK Population in 2015* (London: The Nuffield Trust. 1999).
4. G Robert *Trends and Issues in Science and Technology Forward to 2015: Implications for Health Care* (London: The Nuffield Trust. 1999).
5. P Kanavos *A Prospective 1'iew of the Financing of Health Care* (London: The Nuffield Trust, 1999).
6. R Pahl *The Social Context of Healthy Living* (London: The Nuffield Trust, 1999).
~. E Ferhe *Archetype Change in the Organisation and Management of Health Care[0]* (London: The Nuffield Trust. 1999).
S. C Dargie *Analysing Trends and Policy Issues for the Future Health Workforce* (London: The Nuffield Trust, 1999).
9. M Evans *Reconciling Conflicting I'alues m Health Policy* (London: The Nuffield Trust, 1999).
10. M Barnes *From Paternalism to Partnership: Changing Relationships in Health and Health Services* (London: The Nuffield Trust. 1999).

Each of the papers is available from the Nuffield Trust.

Acknowledgements

Dr Charlotte Dargie is the Nuffield Fellow in Health Policy at the Judge Institute of Management Studies University of Cambridge.

Professor Sandra Dawson is KPMG Professor of Management Studies, **Director of the Judge Institute of** Management Studies and Master of Sidney Sussex College, University of Cambridge.

Pam Garside is a Senior Associate of the Judge Institute of Management Studies, University of Cambridge **and a** management consultant.

Executive Summary

This project examines trends and issues for future United Kingdom (UK) health. An environmental scan, summarised in terms often technical papers has highlighted some important trends and issues which will impact on the health of the UK population between now and 2015. The objective of the project is to use this future analysis to inform UK health policy and health policy makers. The purpose of the project is not to make predictions for the future, but to try and discover how better planning and policy making in health might benefit from a forward look. Published futures analyses often make recommendations for policy, but it is less usual to find an approach that combines both these tasks - an analysis of the future combined with a review of current policy. The project examines how policy will cope with the challenges that he ahead.

This 'Pathfinder' report sets out a policy assessment based on the environmental scan. From the technical papers and in discussions with a multi-disciplinary and multi-interest advisory group the report identifies the issues which health policy needs to address for the future. Each selected issue is described, identified in terms of relevant current government policy and activity, and made the subject of recommendations. The analysis is therefore used to address the gaps in current UK health policy. As the title, 'Pathfinder' suggests, the intention of this report, and the project is both to present its findings, and also to draw attention to the approach taken so that it might be adopted in future work.

The report identifies a series of policy issues for 2015, which are categorised within the health 'system' as determinants, interventions or outcomes in health, and together they form the basis of the Pathfinder report Evidence is presented for the issue in the form of past, present and future trends, an assessment of how policy makers are reacting to trends today is given by describing current policy, an assessment is made, which argues why change is needed and recommendations are targeted towards health policy, health care services, and policy making and management.

In the report's conclusion, a summary of policy recommendations is provided. They are recommendations for the medium to long-term with our time horizon of 2015. They are directed at government in the general sense. Health is a long-term issue, and policy involves a wide range of constituent groups.

Listed below is a set of 6 issues, which the Trust, on the basis of the Pathfinder analysis, considers represent the key areas that need to be addressed by UK health policy in order to deal with the future.

- People's expectations and financial sustainability

Expectations of health continue to rise amongst the population. At the most basic level people expect to feel safe and secure, and the health service contributes to that. People have expectations about how long they are going to live, and also the quality of their life. They have expectations about the type of service they receive when they interact individually with health services, which might include whether they are treated, when, by whom, what alternatives to treatment are offered, how successful their treatment is, whether they have to contribute financially in any way, and how well they recover their health. People have expectations about those who deliver health services to them, which include the ability to communicate with them on a personal basis. People's expectations need to be recognised and managed. This involves deciding what people should expect from health services and how progress towards achieving those goals is tested. It also means adapting the health system in order for the health workforce to be able to deal with a sophisticated public. Finally, managing public expectations means thinking about the long-tem financial sustainability of the health service in its current form of universal access funded from general taxation.

- Demography and ageing

The UK population is becoming older and this trend, in conjunction with a smaller working population to provide taxes to support health services will affect the dynamics of health services for the medium and long-term future. Policy for older people reflects policy in general. It involves dealing with financial considerations, considering the rights and the expectations of older people, developing integrated policy and planning for the health and welfare of older people, and furthering the evidence base for policy, which involves both more research on the disease profile associated with ageing and developing broader quality of life indicators for older people on which assessment can take place. Finally, a reorientation of policy towards the individual experience of older people, and an understanding of the wide range of factors in people's lives and the part to be played of family and friend relationships, social networks, environment, and the ability to participate in society are

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important.

- **Information and knowledge management**

Information technology is raising people's expectations. Patients are able to compare health services with those available outside the UK, to undertake research into conditions and treatments using the Internet, and to assess how health services make use of information technology when compared with other services such as banking and leisure. New technology offers many potential benefits to health, which need to be assessed along with their costs. The issue of information technology raises wider questions about the focus and formulation of health policy for the future. For example, viewing information technology in an integrated way across the health sector, sharing policy learning internationally and at the European level, implementing systems to test international pracnce. ensuring proper regulation, and developing training for health professionals. Information and knowledge management also involves the effective communication of public policy, and of risk to individuals.

- **Scientific advance and new technology**

New discoveries are changing what health services do and how they do it. Scientific advance is increasing therapeutic potential, providing new knowledge about preventive strategies and increasing technical expertise in health. These developments have consequences for health policy, which have to be managed, for example, a shift from tertiary towards secondary care, a shift from primary care to preventive strategies, and from people to mechanics and technology. They also illustrate some of the underlying tensions that exist in health policy; for example, between new knowledge facilitating preventive strategies in society and the right of the individual to refuse treatment, between increasing therapeutic potential and increasing pressure on the health workforce, and between increasingly complex scientific processes of manufacturing, process and treatment and demand for assurances on public safety issues. A particular impact of scientific advance and new knowledge concerns the locanon of care. On the one hand, larger, fewer and more concentrated centres of specialist expertise are developing, and on the other, there is a shift towards treatment outside hospital including self-diagnosis and home care.

- **Workforce education and training**

The health workforce is under increasing pressure to adapt to new knowledge, new treatments, and new ways of working. An example is the need for health professionals, along with other sectors, to be trained in the use of information technology. Training and education needs to be continuous throughout the health professional's career in order to keep up with evidence and new knowledge in the health field. Roles are shifting in health and attention needs to be directed towards assessment of the roles of professionals for the future, and their continuous education and training needs. The health workforce might reflect other sectors in terms of greater flexibility- and choice in career patterns, improved incentives and motivation, and greater protection. A longer-term perspective should be taken on workforce planning and alternatives to the current workforce planning systems explored.

- **System performance and quality (efficiency, effectiveness, economy and equity)**

Performance and quality issues provoke the question, how is the health system doing overall? There are incomplete mechanisms, particularly in terms of international comparison, for assessing how UK health performs. For the longer-term, policy would benefit from using international health outcome measures to benchmark the UK internationally over time. There needs to be development of outcome measures and more work to improve the measures. Such measures could be used to evaluate health policy. Quality and performance measures are currently being developed within the UK health sector. A focus on monitoring, evaluation and review should be extended to the performance of the health system overall, in addition to specific areas or services within it.

What the Policy Futures for UK Health Project represents is an agenda for health. It promotes the idea that new, innovanve, and long-term strategic thinking needs to take place to deal with the issues that will determine the future of health. The agenda for action refers to policy makers, staff in the NHS, patients, consumers of health services, and the public.

An early Trust offspring of the Policy Futures work was the establishment of a separate project on genetics futures. A genetics scenario programme is being carried out jointly with the Public Health Genetics Unit, Cambridge, led by Dr Ron Zimmern, which will report in Spring 2000. In consequence, the Pathfinder report

does not seek to cover the impact of advances in molecular biology and genetics on health.

Each of the 6 issues listed above requires new thinking and priority setting in health. It will involve thinking about the health service in a different way. The Pathfinder report represents a first step in new thinking in terms of making a full assessment of the factors affecting the future of health, helping to decide where UK health wants to be in the world in 2015, and planning policy and priority setting for achieving those long term goals in health policy.

Introduction

This project examines trends and issues for future United Kingdom (UK) health. An environmental scan, summarised in terms often technical papers has highlighted some important trends and issues which will impact on the health of the UK population between now and 2015. The objective of the project is to use this future analysis to inform UK health policy and health policy makers. The purpose of die project is not to make predictions for the future, but to try and discover how better planning and policy making in health might benefit from a forward look. Published futures analyses often make recommendations for policy, but it is less usual to find an approach that combines both these tasks - an analysis of the future combined with a review of current policy. The project examines how pohcy will cope with the challenges that lie ahead.

This 'Pathfinder' report sets out a policy assessment based on the environmental scan. From the technical papers and m discussions with a multi-disciplinary and multi-interest advisory group the report identifies the issues which health policy needs to address for the future. Each selected issue is described, identified in terms of relevant current government pohcy and activity, and made the subject of recommendations. The policy recommendations in each of the areas highlighted in this report attempt to address those gaps. As the title, 'Pathfinder' suggests, the intention of this report, and the project is both to present its findings, and also to draw attention to the approach taken so that it might be adopted in future work.

Structure of the Report

The report begins by setting the scene, which involves identifying some common definitions of health and related health policy objectives, looking across to European counterparts to compare UK health, and before embarking on a forward look in health, reflecting back on changes that have taken place in the previous fifteen years in UK health. The main body of the report is then divided into three parts. Part 1 describes the determinants of the health system that have been analysed. Part 2 describes health interventions and Part 3 describes health outcomes. In each part the report analyses issues for 2015 by describing relevant trends, looking at the implications and making policy recommendations. In concluding, the report reflects on some of the major themes that have come out of the report and provides a summary of recommendations.

Objectives of Health Policy

The assessment of health policy is challenging because it encompasses many different types of pohcy, for many different groups of people, and for different types of outcome. Health outcomes are themselves difficult to measure and compare. The public health paper, *Our Healthier Nation* makes reference to several elements within a concept of health:

- 'Good health ... It's what everybody wants for themselves, their family and friends'

- 'The NHS [which] is there to provide treatment and care when people fall ill'

- '... tackling the root causes of avoidable illness. In recent times the emphasis has been on trying to get people to live healthy lives, where necessary by changing their lifestyle. Now we want to see far more attention and Government action concentrated on the things which damage people's health and are beyond control of the individual ... air pollution, poverty, low wages, unemployment, poor housing, crime and disorder, which can make people ill in both body and mind.' (1: p. 2-3)

So. health is defined as both a social 'good', which enables the individual to function within society, and also subjectively by the individual. Health also refers to treatment and care, and the prevention of the causes of ill health in society. From their constitution the World Health Organisation (WHO) defines health as:

'A state of complete physical, mental and social well-being and not merely the absence of disease or infirmity' (2: p. 211).

This definition also includes social and economic factors that affect health. It identifies health in pohcy terms both as 'a fundamental human right and a world-wide social goal' (2: p. 211). However, as WHO acknowledge,

such a definition makes the task of setting targets for achievement in terms of health policy a difficult one. So, the WHO 'working definition' of health for such purposes is:

'The reduction in mortality, morbidity and disability due to detectable disease or disorder, and an increase in the perceived level of health' (2: p. 211).

The WHO definition does not say whether it means perceived by the individual or through some means of external assessment. The four public health documents for the UK (1, 3, 4, 5) include national targets for improvements over time in the levels of major causes of death, such as cancer and strokes. WHO has set many targets for achievement in terms of its 'Health for All' strategy which are used for countries throughout the world. In the European region of WHO, the 'Health for AIT strategy previously identified 38 targets to be achieved by member countries by the year 2000[1]. As an example of the kind of targets that are established for public health, targets for accident numbers have been set both for the WHO and *Our Healthier Nation* targets. In the former, target 11 of the WHO Health for All strategy was that 'by the year 2000, injury, disability and death arising from accidents should be reduced by at least 25%'(6). In *Our Healthier Nation* one of its four main targets refers to accidents with a target of reducing accidents (whereby accident involves a hospital visit or a consultation with a family doctor) by at least a fifth by the year 2010.

Health policy in this context is therefore concerned with the overall health of the population, and policy is judged in terms of making improvements in national indicators over time. What is more difficult to tackle is the health of the poorest in the population - the group who often contribute most to national figures on injury and sickness. Policy has also neglected an assessment of the performance of the health *system* in terms of whether it actually achieves better health outcomes for the population. An assessment of how well health policy is doing could attempt to bring these elements together, so that policy is assessed in terms of health outcomes, the performance of health care services (including the interface with other important social, transport and agricultural services), and in terms of the policy making and management processes themselves.

How does the UK Compare with European Counterparts on Health and Health Care Services?

A recent WHO and European Union (EU) assessment of the UK highlighted some positive and some negative trends[2] (7). On the positive side, the following features were highlighted: increasing life expectancy; mortality from external causes (e.g. accidental and violent deaths and suicides) being lowest among EU countries for women, and second lowest for men: a low standardised death rate (SDR) from car accidents; a declining and low suicide rate for women; a below average cancer mortality rate for men; and positive trends in adult smoking and nutrition patterns.

Negative trends were often focused on women. They mcluded: UK women ranked fourth highest in years of life lost through death before 65 years, and life expectancy at that age was comparatively low for both sexes; high SDR for those aged 0-64 years for cardiovascular diseases (second highest in women and third highest in men); second highest SDR for ischemic heart disease for both men and women, despite reductions; high mortality for women aged 0-64 for all cancers, again despite reductions; high teenage pregnancies; worrying trends in smoking amongst girls aged 11-15, and above EU average women smokers.

According to (Organisation for Economic Co-operation and Development (OECD) data for 1995 (8), the UK is placed 14th of 29 countries in terms of infant mortality; 11th for male life expectancy, and 18th for female life expectancy.

In a recent comparative report by the United Nations, the UK faired poorly (9). Whilst the country is advanced, it is divided. There are high levels of illiteracy, with one in five British adults being 'functionally illiterate'. One in six British people are said to live in poverty. Of the top 20 most advanced countries in the world, Britain has the highest number of young prisoners, and the longest working week.(10)

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[1] The 38 targets have since been revised. 21 targets now refer to a 2020 achievement date, and interestingly, do not contain quantifiable reducnons. but contain general statements about reductions across the European region as a whole (2).

[2] 18 countries which made up the comparison included the 15 countries of the EU plus Iceland, Norway and Switzerland.

In terms of health services, the UK operates a low cost health system compared to EU counterparts by spending approximately 7% of Gross Domestic Product (GDP) on health, compared with 10% in Germany, about 10% in France and almost 9% in The Netherlands. From 1992 figures[3], the UK sits in the lower half of EU countries in terms of hospital care spend (as a percentage of GDP); third from bottom of all EU countries in terms of GDP spend on ambulatory care, with only Denmark and The Netherlands below; second place in terms of nursing care spend, with only Denmark spending *more;* in the bottom third of EU countries in terms of spend on medication; and only Ireland spends less on dental care amongst EU countries as a proportion of GDP. In all but nursing care countries like Germany, France, Sweden, Austria, Denmark and Italy spend a larger percentage of GDP on health care. The UK has the lowest number of beds per 1000 inhabitants compared to Germany, France, The Netherlands, Austria, Denmark and Sweden; the lowest average care period in days; and me lowest number of doctors per 1000 inhabitants. The low health spend in the UK, partly due to being taxation funded which is a curb on costs, is argued to be the result of the general practice based primary care system which acts as 'gatekeeper' to the expensive hospital sector.

Health Policy Development: Reflecting on the Past and Analysing the Future

There is now a wide literature in health policy analysis, as well as an interest in health futures. WHO has addressed health futures (11) and the OECD now runs a futures programme. There are several ways in which a futures analysis could be conducted. For a summary of the process adopted for this project, and an overview of futures methodologies, see the appendix to the report. Published futures analyses often make recommendations for policy, but it is less usual to find an approach that combines both these tasks - an analysis of the future combined wiui a review of current policy. The aim of this report is to combine these two elements in order to provide a meaningful assessment of health policy today; that is, the report examines how policy will cope with the challenges that he ahead. Addressing future trends and issues allows a broader and more reflective view of policy. It analyses issues without the constraints of pressing current concerns and the debates of the day, which tend to consume discussions of health policy.

Reflecting on the Past

One possible starting point for the analysis would be to look back over a similar period to the forward look, and assess what has changed in the same time period to the present day. One of the advantages of doing this exercise is that it presents a more realistic picture of what might be achieved in a given time frame. Of course, health is a rapidly changing area, and could be subject to fundamental change in the future. However, the exercise serves as a useful counter to many future projections that tend to assume the impossible will be achieved in a short time span. In particular, the project has found in the area of scientific and technological discoveries that future projections are often over-optimistic about what will be discovered by when, and make unrealistic assumptions about the implementation of discoveries into everyday use.

In order to assess what has changed in health and health care services in the UK in the last 15 years the report begins by pursuing an alternative argument which involves asking the question, what has *not* changed in the intervening period? It may be surprising to note that funding levels for the health service have remained at a similar level of GDP over the last fifteen years. Health spending has increased since the National Health Service was launched in 1948, and despite cost controls in the 1980s, levels have increased above inflation in the last fifteen years, by similar amounts. So. there has been no significant overhaul of funding levels, either in terms of a reduction or increase. Despite cost pressures and conversely impetus in the 1980s and 1990s to reduce government expenditure, health spending has moved along a fairly steady increment.

Second, the provision of health services within the UK has remained predominantly within the public sector. There has not been an extensive programme of privatisation in the health service with hospitals moving to the private sector. What has taken place is the removal of some services from public provision, such as dental and optician treatments; the shift of some forms of care from the health sector to the social services sector, in particular residential care for older people; and the privatisation of many contracts for ancillary services within the health service which were previously provided in-house, such as catering, cleaning, and laundry. The

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[3] Schneider et al. (1995) cited in (7).

programme of market testing in the 1990s ensured that public sector provision competed against private sector contractors for non-clinical services. Finally, there is the Private Finance Initiative, which involves private ownership of public capital assets, a practice that has been recently established, and currently accounts for a small number of properties, but is set to increase in the future.

Third, the financing of health services remains through general taxation. We have not moved to alternative forms of financing such as social insurance or private insurance, although take up of the latter has increased over the last fifteen years. Alternatives to universal coverage for health services such as 'top up' schemes, where people are entitled to a basic package and finance further treatment through private financing, or 'opt out' schemes, where individuals may be subsidised for using private provision, have so far not been implemented.

Fourth, attention is drawn to the NHS workforce, which includes professional and technical, medical and dental, nursing and midwifery, and administrative and clerical staff. The core workforce[4] has increased in all these groups during the 1980s and 1990s, although nursing and midwifery increased more slowly than the rest, so that they were reduced as a proportion of the core workforce. Hospital medical staff has increased in number but both community medical and community dental were reduced. Ancillary, works and maintenance staff are reduced in number due to contracting out. (12) Nurses are still predominantly public sector trained and employed, although private sector and overseas nurses are increasing. Hospital doctors are still NHS employees. Hospital consultants have not seen changes to their contractual status, with constituent rights to private practice. General Practitioners (GPs) still practice as small businesses, with contractor status between themselves and the National Health Service. The reforms of the 1980s and 1990s introduced new conditions of services into GP contracts for the first time in the history of the NHS (13).

Finally, the overall structure of the NHS has remained the same. The National Health Services are administered from the Department of Health (which was previously allied with Social Security and separated in 1988), the Scottish Office, the Welsh Office and the Northern Ireland Office. Funding allocation and other policy decisions relating to the NHS take place in parliament. Central government control of health decisions was illustrated most recently when the Labour Secretary of State for Health, Frank Dobson, issued a central directive on the drug Viagra, which is used to treat impotence, and which has substantial resource implications if it was made freely available on the NHS. Its use has been limited to particular medical cases, and doctors will only be able to prescribe the drug for these designated cases. Service provision takes place locally. Patients register with a local GP, and are referred by their GP for treatment at a local hospital or possibly further afield for more specialist treatment. Resources are distributed through local health authorities, and their equivalent structures in Wales, Scotland and Northern Ireland. Regional health authorities were abolished in England and now regional offices of the NHS executive maintain a regional link between the centre and local provider organisations.

So, what has changed? The changes that have taken place in health and health care services in the UK over the last fifteen or so years could be summarised as those concerned with internal financial allocations and targets, organisation and management, and technological and clinical developments. Whilst the fundamental principles for the NHS have not changed, there have been lasting changes to its internal organisation and management, to service deliver},- mechanisms, to cost control and financing, and to technological and clinical innovations and developments in clinical practice.

Interestingly, the Institute for the Future has highlighted four 'big issues' to watch for America's health care future which are: service delivery systems; public expectations; managing and monitoring the sick out of hospital (using information technology): and purchasers. Arguably, these themes cover most of the fundamental changes that took place in UK health care from the early 1980s to the end of the 1990s, in terms of organisation and management. An anempt to document the changes of the last fifteen years might start with those listed in Figure 1.

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[4] Excludes ancillary, works and maintenance and nurse learners and students (12: p. 47).

Figure 1 Changes in UK Health in the 1980s and 1990s

Care of mentally ill shifted from institutional to community care

Assertion of managers and managerial controls within the NHS

Long term care shifted to local authority social services

Decline of professional domination of NHS

Reassertion of primary care, predominantly through fund-holding in general practice, and new Primary Care Groups

Introduction of clinical audit

Establishment of evidence-based medicine (EBM)

National Research and Development programme

*Introduction of market mechanisms into service delivery with contracting, **and** split between purchasers and providers*

Rising inequalities

Focus on individual health

Consumerism

New threats to health - HIV/AIDS, BSE (Food), suicides amongst young men, unemployment

Domination of economics and finance and finance considerations in health

More explicit rationing decisions due to increased funding pressures, more transparent systems of resource allocation, rising public expectations

The creation of NHS Trusts, autonomous provider units with corporate governance structures who are charged a return on capital assets

Increasing control measures - measurement, performance indicators, audit, quality

Analysing the Future

Having reflected on the past, let us turn to the main subject of the report, an assessment of the future.

FIGURE 2 CONCEPTUAL FRAMEWORK AND OVERARCHING ISSUES
ENVIRONMENTAL SCAN

POLICY RECOMMENDATIONS
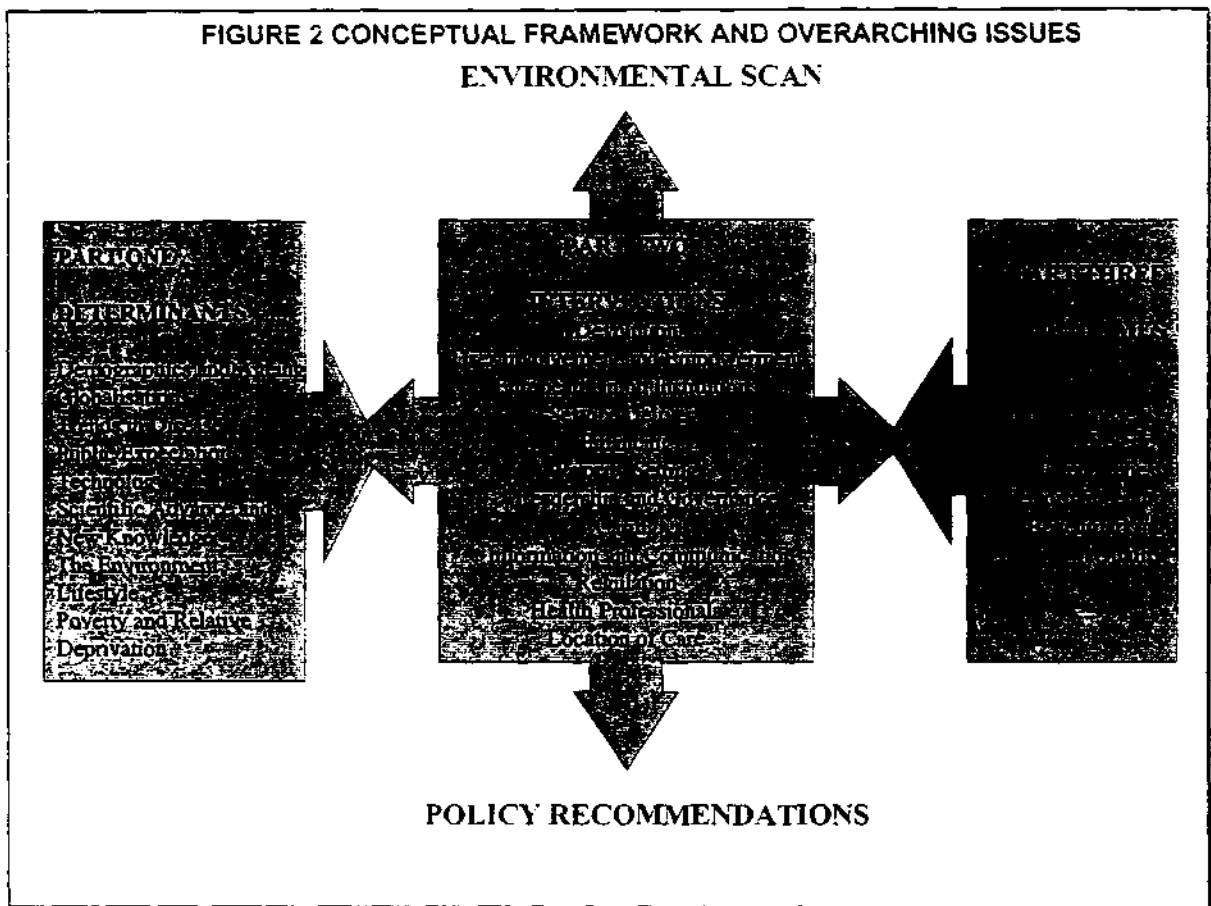
Figure 2 represents the intellectual process followed. The aim of the project is to use a futures analysis to explore broader thinking on health and health policy. In particular, the project hopes to illuminate some of the gaps in current thinking on health policy. International futures exercises have shown that one of their contributions is to allow a focus on health rather than medical issues, since a longer-term perspective allows broader trends in population health to be considered.

The purpose of the project was not to make predictions for the future, but to try and discover how betttr planning and policy making in health might benefit from a forward look. So, an 'environmental scan" was constructed. The aim of the scan was threefold. First, that the focus was *environmental*. That is, a wide analysis of the factors impacting on health and health care. The scan was therefore intended to be broad, and ten subject areas or 'scan categories' were identified as likely to have an impact on health and health care in the future. Figure 5 below shows the ten categories.

Secondly, the scan was *futures orientated,* focusing on factors that would affect health futures. Trend analysis often reflects back on past events to describe the current, and to project into the future. It was more difficult to find future projections than current trends, but the environmental scan used a description of trends to provide a basis for making an assessment of the future. The aim was therefore not to predict, but to examine and question issues for the future so that policy might take account of them now.

The time horizon was 2015. which reflected two concerns: that the issues be longer term than current policy thinking, which is dominated by five-year electoral cycles, and that the period in question was both imaginable and confinable. Looking back fifteen years shows what can change m that period. Those who are engaged in developing population projections agree that longer-term analysis becomes unstable, and less meaningful due to the range of possibilities (14. 15. 16). Thirdly, the process was *systematic* using trend data from various sources

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and building up a bibliographical base to support the value judgements, ideas, themes and debates that were raised.

The aims of the project were ambitious in attempting such a broad analysis in an area as complex as health and health care using academic methods to research and support statements with references. In all likelihood there will be areas that the report has missed, or subjects that are inadequately covered. However the intention of such a 'pathfinder' report is both to present its findings, and also to draw attention to the approach taken so that it might be adopted in further work.

In each of the technical papers, the authors concentrated on presenting trend data, and using bibliographical references to support ideas. The 'pathfinder' report presents an interpretation of that data into an assessment of health policy. The approach taken was to 'read across' from each of the ten technical papers in order to present linked issues. The synthesis of issues attempts to interpret each of the different subjects, disciplines, and specialties that were covered in the technical papers. In contrast to the increasing segmentation and specialisation in health issues, which inhibits any kind of general analysis, the report was written in order to bring together, and to make connections across, specialist areas of policy and research. The report is ambitious in trying to draw out from the technical papers what are some key policy issues.

Figure 3 Environmental Scan Categories

The Global Context

The Physical Environment

Demography

Science and Technology

Economy and Finance

Social Trends

Organisation and Management

Workforce

Ethics

Public Expectations
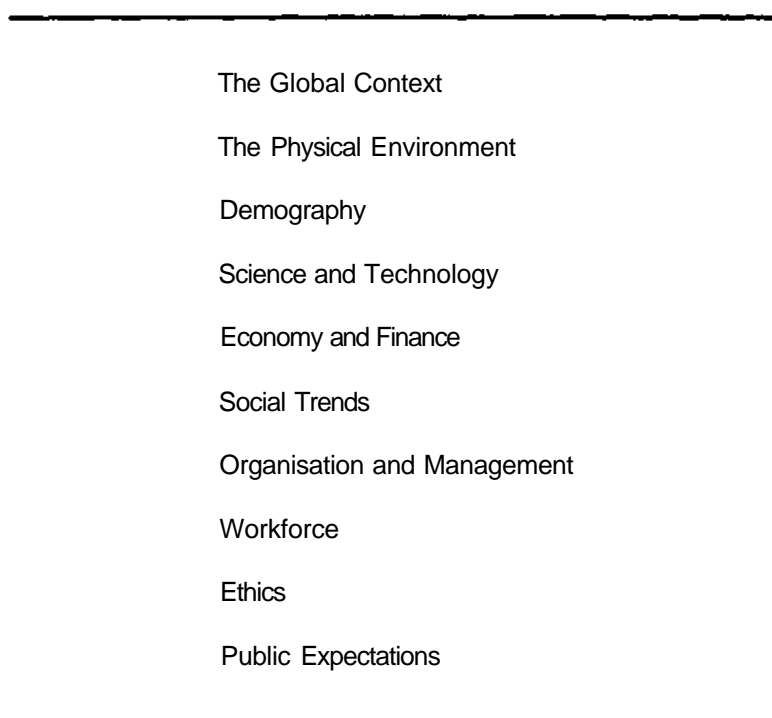
The reading across and interpretation of the technical papers came after a workshop held in Cambridge in January 1999 where each of the papers was reviewed. The process resulted in a series of issues that were identified as key policy issues for health policy for 2015. They are described in Figure 2 as determinants, interventions and outcomes in health.

The set of issues is not intended to be definitive. There might also be alternative ways of grouping the issues that are presented. One example might be to present the issues within four health 'fields', which are made up of environment lifestyle, human biology, and health care organisation. This was the framework adopted by the 1974 Lalonde Report on Canadian health (17).

The series of determinants, interventions and outcomes is intended to represent the stocks and flows that make up the health system. Each influences the other. It was also important that the report focus on practical policy

recommendations, and in that way, attention was focused on interventions in health, areas where those involved in health can make a difference.

The report represents a 'funnelling down' of issues that took place through the project. It began with an attempt to build up the broader picture of health and developed into areas within that broader picture where there were specific recommendations to be made in terms of policy. With this funnelling down process has come an emphasis on policy recommendations for health care and health services, because that is where policy can make a difference.

Finally, the categories of determinants, interventions and outcomes were intended to show that there are different points in the system that can be tackled by policy makers. Several recommendations throughout the report point to the need for unproved performance and benchmarking measures within the health system, and one of the overarching recommendations from undertaking a forward look in health is the need to develop appropriate markers or benchmarks for performance in terms of health outcomes, and in terms of performance of the health system, so that progress might be monitored on an ongoing basis.

Each of the issues represented in Figure 2 is discussed in the report. The format of the discussion follows the process taken through the project. First, evidence is presented for the issue in the form of past, present and future trends. Second, an assessment of how policy makers are reacting to trends today is given by describing current policy. Third, an assessment is made, which argues why change is needed. Fourth, recommendations, or a "call to action", are divided into three categories, which are health policy, health care services, and policy making and management. A summary of the report format is given in Figure 4 below.

Figure 4 Report Format

Trends

FOR: **DETERMINANTS**   THE EVIDENCE

INTERVENTIONS

OUTCOMES   **Current Policy**

HOW POLICY MAKERS ARE REACTING TO TRENDS

Implications

WHY CHANGE IS NEEDED

Recommendations

A CALL TO ACTION
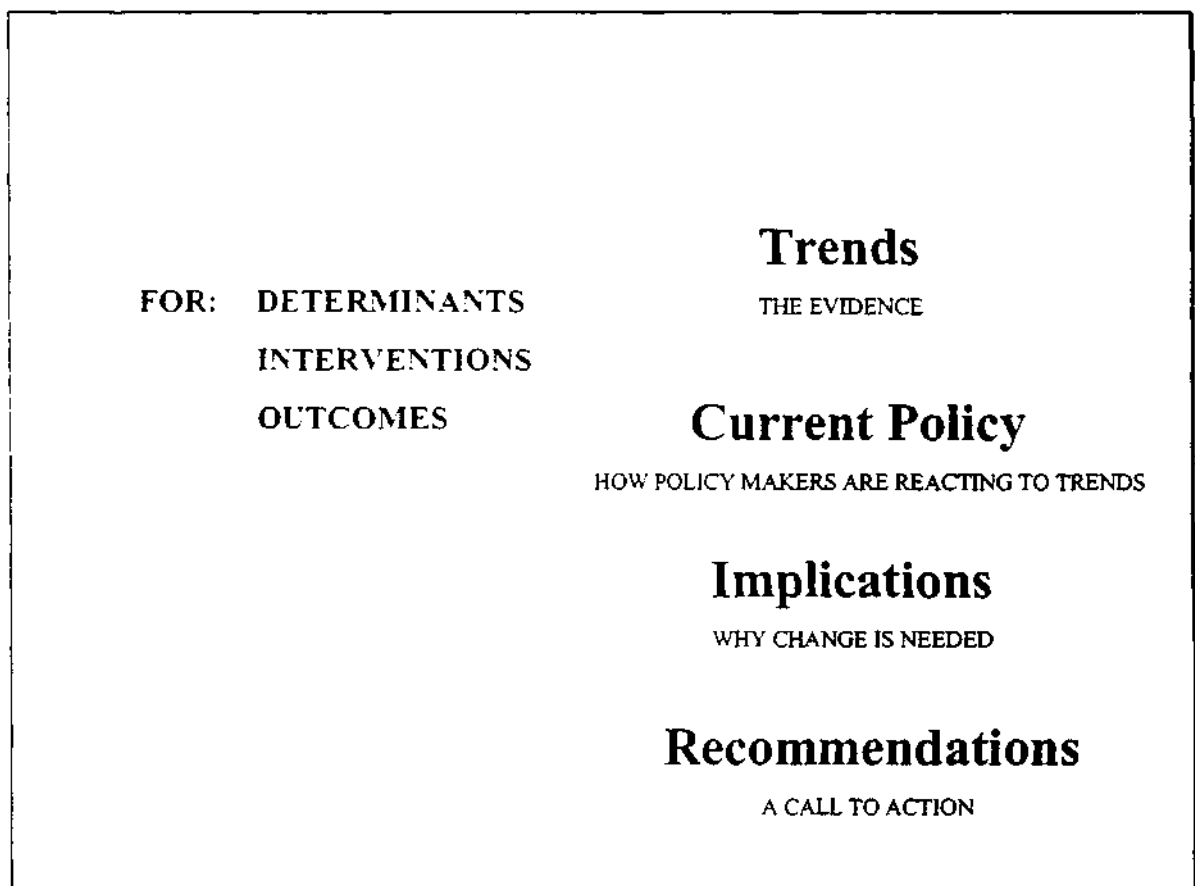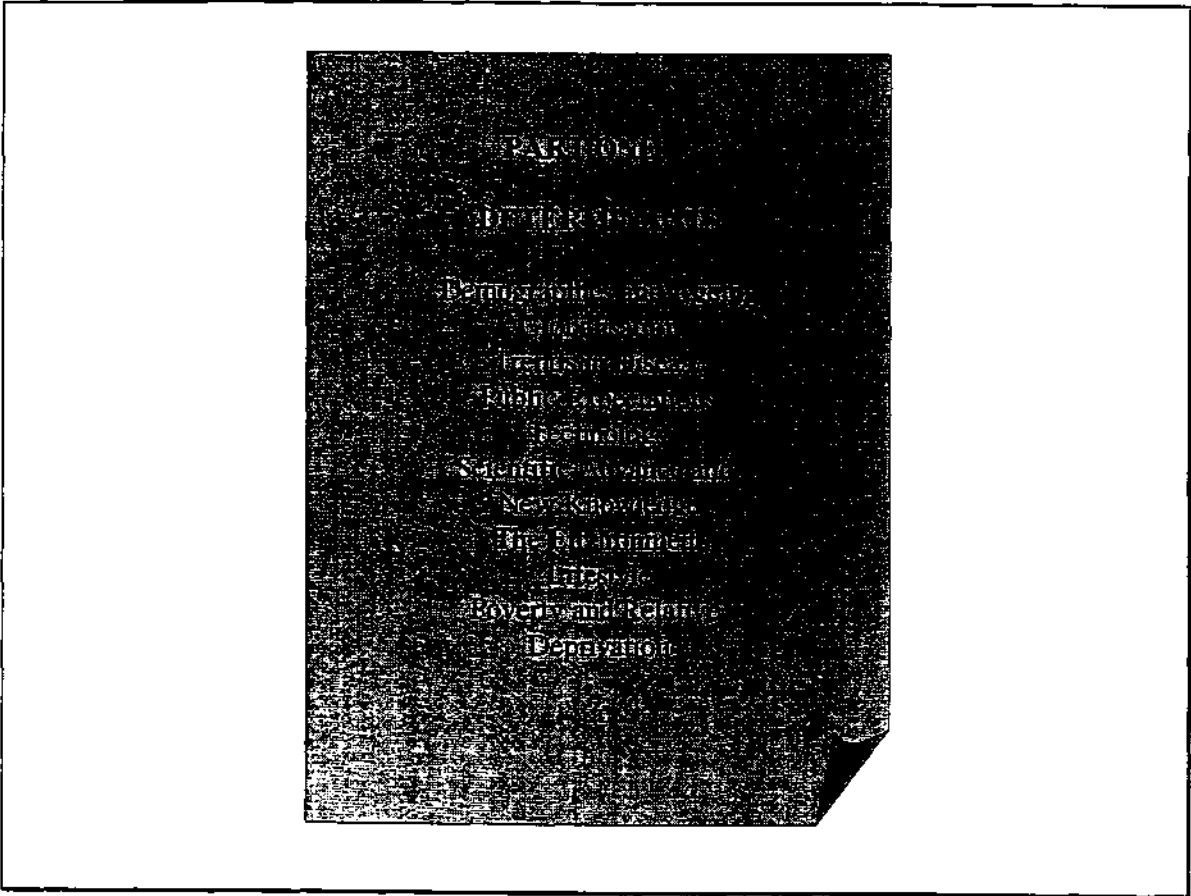
Demographics and Ageing

*"Engaging across sectors **and involving older** people **in determining what should be done** "*

The World Health Organisation (WHO) states that 'by 2025 there will be more than 800 million people over 65 in the world, two-thirds of them in developing countries ... Even in wealthy countries, most old and frail people cannot meet more than a small fraction of the costs of the health care they need. In the coming decades, few countries will be able to provide specialised care for their large population of aged individuals' ((18) p. 5). A recent OECD report, 'Maintaining Prosperity in an Ageing Society' suggests ageing presents its member countries with a 'complex and formidable set of interrelated challenges' ((19), p. 3). Its proposals for policy reform address fiscal, financial and labour market pressures that will hit developed societies particularly after 2010 when there will be a smaller proportion of the population in employment.

The most significant impact of the ageing UK population will take place in about 30 years from now; in 2036 there are projected to be more than 7 million people over the age of 75, whilst there are currently 4.3 million. De Jouvenel presents some alternative macroeconomic scenarios for an ageing population. Examples are: the costs of ageing exacerbate a situation of low economic growth and high unemployment; social welfare systems are called into question, leading to conflicts between beneficiaries and contributors to social security schemes; life cycles generally change, with work, training, and free time succeeding each other throughout life (20).

Trends

> increasing life expectancy (to 77 and 82 for men and women respectively by 2015)
>
> ageing population (15.8% of population aged 60-74 and 7.8% aged 75+ by 2015)
>
> increasing older dependency ratio (308 per 1,000 people by 2015)
>
> Current cost of long term care estimated at £12 billion. Projected to be £34.5 billion by 2030 (London Economics)

Current Policy

Ageing is one of five major themes of the Government's Foresight Programme, which has produced 'Agenet', an Internet based organisation that brings together researchers and provides information on research into ageing and the lives of older people. The Millennium Debate of the Age, which looks at demography in relation to work, health, pensions, environment, and values, was recently launched. Many voluntary and research organisations are looking into issues affecting older people, which cover both medical and social issues. The Royal Commission on the Funding of Long Term Care has just reported to the government, recommending changes to funding which could lead to increased taxes. The government will respond to the commission's report later in 1999. Currently, medical care is paid for under the NHS, and the individual, and/or the local authority depending on means pay for long-term care.

The government reported on older people in 'Building a better Britain for older people' in 1998 (21). Twenty-eight local authority pilots have been set up to explore inter-agency strategies and innovative ways of delivering services to older people over the next two years. In addition, the government has launched 'Passport 50 plus', which sets out the legal rights of older people in particular areas including healthcare.

Implications

For Health Policy:

- A need to maintain and promote the health of older people.

For Health Care Services:

- A shift in resources towards older people particularly in relation to the treatment and long-term care of those with chronic diseases.

- A broad range of health service needs of older people includes housing, medical care, transport and support links.

For Policy Making And Management

- Funding long term care; in particular, the relative contribution of individual versus public funds.

- Ethical issues about treatment for the very old.

- Overall resource implications for health services. Some estimates put the increased real expenditure required for demographic changes to 2015 at around 8% (Harrison et al cited in 22: p. 17).

- Questions about the ability of the working population to support the dependent population.

Recommendations:

For Health Policy

- OECD policy reform proposals tackle pensions, participation in employment and society, economic growth. and long term care provision. Reforms such as removing financial incentives to early retirement, and reducing public debt are proposed. (19)

- State more clearly the individual rights of older people - to dignity, choice and to participation in society, through work, leisure activities, or family and social networks.

- More research is required into the profile of diseases specifically associated with ageing.

For Health Care Services

- In health care, OECD policy proposals are macroeconomic in scope, highlighting cost effectiveness, medical expenditure and research that is focused in reducing dependence, and explicit policies for providing care to frail older people. Other proposals include the integration of health and long term care, more equitable access to care, and unproved protection against the financial risks associated with disability. (19)

For Policy Making And Management

- Establish a policy goal for older people, for example, to maximise healthy life years, and plan policy for older people around that goal.

- Consider the expectations of older people, as well as the expectations of the rest of the population.

- Integrate the development of services improve the health and well being of older people way with those services mat are currently 'outside' health such as housing, medical care, transport and support links.

- Develop meaningful quality of life indicators in addition to the current scientific indicators that are used to assess the health and well being of older people.

Globalisation

"Take note of the global impact on disease "

A 'process of closer interaction of human activity across a wide range of spheres including the economic, political, social, cultural and technological' (23: p. 2). It also involves the supplantation of the nation state by structures, processes or developments that cut across national boundaries (Moran and Wood, 1996, cited in 24). Globalisation includes both space/time compression and industrial concentration. Globalisation brings both health threats and health opportunities.

Globalisation is currently being examined as an issue of health policy. The new World Health Declaration adopted at the Fifty-first World Health Assembly of the World Health Organisation in 1998 reflects globalisation.

Trends

the emergence of new health risks caused by increasing transborder flows of people, goods, services and capital

increasing opportunities for enhancing health training and education via global information and communication systems

increasing pressure for a system of global governance for health in order to deal with global health issues

---

Current Policy

Understanding and awareness of the specific impact of globalisation on health in the UK among health professionals, policy makers and researchers remains limited. Policy does not yet take account of the threats to health that are part of the global economy; threats such as migration, war and terrorism. Currently trade policy, health policy and science policy remain disconnected within government. Pressures to liberalise trade have so far taken precedence over the protection of public health so that policy does not take account of new threats to health in the UK. Internationally, the World Health Organisation (WHO) is undergoing reform, and there are wider questions among the policy community about the capacity of national governments, regional and international organisations to be able to effectively address global issues.

Implications

For Health Policy:

- Increased trans-border health risks into (malaria, tuberculosis) and out of (BSE/nvCJD, tobacco) the UK.

- Absence of regulation has led to potentially harmful marketing practices of health-related goods and services by foreign companies, for example, over the Internet.

For Health Care Services:

- Increase in burden of infectious diseases and diseases from different climates.

- Making provision for the needs of refugees and asylum seekers.

For Policy Making and Management

- International systems will impact on UK health policy making, and in other areas of government policy.

- Devolution will affect how the UK responds to global health threats and trans-border health risks.

Recommendations

For Health Policy:

- Re-balance policy in favour of the protection of public health against policy concerns with the expansion of trade.

- Address new threats to health caused by globalisation.

- Explore fully information technologies for health purposes.

For Health Care Services

- Provide continuous education and training for health professionals to recognise and treat tropical and other previously rare diseases.

- Provide continuing education and training for health professionals and other front-line staff in situations such as public health measures if new diseases come into the country, practices at points of entry to the country', and the provision of health services to migrant populations.

For Policy Making and Management

Make UK health policy informed by what takes place outside the UK system, and make a contribution to international health policy development.

For example:

- Take advantage of information sharing; for example, a 'global web for health'. Policy makers, health professionals and researchers in the UK need to be more aware of global health issues, which could be achieved through a research programme that would feed into meetings, briefings, consultations and policy initiatives.

- Balance global and local interests. With devolution, integration between regional, national and global health issues will need to be reviewed, for example in areas such as disease surveillance and monitoring. Britain has a key role in multi-national agencies underpinning surveillance of infectious diseases network.

- Establish inter-ministerial or interdepartmental committees to co-ordinate health policies (25: p. 69). Health should be on the policy agendas of other government departments, for example, Department of Trade and Industry to deal with trade impacts on health.

- A stronger emphasis on 'capacity building', providing basic health needs and reducing poverty in relation to international development aid.

- Construct a proper regulatory framework for dealing with the marketing practices of foreign companies.

Trends in Disease

"Ask the question, what will the pattern of disease be in 2015? "

Like other developed countries, non-communicable diseases represent the main burden of mortality and morbidity within the UK. Within that group, deaths from respiratory diseases are increasing. There are adverse trends in smoking and in obesity, which will be important determinants of future disease patterns in the UK. Deaths from stroke in people under 65 declined during the 1980s, but that decline is slowing down (1: p. 57-8). Heart disease and stroke account for a third of all deaths in men and one fifth of all deaths in women aged under 65 (1: 61-63). They have been decreasing, but marked inequalities remain.

Trends in cancer show a steady rise in incidence projected for the future. As now, lung cancer and breast cancers are projected to pose the largest burden for women (1, 26). For men, prostate cancer, colon cancer, and lung cancer will pose the largest burden (26). Increasing incidence of cancers, such as prostate, is associated with an ageing population (27). There are geographical and social inequalities in cancer death rates (1). Many cancer deaths are avoidable, either by prevention, or early detection and treatment (1). Comparing the UK to members of the European Union finds mortality from all cancers around the EU average, with Spain, Portugal and Greece doing better, and countries like Germany, Italy and France doing worse.

Conditions such as diabetes and conditions of the central nervous system are gaining in importance.

Accidents are the biggest threat to life for children and young people, and are a major cause of death and disability in older people (1: p. 65). Like other factors, childhood injury is linked with social deprivation (1: p.65).

Mental health is identified as a priority by UK government and international agencies responsible for health. According to data from the European Region of the WHO (2: p. 41) between 1-3 per cent of a population suffers from severe mental problems. Suicide is prevalent in younger people, and one of the biggest killers of adult men aged 18-24. Poor mental health is increasing in children and young people in the UK (28 cited in 1: p. 76). Depression is one of the most common reasons for visits to the doctor, and it, too is increasing. There are inequalities in mental health by social class in the UK with unskilled men and women more likely to suffer from mental health problems (29 cited in 1: p. 76-77). The WHO says that risk factors for mental health problems, such as unemployment, poverty, and homelessness are increasing (2).

Trends

shifting burden of disease from young to old and communicable to chronic disease, although continued threat of new and recurring infectious diseases

increasing incidence of cancer mainly due to the ageing population

increasing trends in obesity with the proportion of adults aged 16-64 who are obese rising from 13% to 16% for men 1991/2 to 1996 and 15% to 17% for women (30)

increasing proportion of children aged 11-15 who are regular smokers, from 10% in 1990 to 13% in 1996 (30)

increasing poor mental health in children and young people, particularly disadvantaged children

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Current Policy

In *Our Healthier Nation* (1), *Towards a Healthier Scotland* (3), targets have been set for reductions in the UK's biggest killers: heart disease and stroke, accidents, cancer, and mental health. *Our Healthier Nation* also sets out 'National Contracts' for each of these four groups. Each contract is broken up into social and economic, environmental, lifestyle and services. There are policy recommendations made for the following groups: government and national players, local players and communities, and people. Some examples of policy recommendations taken from these four contracts are: 'continue to make smoking cost more through taxation' (1: p. 64, 75); 'target information about a healthy life on groups and areas where people are most at risk' (1: p. 64, 75); 'develop safer routes for school' (1: p. 69); 'ensure professionals are trained in accident prevention' (1: p. 69); and 'work with deprived communities and with businesses to ensure a more varied and affordable choice of food' (1: p. 75). The current Labour government has set up Health Action Zones, which are intended to carry through some of this policy through initiatives such as 'healthy schools' and 'healthy workplaces'. The Social

Exclusion Unit is intended to deal with the root causes of inequalities tackling subjects such as teenage pregnancy, homelessness and exclusion from school.

WHO targets for preventing and controlling disease and injury for 2020 are the following: improving mental health, reducing communicable diseases, reducing non-communicable diseases, reducing injury from violence and accidents (2).

Implications

For Health Policy:

- Asking the question, what does it mean to be healthy?

- Social, economic and lifestyle factors affect health.

- The health of older population is a future concern; for example there is an increase in the incidence of cancer for older people.

- Threats of infectious diseases and antibiotic resistance.

- Smoking, depression and suicide (young men) are problems for the health of young people.

- UK is improving on some indicators, and not on others. Increases in smoking and obesity will affect the incidence of non-communicable diseases in the future.

For Health Care Services:

- Services will need to be organised and planned to deal with burden of disease, for example, the incidence of depression, which is the second most common reason why people visit their doctor.

- More integrated services to tackle interrelated problems.

- Wider responsibility for disease than medical or health professionals - includes businesses, schools, and other community settings.

For Policy Making and Management:

- The limited success of policy making is reflected upon, illustrated by the fact that the poor remain the hardest hit by disease and ill health.

- Messages are missing children, who are increasing smoking. Accidents, poor diet, are associated with social deprivation in children.

Recommendations

For Health Policy

- Appropriate mix of individual and population based measures.

- Improved research associated with common and increasingly prevalent diseases.

- Benchmark UK performance against other similar, developed countries in tackling disease. Learn from successful country strategies.

For Health Care Services

- Traming and education for health care personnel, for example in identifying risk factors and appropriate tools for recognition and treatment associated with mental health problems.

- Appropriate mix of preventive and curative, and community-based and hospital-based treatment.

- Demographic trends are difficult to influence. However, policy needs to be aware of demographic trends. Obesity, smoking, and depression are likely to place a burden on health care services, and on the health of younger people. Health care services need to be planned to anticipate these changes in patterns of disease.

- Strategic planning requires inter-sectoral approaches and ways of working together. Develop national and local policy agreements on shared working.

For Policy Making and Management

Policy recommendations are likely to be tailored to particular diseases or groups of diseases. However there are some common features of WHO policy strategies that relate to preventing and controlling disease, which include (2):

- Public policy approaches that deal with risk factors to health, integrating social, environmental and behavioural risks, with the appropriate allocation of resources.

- Public policy that is broad, and preventive, including incentives for prevention, and screening programmes for non-communicable diseases.

- Make the health sector responsible for inter-sectoral policy approaches that try to control risk factors in both individual and population-based strategies.

- Establish an evidence base for treatments supported by a population-based health information system. Pay particular attention to monitoring and evaluation of programmes.

- Long term collaboration on strategies amongst member states, including information sharing on knowledge and experience, particularly on successful strategies. WHO cite the case of Finland, which achieved a 73 per cent reduction in coronary heart disease mortality over a 25-year period up to 1995, where nutrition policy made significant impact on dietary change (2: p. 58).

Public Expectations

"Working with a more informed public and a highly active media "

A power shift has occurred in the health sector away from professionals and towards patients, users, and consumers of services. In line with developments in other services, patients now have higher expectations of health services, they are more aware of their right to choice and participation in decisions about health care and treatment, they are more assertive in articulating their expectations to health professionals, and they are more aware of the wider context of health service provision through information technology and the various media. Health care has also become more of a tradable commodity that allows consumers to compare health services, their availability and their quality across countries (22: p. 1).

Consumerism has been a trend in the last twenty years, mostly developing in the 1980s, where it has been influenced by the American health care system. Consumerism in health is increasing due to globalisation and the impact of European Union. Complaints have increased with each year of the Patient's Charter. About half the UK population are satisfied with the health care services which compares favourably to Greece, and worse by considerable margins than the Netherlands and Germany (31). The Institute for the Future cites some consumer drivers for the future in the United States as a push towards self-treatment (home care); patients-rights legislation supported by older people; and improvements in the information infrastructure in health care (32).

Trends

increasing individual access to health information that was previously dependent upon professional gatekeepers, particularly through electronic information

the rise of the empowered consumer; increasingly demanding patients and general public, and increasing challenges to professional and expert authority in health

intensification of media role in assigning priority to certain issues and debates at the national and local level

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Current Policy

Current policy is focused on establishing measures for quality improvements, and extending performance measures to clinical outcomes. The government has announced a Performance Assessment Framework that contains 41 indicators in order to assess the NHS in England on service provision and health improvement

The former Conservative Major government did much to drive the consumerist agenda within UK public services, using 'charters' including the Patient's Charter for the NHS. Patients were able to examine hospital performance in terms of published waiting tunes. In addition, they were able to channel complaints through the Patient's Charter. Separate charters were established for England, Wales, Scotland and Northern Ireland. The charters include rights and national standards but are not legal documents. In 1996 the NHS set up a litigation authority and a clinical negligence scheme for trusts.

Changes in the health service reflected changes elsewhere in public services, which were intended to reflect tie service practices of large corporations. The current Labour government has changed policy, replacing the Patient's Charter with the NHS Charter that includes responsibilities on the part of patients as well as rights. The development of charters has seen an increase in the number of complaints against the NHS. There has also been an increase in litigation. In other areas the health service is responding to consumer issues by setting up the NHS Direct system, a telephone help line for patients, and in undertaking the first annual National Survey of NHS Patients in England. The overall theme of current government policy on consumerism is 'partnership' where it is hoped that there will be developments on the part of both professionals and patients to improve services, treatments and outcomes.

Implications

For Health Policy:

• Health will be part of individual responsibility rather than the responsibility of the welfare state, with the possibility of an implicit or even explicit 'contract' for health where the individual has certain responsibilities to undertake in improving their health as well as expectations about treatment and services.

• Health that is focused on health care rather than public health measures or health inequalities.

- A widening gap between those who have access to information and those who do not leading to a differentiation or 'tiers' of consumers. (32)

For Health Care Services

- More explicit standards of care, improvements in standards of care, and increased disclosure of medical information. There is likely to be greater freedom of medical information including more rights for patients over medical records and clinical information.

- A significant increase in self-care.

- More explicit standards of performance in order for consumers to be able to make more informed choices about services.

- Increased choice of supply, with possibly services provided by other European countries, and increased supply of overseas workforce.

- Increased scrutiny, monitoring, benchmarking of services using cross-country comparisons.

- Health providers will have to respond to an increasingly diverse set of patient needs (32).

For Policy Making and Management

- Greater public involvement in prioritisation decisions over service provision.

Recommendations

For Health Policy

- Information from respected sources needs to be targeted at those who do not have access to other sources. There is some work already on patient information, and calls for a national strategy to ensure standards (33) (34).

For Health Care Services

- Effective public disclosure on health issues. The Internet presents potential major benefits for patients, but also challenges to both users and suppliers of information (35). Internet use in health is growing. 1997 figures suggest 10,000 health related websites with a third of Internet users accessing the web to retrieve health and medical information (cited in 33).

- One of the distinctions professionals will have to make is between *information* and *knowledge* on the part of patients, given that there is no regulation of information available on the Internet. (Published criteria for evaluating health related information on the Internet has been proposed (36)).

- All these factors imply new methods of training, of consultation between patient and doctor, and more time to be devoted on the pan of doctors, to reviewing clinical information on patient conditions.

For Policy Making and Management

- Draw on knowledge from other countries and other health systems for new ideas and strategies. With the EU. globalisation, the increasing importance of the health care industry, and the facilitation of information technology, learning from outside UK N'HS expence will be an important driver of consumerism and consumer issues The UK tends to follow US on many of these issues, as the case of the Viagra drug, which was first available in the US. and was driven by market forces in the US health care sector, informed the demand for the drug in the UK. It is likely that cases like Viagra will occur again, and government will need to develop policies to deal with these influences.

Technology

"Health Technology Assessment is vital"

Technology, defined as any health care intervention, is increasingly a driver in health and health care. Current interest is focused on assessing and evaluating what technology can do, at what cost, and what programmes should be funded from health budgets.

Trends

increasing role for technology in health care both in developing the services and treatment offered in health care, and influencing the settings in which treatment and care take place

increasing importance of technologies which allow self-diagnosis and 'self-treatment' or home care

increasing importance of assessment and evaluation of technologies in health care, both in terms of cost and effectiveness

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Current Policy

The Health Technology Assessment programme (HTA) has been established since 1993 to appraise existing interventions. It undertakes research into technologies that have been identified by the Standing Group on Health Technology as priorities. Those who work in the NHS are the recipients of HTA reports. The possible benefits to patients are judged by HTA reports in terms of both improved patient outcomes and the efficient use of NHS resources.

From April 1999, the National Institute for Clinical Excellence (NICE) will appraise new and existing interventions. A National Horizon Scanning Centre will provide a selection process for a 'short list' of interventions to be appraised. NICE provides appraisals and guidance. Appraisal is defined as the 'clinical cost-effectiveness of the intervention', which means the intervention is cost effective on the basis of health improvement achieved for given NHS resources, compared with other potential uses of these resources (37: p. 12). So far, reports do not say how 'health improvement' will be measured, or how many people have to be affected, although different groups of the population are mentioned. Like HTA therefore, NICE appraises cost and outcomes together.

Information technology is one of the key drivers in society. In health, NHS Direct, a telephone service for NHS users was launched in 1998 and is expected to cover the country by the end of 2000. (See also 'Information and Communication' under Health Interventions).

Implications

For Health Policy

- Individuals will take more responsibility for their health using technological developments, including self-diagnosis and self- treatment or home care. Older patients may benefit from treatment within their homes rather than being hospitalised, particularly if family and social support networks surround them.

- Many new technologies focus on the individual, and given the cost of developing the technologies, such investments are likely to intensify the socially induced inequalities in health status (38: p. 27).

- The potential to screen and treat serious conditions so that disease prediction and prevention become higher priorities within health.

For Health Care Services

- Planning and decision making about data storage, patient access to information and communication between organisations in the health service.

- Improving the potential for screening and treating serious conditions.

- Influencing the location of care:

    A greater concentration of specialist expertise and equipment in a smaller number of larger centres dealing with complex cases, driven by the increasing sophistication of medicine.

More diagnosis, treatment and monitoring taking place outside the hospital, including increases in self-diagnosis and home care.

More conditions treated locally in small centres linked telemetrically to specialist centres.

Increasingly blurred distinctions between primary, secondary and tertiary care.

Reductions in lengths of hospital stay.

For Policy Making and Management

- Influencing who provides care:

  Role substitution amongst health professionals.

  Training and education of health professionals to deal with new technology.

- Increasing the need to research, anticipate, monitor and evaluate new technology.

- Acceptance of rationing and managed entry of technologies.

Recommendations

For Health Policy

- Link developments in technology to health outcomes. Evaluate technologies on the basis of costs and benefits, including those associated with health outcomes.

- Explore the overall impact that technology is currently having, and will have, on health inequalities.

For Health Care Services

- Include planning for technological developments in resource allocation decisions.

- Keep in touch with new technology in terms of education and training, as well as for staffing and service delivery.

For Policv Making and Management

- Address the overall quesnon of the investment in new technologies at the centre of policy making as well its assessment and review.

- Explore the socio-economic impact of new technologies and include it in the evaluation of new health care technologies. We cannot and should not separate science and technology from social and environmental issues.

- Develop an 'early warning system' for identifying health care technologies prior to their widespread adoption (39).

Scientific Advance and New Knowledge

"Critically appraise and educate in critical appraisal"

Trends

developments in genetics including increasing expectations and also discoveries from the Human Genome Project, which promises cures in untreatable areas, drug discoveries, screening and treatment in the area of molecular genetics

developments in bioengineering and biotechnology to make useful products for medical treatment such as artificial blood and artificial internal organs

increasing diversification and sophistication of scientific developments in relation to medicine and health care, including, for example, robotics, imaging and other technologies in the operating theatre, and telemedicine

---

Current Policy

Science policy is located within the Office of Science and Technology. Scientific funding has recently received an increased commitment from the government. Government has a role as both funder and regulator of scientific research and its application to medicine. It relies on the advice of advisory committees to help in its regulatory role such as the Advisory Committee on Genetic Testing and the Human Genetics Advisory Commission. The Health Technology Assessment programme that is described above appraises technological interventions in health. The Foresight Programme takes a forward view on scientific and technological developments for the government. Its Health and Life Sciences Panel has been replaced by a Healthcare Panel, and it second round of deliberations began in 1999. It is difficult to summarise the content of government policy on scientific advance. Scientific advance is seen as an engine of growth in the economy, a provider of education, training, jobs and international business opportunities.

Implications

For Health Policy

- Increasing individual responsibility for health that may occur as the result of genetic knowledge. For example, someone who is identified as being 'at risk' of developing a particular disease may be eligible for a programme of behaviour change or preventive medicine in order to reduce the risk of the disease developing.

- Some people may be targeted for behavioural and lifestyle changes as a result of newly acquired genetic knowledge. Equally, some people will undertake certain lifestyles and behaviours because they have been identified as *not* being susceptible to 'lifestyle' disease.

- Changes to the insurance market and insurance companies including information sought and eligibility criteria for securing insurance.

For Health Care Services

- Some diseases may be treatable for the first time.

- Doctors will become better at treating some diseases and able to treat some diseases for the first time.

- A change of emphasis of treatment from 'diagnose and treat' to 'predict and prevent' with developments in genetics. There are implications here for professional roles, education and training. For example, professionals may all have to be geneticists in the future, thus changing traditional demarcations of disease, and protocols for treatment[5].

- Developments in surgery may further reduce lengths of stay, and reduce the need for traditional acute hospitals and operating theatres. Services are already beginning to reconfigure towards primary, local centres and specialised care, cutting out the district general hospitals.

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[5] The Nuffield Trust is funding a project using scenarios and forward thinking on the subject of genetics by Dr Ron Zimmem, Director of the Public Health Genetics Unit located in Cambridge. The results of the Nuffield Trust Genetics Scenario Project are planned for 2000.

For Policy Making and Management

- A range of factors that are interrelated including:

    Regulation and control of scientific advance.

    Ethical dilemmas.

    Public support and also mistrust of scientific developments in health.

    Organisation and planning of health services, including settings or location of care and role substitution amongst professionals.

    Financing and the allocation of limited resources.

    Evaluation and review of scientific advance.

    Increasing gap between what science discovers, and what can, and should, be implemented in terms of health policy and the provision of health care services.

Recommendations

For Health Policy

- Link systematic evaluation of the promises of science to benefits in terms of health outcomes.

For Health Care Services

- The Nuffield Genetics Scenario Project (see footnote 5) will produce specific recommendations for health care services as a result of developments in genetics. Evaluation of the impact of scientific advance on health care services is required for policy making that does not assume scientific advance will improve services overall, but weighs up the costs and benefits in a systematic way.

For Policy Making and Management

- Develop genetic awareness amongst the population. Raise awareness of and investigate the consequences of developments in genetics for the insurance industry.

- Develop an appropnate ethical framework in order to evaluate scientific advances. For example, in terms of how do we deal with the issue of genetic information. What rights do people have *not* to know, and what rights do they have to not be penalised for not knowing genetic information about themselves?

- Be responsive to. and include, public attitudes to scientific advance. On genetically modified food, we have seen policy change as a result of media-driven public pressure. Medical and other scientific and social scientific organisations and publications such as the Journal of the American Medical Association (JAMA) are coming to terms with policy issues in this subject area. For example, November 1999 sees the British Medical Journal (BMJ) publishes a complete issue on the impact of 'new technologies in medicine', including ethical issues, regulation, and the effect technologies might have on health inequalities. Policy should draw on these discussions and debates, nationally and internationally.

- Develop a policy making process to ensure the systematic evaluation of scientific advance that includes all relevant costs and benefits to individuals and society, including ethical constraints, public opinion, and opportunity costs.

The Environment

"Link the social and the physical environment

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Trends

    improvements in air quality from reductions in the major sources of pollution – particles, oxides of
    nitrogen, ozone and carbon monoxide; there is increasing evidence linking air quality with health

    increasing public concern with food safety due to changes to processing methods, transference of diseases
    from animals to humans, rise in incidence of infections in poultry meat, and consequences of commercial
    pressures to intensify production and waste disposal

    emergence of new diseases (BSE) and the re-emergence of once controlled diseases (TB)

    increasing link made between housing and health, with poor housing linked to long term illness, respiratory
    disease and psychological problems
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Current Policy

The green papers on public health in the UK identify the need for 'health impact assessment' across all policy areas but the techniques for making this part of routine practice have not yet been developed (40).

In 1996 the UK government published its National Environmental Health Action Plan to take forward Agenda 21. Specific environmental hazards identified were water, air quahty, food, solid wastes and soil pollution, ionising and non-ionising radiation, natural disasters and industrial and nuclear accidents.

Implications

For Health Policy

It is difficult to summarise the health implications of the considerable range of environmental factors that will impact to 2015. Some issues are therefore highlighted.

- Most of the air pollution components look set to reduce before 2015, which has positive implications for health. For example, Ozone levels are anticipated to fall, which are associated with numbers of deaths and (particularly in the elderly) hospital admissions for respiratory disease.

- There is a lack of clear evidence on the impacts of changes in food production and food safety.

- The link between housing and health is under-researched but examples include evidence that radon is a significant problem in some areas of the country and has been linked to increased risk of lung cancer and childhood cancer, and that exposure to tobacco smoke and house dust mites during early childhood is associated with increased risk of asthma. A growing problem is community safety on 'sink' estates. (40: p. 11.22).

For Health Care Services

- Environmental trends have implications for the success of health care services that are considered in isolation from other factors affecting health, particularly the root causes of ill health, which may well be social or economic in nature.

- Health care services have to respond to new sets of diseases, such as BSE, where there is limited knowledge from research. Treating new diseases have knock-on effects in terms of staffing, education and training, and the ability to treat other diseases.

For Policy Making and Management

- Methods of assessing the health impact of environment perspective are in their infancy. Techniques in this area are likely to increase. Environment and health issues will continue to increase in importance in policy terms, to become a dominant focus in health policy development (40: p. 3).

- Environmental policy making has to take an increasingly global perspective on issues, because of new diseases and environmental hazards that may be global in nature, and because of the spread of diseases due

to mobility. For example, the global spread of HIV within only a few years of its emergence on USA and Europe is directly attributable to business and tourist travel (40).

Recommendations

- In adults, socio-economic factors in health inequalities have been linked to relative differentials in income and to psychosocial stress, which is related to unemployment, social integration, social inclusion and the workplace environment. Policy needs to consider environmental factors not only at the individual level but also at the community level and within specific settings. (40).

- Integrated health policy that tackles causes of ill health, which may be social, environmental, and economic in nature.

- Policy links between Department of the Environment, Transport and the Regions, Department of Trade and Industry, Department of Health, and other related departments.

- Link policy on health inequalities to environmental causes of ill health.

- Targeted policymaking. For example, policies in the criminal justice system have implications for emerging infections. In the United States the development of multi-resistant tuberculosis arise particularly in overcrowded prisons with inadequate medical care. Needle sharing in prisons has had an amplifying effect on hepatitis B, C and HIV epidemics in many countries. (40).

- With recent headline cases such as BSE. E-coli and salmonella, there is increasing confusion among the public, professionals and policy makers over the identification and communication of risk[6]. People perceive there to be high nsks in society that do not match calculated evidence. With genetic developments there is an increasing need to get public communication of risk, right.

- Develop improved understanding of how nsk is perceived and responded to by individuals, improvement of understanding of how to frame and present the known costs and known benefits of a decision to an individual and society to allow best decision-making.

- For communication of nsk to the public, a single classification of risk terminology may be helpful. (41)

- Improve the relationship between the science base, knowledge available, evidence accumulated, and public policy which derives from them, as all these are involved in communicating risk to the public (41).

- Undertake interdepartmental action in communicating risk, including social risk as well as medical risk.

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[*] A recent article cites research study of medical literature that showed an 80-fold increase in articles containing the word risk between the 1970s, and the 1990s. *(McKie, R., 'There is nothing **like a scare', Science and Public Affairs,** 1999, (Aprils 7.)*

Lifestyle

"Getting the message across on smoking, diet and lifestyle "

Lifestyle factors in health, which may encompass behaviour, diet, exercise, sexual activity, and personal decision making over health, are becoming increasingly pertinent in UK health, and in the broader context of developed countries. The WHO highlight ill health and disease associated with social, environmental and lifestyle factors. One of the biggest killers, cancer, is predicted to increase because of lifestyle and smoking habits.

The annual report of the Chief Medical Officer for 1997-8 highlights adverse trends in two areas, obesity and smoking, which, it says, are important determinants of future disease (42). Obesity has been raised as an important health problem by, amongst others, the British Council, who addressed the issue at an international seminar in October 1998. The council cites the fact that in some Western countries between 15-30 per cent of the adult population are now classified as clinically obese, as evidence of a major public health problem. WHO held a consultation on obesity in 1997, and produced a consultation document entitled, 'Obesity: preventing and managing the global epidemic' (43).

In terms of sexual behaviour there are worrying disparities amongst births to girls under 16[7]. Four out of every five authorities with above average rates of births to girls under 16 are in the Norm and West Teenage girls from social classes III and IV are more likely to conceive and give birth than those from classes I and II. The effects of young motherhood are repeated across generations. Internationally, in 1990 the UK had the highest rate of births to women aged 15 to 19 years of any EU country. (44: p. 61)

There is increasing public concern over food production, particularly through the use of scientific advances (BSE, E coli, and genetically modified food). Threats also come from human development and lifestyle in the form of changes to climate and natural environment e.g. global warming, migration and travel changing patterns of disease and facilitating spread of infectious diseases like HIV/aids, changes in food production, waste and pollution.

Trends

proportion of children aged 11-15 who are regular smokers has increased from 10 per cent in 1990 to 13 per cent in 1996 (42)

proportion of adults aged 16-64 who are obese has increased from 13 per cent of men and 15 per cent of women in 1991/2 to 1996 to 16 per cent and 17 per cent respectively in 1996 (30)

rising trends for many of the more common cancers such as lung cancer linked to tobacco smoking; and colorectal, breast and prostate cancer linked to the so-called "Western lifestyle" ... (WHO) (45)

births to girls under 16 have been rising since 1993 to the highest recorded level ever in 1996 (44)

Current Policy

Several policy areas are included here. They cover public health, health promotion, environmental health, health education as well as other, broader policy areas. The Social Exclusion Unit, which was set up by Prime Minister Blair in 1997 has a remit to look at ways to reduce the combined effects of problems such as unemployment, poor skills, low incomes, poor housing, high crime environments, bad health and family breakdown. Located in the Cabinet Office, it reports directly to the Prime Minister and works on specific problems, either that require interdepartmental work or that are not addressed by other departments. So far reports have been issued on truancy and school exclusions, rough sleeping, worst estates and teenage pregnancy. Of particular concern to the trends outlined above, the Unit's report on teenage pregnancy set out a strategy from the Government to halve the rate of teenage conceptions by 2010 (46). It has also involved the setting up of a Teenage Pregnancy Unit, reporting to an advisory group, and to the Minister for Public Health. The report from the Social Exclusion Unit applies only to England, with devolved administrations in Scotland, Wales and Northern Ireland considering their own particular priorities in the light of the report.

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[7] Figures here relate to England and Wales only. Wales is counted as part of 'North and West' (44, p. 60).

Implications

For Health Policy

- Trends in child health have particularly serious consequences for the health of the UK population in the future.

- Lifestyle trends will manifest in the incidence of diseases in the future, which are already starting to come through.

- Persistence of health inequalities with factors such as teenage pregnancy being concentrated in lower social groupings.

For Health Care Services

- Increased burden on health care services in the form of increased incidence of disease and ill health associated with factors such as smoking and obesity.

- Difficulty for traditional health care services in dealing with consequences of adverse lifestyles, including ineffective impact of health promotion programmes.

 For Policy Making and Management

- Discrepancy over causation in terms of risk and ill health, with increased sanctions against 'risk-taking' behaviour that has health impacts.
- Increasingly complex interrelationships between causes of ill health that have to be tackled by departments responsible for health policy.

- Increasing overall conception of risks to health amongst the public.

Recommendations

For Health Policy

- Targeted policy, including innovative ways to reach groups who do not respond to traditional campaigns to improve lifestyle.

- Focus on child health. A recent report by the BMA cited the UK's poor record on child health and recommends an annual report into the state of children's health and the appointment of a Children's Commissioner (47).

For Health Care Services

- Interagency working to tackle the root causes of ill health. Primary Care Groups may be effective here in taking a lead on tackling issues at the local level.

For Policy Making and Management

- WHO supports targeted cross-sectoral policy making, supported by local measures. Here, the Social Exclusion Unit and Primary Care Groups have the potential to tackle some the issues outlined above in accordance with WHO recommendanons. WHO emphasis on healthy settings, multi-sectoral responsibility for health, and accountability for the health effects of policies, are supported (2).

- WHO has also set itself up as a potential 'auditor' for health policy, citing its "health audits" carried out in Hungary and Slovenia (2: p. 105). There is potential for WHO to act as an independent auditor of policy, particularly as targets for policies such as reducing teenage pregnancy relate to European averages.

Poverty and Relative Deprivation

"Tackling causes of poverty will improve health outcomes"

There has been an increase in income inequality over the last twenty years in the UK. In addition, lowest income groups have experienced an absolute fall in income. Poverty is increasing in Britain in both relative and absolute terms. In 1991-2, 13.9 million people had a household income of less than 50% of the UK average, including 5.2 million couples with children, 2.1 million lone parents with children, and 3.2 million pensioners (48: p. 70).

Lone parent families, and couple households with two or more children, when both parents are out of work, are particularly at risk. Child poverty is increasing. (49).

There are social, economic, geographical and ethnic inequalities in health in the UK. The poorest in society are hit harder by major causes of death; they are ill more often and they die sooner. Health improvements have benefited higher social groups more than lower social groups. (1). Health inequalities have been worsening in last twenty years (1, 50).

Trends

doubling of the proportion of households living on low incomes (defined as half the average income) between 1961-1990 (29: p. 29)

increasing health gap in the last twenty years between the best and worse off in society, caused by health gains to most groups and worsening health for the lowest social groups, including worsening mortality rates for social class V men (50)

1991-3 the all-cause SMR for men aged 20-64 was almost three times higher among unskilled manual workers in social class V than among professional men in social class I (50)

there is a life expectancy at birth of 75 years for class I/II compared to just under 70 years for class IV/V men, a difference of five years, with 80 and 77 years respectively for women (50)

Current Policy

There are separate public health documents for the constituent countries of die UK that address health inequalities seeking to improve the health of the worst off in society and narrow the health gap (1) (3) (5) and (4). *Our Healthier Nation* (1) has set national improvement targets for heart disease and stroke, accidents, cancer and mental health. *Towards a Healthier Scotland* (3) has 7 'headline targets' including heart disease, cancer, smoking, teenage pregnancy, and alcohol misuse. *Well into 2000* (4) has no stated targets.

The recently completed 'Report of the Independent Inquiry into Inequalities in Health' chaired by Sir Donald Acheson supported the basic conclusion that poverty leads to poor health. (51). The Acheson report recommended three areas that were crucial to tackling health inequalities: priority be given to the health of families with children; steps to reduce income inequalities; and improving the standards of poor households. In response the Prime Minister Tony Blair has launched a twenty-year programme to eradicate child poverty (52). The government has accepted the links between life chances, deprivation and poor health. Some policies which focus on specifically targeted groups include the following: the welfare-to-work programme for 18-25s; pension reform and minimum income guarantee; child support reform; and working family tax credit

Implications

For Health Policy:

• Worsening mortality rates, and higher differentials between social classes for stroke, lung cancer and suicide mean poorer people in the UK population have worse health than those better off. They have failed to gain from health improvements in the way that higher social classes in society have.

• Poor health amongst children is marked, and affects health status in adulthood. Children in manual classes are more likely to suffer from chronic sickness than children in non-manual classes and the difference is greater for boys than for girls (50). Children from manual households are more likely to suffer from tooth decay, and to have a greater number of teeth affected, than children from non-manual households (50).

• Increases in incidence of diseases that are directly associated with poverty.

- The threat to health from poverty is more pervasive than the incidence of specific diseases. It includes social depnvation, alcohol and drug abuse, poor diet, and smoking. The poorest in society are more likely to die of all common diseases. Mortality rates are higher for the poorest in society. From the 1970s to the 1990s, mortality for men was found to be almost three times higher in social class V than in social class I, and whilst mortality rates improved for most people they actually worsened for men in social class V. Larger differentials can be found for stroke, lung cancer and suicide (50).

For Health Care Services:

- The 25 most deprived local authority districts, which together cover about 14% of England's population, have higher proportions of people reporting long-standing illness (29: p. 40).

- Increased burden for health care services.

- Inequalities of access and staffing problems in deprived areas.

For Policy Making and Management

- Community and public health measures remain a relatively small part of the total health budget. Health promotion and prevention account for 1 per cent of the UK health budget (22: p. 7). It is likely that measures to tackle poverty will require more targeted resources in the future.

- Scotland and Wales currently have worse health outcomes than England. There are implications here for funding allocation after devolution. Scotland, Wales and Northern Ireland currently obtain more per capita funding for health than England, although there remain worse health outcomes.

- There is internationally heightened concern about widening gaps in health.

Recommendations

For Health Policy

- Health is the outcome of multiple determinants and policy needs to tackle the root causes of poor health outcomes. A 1998 United Nations report criticised the UK for being an unequal society (cited in 9).

- Leam from international experience, and set international standards or benchmarks for comparison. Ask the question, where is Britain in international ranking? On mortality, Britain is frequently placed in the middle in comparisons of the relative size of differentials, with larger inequalities in mortality than Sweden and Norway, but smaller than France and possibly Finland (50: p. 62-3). Morbidity is more difficult to measure and then compare across countries. Relative rather than absolute morbidity is compared using self-assessed health. The US has the largest relative inequalities. Sweden is one of the most equal. Britain generally sits in middle to low ranking in comparison with developed countries (50).

- Target health indicators for improvement where the UK performs poorly against other countries. The Acheson report and the public health paper *Our Healthier Nation* do not benchmark the UK internationally. Linking health care services to health outcomes, developing indicators based on health outcomes, and developing international benchmarks for those indicators could help address health inequalities from a broader perspective.

For Health Care Services

- A more explicit link between health expenditure and health outcomes in local areas, so that health care expenditure can be targeted at the areas of greatest need.

- Information gathering on inequalities of access to health care services and health care treatments. For example, a recent empirical study found that cancer patients suffered inequitable treatment in areas with high levels of deprivation. The study advocated further national information gathering for other treatments and services. (53)

For Policy Making and Management

- Tackle the determinants of poverty. Tackling what causes poverty will improve health. Less equal societies have poor health outcomes.

- Use public policy as "springboards' rather than a 'safety net' to help disadvantaged groups in society because of accumulated disadvantage (54: p. 16-17).

- More funding than at present, where only 1% of health spend goes on health promotion and prevention (22: p. 7). This will mean the redistribution of health care resources from other areas because at present the

overall percentage of health spend as a proportion of GDP is not going to be increased, and resources should be managed by local groups who have local knowledge and understanding.

- Leam from international expenence. since many countries have experienced widening disparities in health, and some countries have since managed to reverse the trend such as Sweden, and recendy Spain (50: p. 53-54).

- Make inequalities relevant to the lay public and policy makers. For example, in the Netherlands 'health' expectancy is used as an indicator (life expectancy minus the number of years that will be spent in poor health) (50: p. 49-50).

PART TWO

INTERVENTIONS

Definition
User Involvement and Empowerment
European Human Resources
Service Delivery
Financing
Private Setting
Leadership and Governance
Pricing
Information and Communication
Regulation
Health Professionals
Location of Care
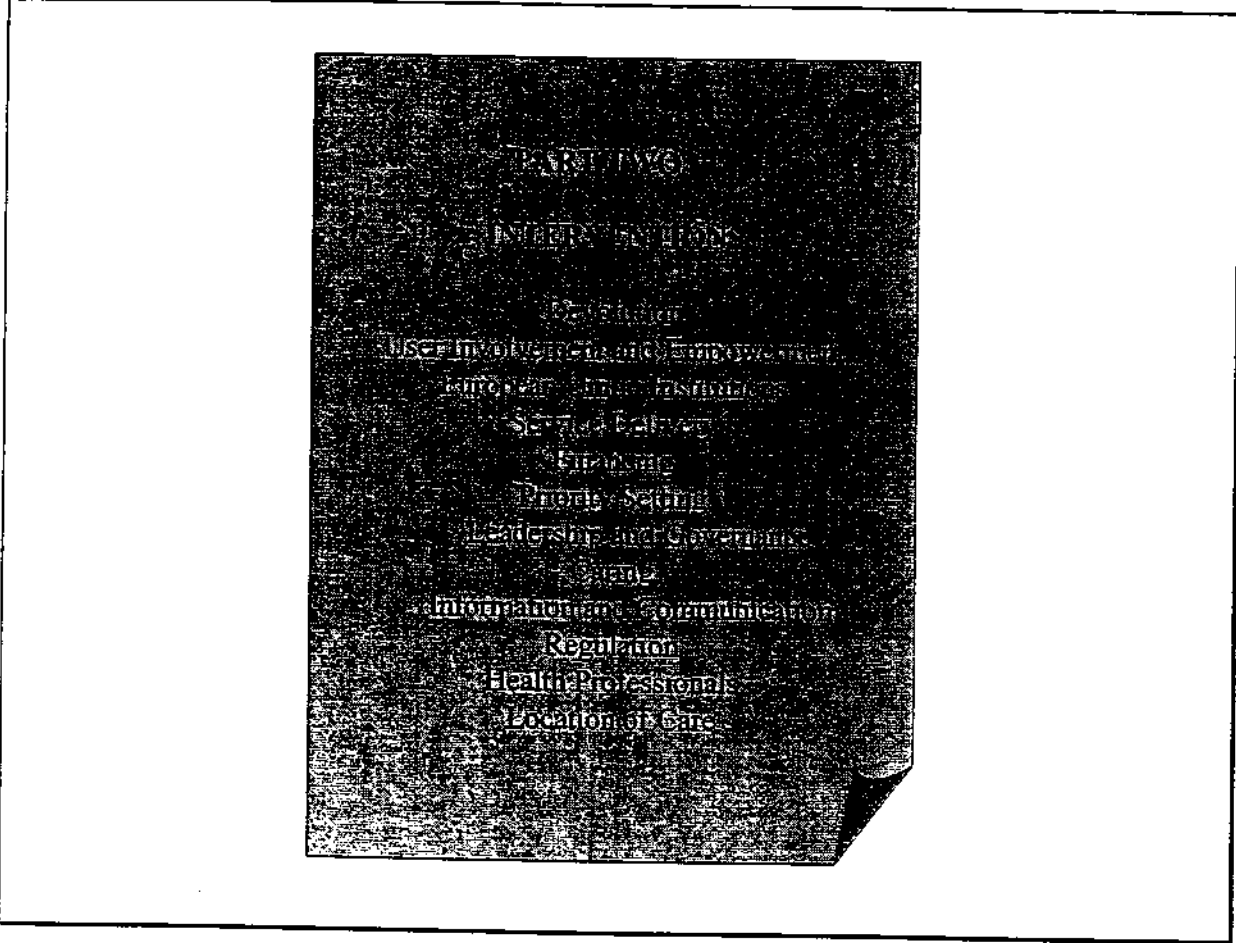
Devolution

"Don 't miss the health lessons of Scotland, Wales and Northern Ireland"

Change from administrative to political devolution of health matters to Scotland, Wales and Northern Ireland. Matters of health may also be devolved to the English regions.

Scotland has voted in favour of a Scottish Parliament, Wales voted narrowly for a Welsh Assembly and Northern Ireland voted for the Northern Ireland Assembly. Scotland and Wales took democratic responsibility for health after early summeT elections in 1999, and the Northern Ireland Assembly is in place.

Trends

in 1995-6, the Scottish NHS received 25% more funding per capita than the English NHS, and Wales and Northern Ireland received 18% and 5% more, respectively (55)

higher funding in Scotland, Wales and Northern Ireland does not seem to be associated with better health outcomes (55)

within the current parliament elected in 1997, plans were approved to devolve democratic power to Scotland and Wales, which includes power over health

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Current Policy

With the establishment of the Welsh Assembly and the Scottish Parliament, health matters have become the democratic responsibility of these constituent countries, in addition to the administrative responsibility that they currently have. Scodand and Wales will have the opportunity to plan and develop their **own** health policy. Wales will have to work within current funding levels and the Scottish Parliament is able to raise taxes by 3 pence in the pound. Wales and Scotland already produce their own NHS and public health policy papers that exhibit differences in organisation to the English model.

There are no current proposals for health to become part of the remit of the new Regional Development Agencies in England, and they do not correspond as geographical areas to the regional offices of the NHS Executive, which themselves have just been reorganised.

Implications

For Health Policy-:

- On general indicators. Scotland and Wales have poorer health than England. They currently gain from UK funding formulae. With devolution. Wales and Scotland will be looking to improve the health status of their populations over time.

For Health Care Services:

- Some formal change will take place; for example, the Department of Health will no longer be responsible for drafting legislation m health for the Scottish Office, as it will be done by the Scottish Parliament. The model of the NHS (funded through UK taxation, distributed by the Treasury) will not change. Scotland has little, and Wales has no power to change funding levels. However, they can change the distribution of funding, health care planning, organisation and management. Wales and Scotland have proved good policy models for health, because of their smaller populations. They may provide alternative models for the provision of health care services. (56)

- Increasing the democratic accountability of health decisions.

For Policy Making and Management

- Scotland and Wales have been proposed as models for English health policy as they benefit from smaller populations who are concentrated in fewer urban areas. Scottish, Welsh and Northern Irish National Health Systems receive more funding per capita than the English NHS; Scottish Trusts are under less financial pressure; English people are more dissatisfied with their NHS; and higher funding in Scotland, Wales and Northern Ireland is not associated with better health outcomes (55). One possible implication of devolution is that funding for health systems is reassessed in order to reduce the differential between England and the constituent countries of the UK, although Prime Minister Blair has ruled out this change in the near future. However, as health systems diverge in the future, and the individual countries are more involved in

decisions over their own health policy, it may be considered a fair trade to relinquish privileged funding status in exchange for overall control.

Recommendations

For Health Policy:

• Maintain UK targets for public health indicators. All countries are working to break down the health/social care divide. Devolution presents an opportunity for countries to set country priorities in order to improve health status.

For Health Care Services

• Take the opportunity to learn from alternative systems, and to give people the opportunity to become more involved in decisions about health policy in their own country.

For Policy Making and Management

• Sustain means to secure policy learning across the four countries of England, Scotland, Wales and Northern Ireland is important.

• Decide on the new role for the Department of Health. Possible roles include a co-ordinating ministry for UK benchmarking, policy learning and planning, using the principle of subsidiarity.

• Establish "policy villages' to ensure consistency of health policy across the UK and throughout health services.

• Establish governance structures for England in the light of devolution. Decide on role for the regional agencies.

• Establish a Standing conference on devolution in health to establish discussion and planning across the new institutional structures in order to enhance policy making across the UK.

User Involvement and Empowerment

"Make sure you involve users properly and have structures to do so "

Patients and user groups are becoming more involved in health care decision making. Action to increase public involvement in decision making has been taking place across the public sphere. Within the NHS this has been gathering pace since the early 1990s, although the establishment of Community Health Councils (CHCs) in 1974 and the Griffiths Report of 1983 both (in different ways) gave expression to the need for the public interest to be represented to health professionals and decision makers (57).

Trends

a shift away from 'blind trust' in experts, with some loss of confidence in public services

increasing public involvement in public sector decision making

a shift from an individualist model of health to a new partnership model

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Current Policy

At the national level the NHS Charter is replacing the Patient's Charter as an instrument for ensuring responsiveness, either in the form of indicators which the service has to meet, or through complaints. At the local level there is different policy and organisation. Some public priority setting exercises have taken place, including Citizen's Juries. Other mechanisms to respond to the public and users include the new Performance Assessment Framework that contains 41 indicators to assess the NHS in England on service provision and health improvement, and the first annual National Survey of NHS Patients in England, which was completed at the end of 1998.

Implications

For Health Policy:

• People take responsibility for their health, which could mean increasing their knowledge of a condition they may have or becoming knowledgeable about threats to their health, which they may then be able to avoid.

• Benefits to health through people maintaining their health status and in improving how they deal with their illness, and through improved recovery time from hospitalisation.

• Potential to achieve better outcomes of treatment and care (57: p. 15).

For Health Care Services

• A crystallisation of differences between professionals involved in health care and users or patients and a shift to one side or the other.

• Benefits that may accrue from empowerment:

   More appropriate use of health services by the public.

   Potential for cost effectiveness.

   Sharing responsibility for health care by the public.

For Policy Making and Management

• More public involvement in decisions about priorities, treatment and funding decisions within the NHS.

• User and citizen perspectives highlight the lack of co-ordination in service delivery and lack of fit between policy objectives. Increasing public participation is likely to challenge administrative boundaries and existing parameters of policymaking (57: p. 17).

• Information will become a focal point, both in terms of the use of it and access to it.

Recommendations

For Health Policy

- Develop strategies to build on an analysis of barriers to and benefits of, public participation (NHSE, IHSM, NHS Confederation 1998 cited in 57: p. 13).

For health care services

- Substantial skills, attitudinal and organisational development within the NHS to support user and citizen involvement in decision making (57: p. 16).

- Change existing administrative structures to involve user groups.

- Include social science and user perspectives in professional education and training to enable clinicians and others to develop a model of professionalism based in working with users and citizens (57). It is relevant that approximately 70% of prescriptions are repeat, to understand the role that patients have to play in learning about and managing their care with health professionals.

For Policy Making and Management

- Give time and resources to develop more effective models of enabling users and citizens to engage in dialogue and deliberation about service and policy issues. There will be tensions between achieving these developments and meeting the government's service targets (57).

European Union (EU) Institutions

"Europe drives more of our policy than we think.
Make sure we learn and be aware of what's going on in Europe "

The impact of European Union institutions on health policy and health care services is increasing. EU institutions impact on UK health today. With European integration, the EU is likely to have increasing impact towards 2015.

Trends

health policy making at the European level is increasing including changes to EU treaties

the impact of 1998 European Court judgement that a good or service should be available without restriction throughout the EU will be felt in the future

there is increasing transparency and therefore comparison between health care in each of the EU nations

free movement of people across EU countries in increasing unitary labour and consumer markets

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Current Policy

The onginal Treaty on European Union had a framework for action in public health. Two types of action followed. Firstly, horizontal actions concemed mainly with health promotion and health monitoring, and secondly, multinational programmes covering certain priority areas, including cancer, drug dependence, AIDS and other communicable diseases. Health is a growing interest, with crises like BSE contributing to awareness of the need for health policy at the community level. Other trends among member states which have contributed to this growing awareness include the ageing European population, increasing population mobility both into and between member states, changes in the environment and work setting, rising expectations, and socio-economic problems in the community including social exclusion.

Consequently, the Amsterdam Treaty in 1997 extended the Community's public health activities. Specifically, there was a focus on improving public health, preventing human illness or disease and sources of danger to human health; community action complementary to member states in reducing drugs related to health damage; and measures setting standards of safety and quality of organs and blood. In addition, judgements from the European Court in 1998 have upheld that goods and services, including health care, are available without restrictions throughout the EU. (58)

Health is an area for convergence on the Maastricht Treaty, but there is a lack of clear focus on health within the European Community. There is currently no single Directorate General for health, although the new European Commission President Prodi announced in June 1999 that there will be one in the future (59). There is currently a lack of co-ordination on health issues at the European level, and some argue that the current institutional and legal backdrop does not provide a favourable basis for the development of a coherent EU public health framework (56).

Implications

For Health Policy

• International comparisons may lead to improved services with improved outcomes of care.

For Health Care Services:

• Areas in which European policies have had, or could have, an impact on cross-frontier health care include: the Working Time Directive; the BSE outbreak; tobacco advertising; medicines regulation; pharmaceutical pricing; health insurance market: and developments in telemedicine and IT (Information Technology) (Mossialos and McKee 1997 cited in (56: p. 73).

• The single market allows professionals to practice throughout the EU.

• People will be able to go to alternative EU countries for treatment and services and their bill to their home country.

• UK health care services will be compared to their European counterparts.

For Policy Making and Management

• UK health policy making will be expected to adhere to European level policy and legislation.

• Increased pressure on policy makers, as consumers and patients are able to compare packages of care across the EU. Policy makers will have to justify to the electorate when their care packages are comparatively less generous.

Recommendations

For Health Policy:

• Use European / EU performance on health as a benchmark of where the UK wants to be in health terms in the future. For example, aim to be 'best in Europe' or 'top ten in Europe' on selected key health indicators as a policy goal.

For health care services:

• Comparison of health services should drive performance and better outcomes. Lessons could be learnt from and shared with EU counterparts.

For Policy Making and Management:

• EU-wide policy on health and health care could achieve more change than WHO (World Health Organisation) policy because there are legal and institutional frameworks on which to base policy.

• Take advantage of information sharing and dissemination to improve policymaking and service delivery.

Service Delivery

"Appropriate settings for appropriate care"

Service delivery has become more managed and externally regulated. Small-scale primary care settings are favoured, although mergers are increasing in the hospital sector (60). Organisations have been influenced by private sector styles of management and organisation. Hospitals that are now NHS Trusts have greater autonomy in the organisation and management of services.

We are currently undertaking further reform of service delivery organisations. Primary care organisations, currently Primary Care Groups (PCGs) are being grouped as purchasers of care.

Trends

increasingly more managed and externally regulated system of service delivery in health

increasing desire to move away from large-scale bureaucratic forms (such as hospitals) to smaller-scale units of production (such as primary care settings)

increasing influence of private sector management styles and organisation, including the Private Finance Initiative (PFI)

increasing opportunities for public-private partnerships

Current Policy

The purchaser/provider split remains in health care services, but there have been changes made to purchasing roles, and in the relationship between purchasers and providers, which represents a shift away from competitive relationships and short term contractual relationships, to greater co-operation and longer term service agreements. Regional and local arrangements for the purchasing and providing of health care services differ across the UK, and are reflected in the NHS policy documents for England, Scotland, Wales and Northern Ireland (61, 62, 63, 64).

Piloting of a nurse led telephone service, NHS Direct began in March 1998. The end of 2000 expects full coverage of the service in England.

Health Action Zones have been established since April 1998 and a second wave was planned for April 1999. They have two important characteristics for future service delivery. First, they are encouraging people to work across organisational boundaries to improve health and health care services. Second, they have health improvement targets to achieve over time.

Implications

For Health Policy:

- Combinations of specialist centres that are able to invest in expertise and equipment and local primary care settings for more routine treatment are designed to increase efficiency and effectiveness of treatment. Increased efficiency will mean more resources made available for other services within the NHS.

- External regulation of service delivery intends to improve consistency of health outcomes, including patient experience.

- The changing role of the district general hospital may have implications for geographical equity of access, particularly in rural areas.

- The telephone service, NHS Direct is designed to improve access to the health service, particularly for groups having difficulty with the current system. Early research shows 40 per cent of calls have been about young children. Telephone services have the ability to make the NHS use professional resources more efficiently by differentiating urgent and non-urgent demand, and administering immediate advice to patients on action they should take.

For Health Care Services:

- Location or settings of care will change. Services are more likely to be provided in primary care settings in the future as a result of advances in treatment and technology, and they will be combined with specialised centres at the regional and national level.

- Role substitution for health professionals. For example, a shift towards primary care provision increases functions to be performed by nurse practitioners that were previously undertaken by doctors. Future could see nurses prescribing some drugs in primary care settings.

- Health care funders and providers are likely to remain publicly owned and publicly funded, although there may be implications for capital ownership from the Private Finance Initiative (PFI).

For Policy Making and Management

- Reduced scope for central NHS departments to participate directly in day to day service delivery matters.

- Possibility of further redefinition of central departmental roles in each of the constituent countries of the UK, from one of direction and control, to one of monitoring and regulation.

- More strategic planning role for central departments with localities making purchasing and service delivery decisions.

- Countervailing trends of decentralisation and centralisation.

Recommendations

For Health Policy:

- Develop a more direct link between service delivery and health outcomes, using indicators such as access to services.

For Health Care Services:

- State clearly what the different organisational roles and objectives within the health service are.

- Assess fully the factors of role substitution and changing settings of care in health care services. There needs to be a combined approach of planning who does what in the health service, and where that treatment and care takes place.

- Use mechanisms to increase flexibility in role substitution and settings of care.

For Policy Making and Management

- Set identifiable objectives for organisations within the health service and consider whether changes need to be made in order to achieve them. Appraise reorganisation and change in the health service on the basis of achieving objecnves that are based on improving efficiency, service delivery and health outcomes.

- Assess ability of educanon and training to deliver professional and non-professional roles that re-designed health care services require.

- Decide on role of centre in service delivery, and ensure compatibility with local approaches.

Financing

"Is the NHS sustainable in its current form? "

The current UK system consists of a National Health Service funded through general taxation. Increasing pressures have been met with tight resource constraints in health expenditure. No change has occurred as yet in types of finance or provision from the publicly funded system. There has been no increase in the proportion of private health expenditure, although private insurance could provide an additional means of payment in the future. An important question for government is the future sustainability of the health care system in its present form, or whether there will be gradual changes in the form of increased co-payments, medical savings accounts, a more widespread use of voluntary health insurance, or a combination of these measures.

Trends

The UK spends 6.7% of GDP on health, compared with an OECD median of 7.6%. It has achieved a lower than average increase in spending since 1960, also expressed as a percentage of GDP (6S).

increasing demand pressure on health financing due to technology, the internationalisation of health care and rising public expectations

an ageing population and a contracting dependency ratio place pressures on the sustainability of NHS financing through general taxation

increasing use of rationing in the form of excluded or restricted services

increasing pharmaceutical expenditure due to changes in technology and switch to newer medicines

share of private health insurance is steady at 12% of total health spending in the UK

Current Policy

The public, national service funded from taxation performs well internationally in terms of equity and cost control. The UK also achieves better outcomes on some indicators <u>than</u> some larger spenders within OECD countries do. There are, however, increasing pressures on health care funding. The government, whilst contributing increased funding to the NHS, along with education, is committed to tight public spending controls, and health competes with other welfare services, for a share in this overall pot.

The government is committed to introducing clinical guidelines for treatment, which have cost implications. The National Institute for Clinical Excellence (NICE) has already stated that it will work within government financial commitments, which means economic and clinical outcomes will be considered together. The current Labour government has not increased the scope of user charges, but rationing takes place at the level of local health authorities, the health purchaser. The government made an important central decision on the new drug Viagra, by limiting its use to certain cases, which may provide a test case for future interventions that have substantial resource implications across the NHS.

The Labour government has continued and expanded the role of private finance (PFI) in the health care system.

Implications

For Health Policy:

- Higher user charges and increased rationing of services are likely if funding and expectations continue on current trajectories.

- Restriction of services that do not have proven outcomes.

- Competing pressures for funding.

For Health Care Services:

- A more restricted range of services on offer through the health service in the future. Some services are partly excluded now, such as dental care, optical care, and long term care.

- Stricter eligibility criteria for certain services, both on the side of the patient, and of the treatment itself in terms of evidence-based criteria.

For Policy Making and Management

- More explicit forms of rationing within health care services taken at the centre of the health service. Cash limits for primary care groups may solve this problem, but will be unpopular, particularly with physicians.

- Additional taxation may be required to fund health care.

- Questions are raised about the sustainable financing of the health system in its present form.

- The Private Finance Initiative (PFI) has yet to be fully evaluated, but leading critics suggest that increased returns to capital demanded by private finance corporations will be met by taxpayers, by staff cuts, or through reductions in bed numbers or other services. (66, 67, 68).

Recommendations

For Health Policy

- Establish explicit links between expenditure and outcomes so that expenditure is directed to those areas where it will have the greatest impact on agreed objectives in terms of health outcomes for the population.

For Health Care Services

- A system that assesses the impact of an intervention and will provide a systematic basis for rationing that is fair and explicit is needed. Value for money should be included in the assessment criteria for technology.

- Devise a system that maintains the principal of equity in the face of constrained resources and increasing pressures on health care services.

For Policy Making and Management

- Give more attention to the consideration of the long-term finance of health care services, including long term planning.

- Fully evaluate the PFI initiative and consider pessimistic long term scenarios for increased capital repayments to private contractors, which will have implications for taxation funded NHS.

- Some financing options for the future might be:

    Greater emphasis on social insurance in addition to revenues from general taxation.

    Increasing tax rates to cover pressures on spending.

    Shifting attention to voluntary health insurance.

All the above options involve a break with tradition and political costs. (58)

Priority Setting

"Learn to cope "

Health can be described as a public good in economic terms because it is a taxation-funded service from which people are not able to reject contributing through taxes, or to exclude others from the service. However, it does not have these characteristics intrinsically. Government could allow those who opt for private health schemes to have their contributions to the National Health Service reimbursed. There are also restrictions on access to services; through fixed budgets or fixed facilities available, through waiting times, or through characteristics of the patient, for example, assessing the medical need of a patient for a service through a primary care physician. Finally, health is not a non-rivalrous public good; one person's use of the service does prevent another's use. For this reason, services have restricted access in some way. Health is also described as a luxury good, because spending on health increases more than proportionately with an increase in per capita income of a country (58). Some manipulation of demand and or supply of health care services exist because of the infinite demand for health and the budgetary constraints imposed by central government spending limits.

Increasing cost pressures as a result of rising staffing costs and technology, and demand pressures from an ageing population and overall higher public expectations, all have implications for future priority setting in health policy. The government has to set overall priorities for health spending, as well as set up frameworks for more detailed resource allocation decisions within those overall priorities. Wider priority setting includes the relative focus on preventive health measures versus health services. Whenever targets are set in terms of health policy, for example, in terms of screening, there are resource implications for other services. Rationing or restriction of services can take place at the national level or local level.

Trends

increasing resource pressures in health due to rising demands, rising costs and fixed budgets

increasing scope and level of explicit rationing including exclusion of some services and strict eligibility criteria for others at the national and local level

conflicting trends of decentralisation and centralisation of rationing decisions involving decision making at the local level and new institutions at the national level

new forms of rationing such as evidence-based medicine

Current Policy

Since the NHS began services have been rationed through waiting lists. Recent successive governments have been committed to reducing waiting lists but they have reached record levels in the late 1990s.

The National Institute for Clinical Excellence (NICE) will assess treatments and interventions according to clinical and also cost effectiveness. It could be the overarching rationing mechanism of the future. The Conservative governments of the 1980s and 1990s emphasised choice. Pressures on the National Health Service may mean that in the future people are encouraged to pay or to go outside NHS services in order to exercise choice.

Previously health authorities and their equivalent organisations in Scotland, Wales and Northern Ireland were responsible for local access to health services through their role as commissioner. Now that role will be transferred to smaller-scale PCGs for community and secondary care.

Implications

For Health Policy:

- Low-income groups would suffer most if a broader range of services were withdrawn from the NHS. So far more peripheral services have been cut or services have become means tested.

- Greater individual responsibility for health. Less solidarity.

- Evidence-based medicine is designed to improve health outcomes.

For Health Care Services:

- Possible elimination of regional vanations in treatment on offer and eligibility criteria across the NHS.

- Primary Care Groups making decisions on a smaller scale will make treatment more restricted geographically.

For Policy Making and Management

- Increased number of excluded services, increased patient payments and co-payments for treatments.

- Private cover will be encouraged for certain groups.

- Central government intervention on limiting treatments is likely to increase in the future.

Recommendations

For Health Policy

- Promote consistency.

- Use information technology to inform patients about priority setting.

For Health Care Services

- Look at successful international priority setting measures that provide possible alternatives to waiting lists (58: p. 8).

- Move to a priority setting system that includes an assessment of need.

For Policy Making and Management

- Debate priority setting at the UK level.

Leadership and Governance

"Be clear about the values "

Leadership and governance involves making decisions about who takes responsibility for health and how is that exercised. It also includes leadership roles in organisations involved in health services provision. Leadership in health is understood as custodianship, and the management of limited resources.

For the last ten years we have had a system of corporate governance in NHS trust hospitals and health authorities. General management pnnciples were instigated with the Griffiths repon in 1982. With the Labour government elected in 1997, leadership and clinical governance are likely to be themes that dominate organisational discussions in health.

The system of 'clinical governance' is being implemented in the NHS in 1999.

Trends

increasing importance of networks, collaboration and inter-agency working in health

increasing importance of leadership roles in health that involve responsibility beyond traditional roles according to hierarchical position or professional occupation

shift in governance concepts from financial and managerial control, responsibility and accountability to that of clinical standards and performance at the level of the individual organisation

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Current Policy

Clinical governance is defined as: 'a framework through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish' (69). The Chief Executive of an organisation such as a NHS Trust will be accountable for clinical performance in the same way that he or she is for financial performance. The policy is intended to improve the quality of care, and to have a system that will eliminate recent high profile failures in the monitoring and auditing of clinical procedures in hospitals. The specific system along with standards, accountability mechanisms and sanctions has not yet been established.

Implications

For Health Policy:

• Better health outcomes as a result of improved organisation, management and service delivery.

For Health Care Services:

Implications for health care services can be grouped in the following way:

• professional accountability; clinical governance and the quality agenda could produce explicit mechanisms of accountability for professions, when previously more implicit controls, and professional self-regulation dominated

• professional autonomy; more explicit measures of performance and control will reduce professional autonomy within the health service

• clinical standards; new mechanisms will increase external regulation and control of clinical standards

• staff motivation; securing commitment from professional, managerial and administrative staff to improve performance within health care services

For Policy Making and Management

• Changes to central-local relationships within the NHS.

• Greater complexity in management processes and lines of responsibility within NHS organisations.

• National policy making will have to address clinical and standards of care in terms of accountability mechanisms, in addition to the financial accountability that currendy exists within the NHS.

Recommendations

For Health Policy

• Link leadership and governance mechanisms to health outcomes and desired objectives.

For Health Care Services

• Motivate staff in the NHS. particularly clinical staff. The new mechanisms need to be 'owned' by staff in the NHS for them to be successful.

For Policy Making and Management

• Decide who is accountable to whom, and for what, in the devolved, decentralised, primary care-led NHS?

• Include all staff gToups in management and leadership plans.

• Allow flexibility in local arrangements.

• Specify objectives of developments in leadership and governance arrangements.

Caring

"Provide better support for carers "

Most care is provided informally in the UK, but demographic trends suggest that this pool of carers will not be available in twenty or thirty years' time. There are currently almost 6 million carers in the UK, approximately one in eight people. Three-fifths look after someone with a disability, and 855,000 carers provide care for more than 50 hours a week. Most carers are women, and there may be implications for the future of informal care with tie increasing participation of women in the labour market. There has been a decline in the number of carers most recently, although longer-term trends show an increase. Carers are also ageing. The increasing rate of divorce and the increase in single person households point to a decline in the future group of carers. (70)

Trends

diminution of caring in modern concepts of health care

caring professionally undertaken by nurses who now have increased technical, administrative and managerial roles

most care remains informal and unpaid. With demographic shifts there will be fewer resources available to continue this care in the future

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Current Policy

Health secretary Frank Dobson announced a National Strategy for Carers in 1999, which looks at role of carers in society (70).

Implications

For Health Policy:

Direct health benefits are available from caring in terms of treatment and recovery from illness, prevention, and understanding of people's needs.

For Health Care Services:

- The under-valuation of caring means the true costs of health care services are distorted.

- There are several tensions within this area that are identified by Crawshaw (cited in 71: p. 1649):

     growing preoccupation with quantitative considerations of economy over qualitative issues of caring

     worst case scenario is that unlimited medical technology continues to be provided to a few, while other groups (needing care) are denied the right to treatment and care

     growing marginahsation of professional care through the "reskilling", re-engineering, or downsizing of the nursing profession and nurses' replacement with technicians and care assistants.

     Health care services become more technical and medicalised, leaving no room for more human values like caring or nurturing.

For Policy Making and Management

- With less informal care, society, the economy and the state will see an increased burden on formal care arrangements.

Recommendations

For Health Policy

- Begin to build caring into health costs in an explicit way (71). This would ensure a proper valuation of caring and its benefits to health. The work that is done by carers should be given a proper valuation by society.

For Policy Making and Management

- Like the recommendations for health and health care services, policy making and management process should include caring in its assessment of both health costs and health benefits. As Kitson suggests above,

systems in health which promote health and well being might be more inclusive of caring than has traditionally been the case.

- Current informal, and therefore unrecognised, costs related to caring may have to be budgeted in as a formal cost in the future, which with the ageing of the population will require substantial planning in terms of both financial and human resources within the health service.

Information and Communication Systems

"Use IT to help drive your care and have IT systems that help you do what works "

According to a 1995 Audit Commission survey of acute hospitals, 15% of hospital resources are spent gathering information, and up to 25% of doctors' and nurses' time is spent collecting and using information (72). A consideration of information and communication covers both organisational communication - between hospitals, GPs, and health authorities, for example - and information and communication to the public. The introduction of IT systems within the NHS has been fraught with difficulty and the alleged waste of public money. Information and communication is linked today with developments in IT that are largely driven outside health services, and in public expectations of openness and communication from health professionals - both nationally, and on an individual basis.

It is unlikely that some of the changes predicted by future thinkers for IT will have the proposed impact on health care in the UK at the times they suggest. Examples include linked computerised patient data between all hospital, community and primary care services and settings by 2007; remote consultation commonplace by 2000; artificial intelligence-based elderly and handicapped support devices by 1998; full personal medical records on smartcard by 2000; personal wearable health monitor by 2005 and computers being used by clinical departments for data collection by 2001 (39). A 1995 Audit Commission Report on Patient Health Records found that 36% of case notes were not immediately available and there were multiple records for the same patient in 75% of hospitals (73). The health service is slow to invest, and resources for information technology fight within fixed budgets.

Trends

increasing use of sophisticated information technology as the means of communication within health care systems

increasing pressure within the health service to plan and implement information technology systems that reflect developments in other industries

information technology increasingly being understood from the perspective of the individual user rather than as a large scale organisational system

marriage of clinical and financial data

relating individual to social data

Current Policy

The NHS Executive launched 'An Information Strategy for the Modem NHS' in 1998. There are no Performance Indicators on information and communication in health care services, however.

NHS Direct, a telephone service for NHS users, was launched in 1998 and is expected to cover all residents of England by the end of 2000.

One of the most pressing concerns within IT is the ability of systems to cope with the year 2000 changes, or YK2.

Patient records are currently in the process of being computerised. One of the main challenges will be to link patient record systems across the health service. This could mean a patient held record.

There are plans to introduce booking systems for doctor appointments rather than the current system of waiting in surgeries, and booking appointments through the surgery reception.

All GPs are planned for connection to the NHSnet by 2002.

Implications

For Health:

• Individuals take more personal responsibility for their health care.

• Improvements in health as a result of better information, an increasing focus on individual responsibility for health including preventive medicine and better-organised health care systems.

For Health Policy Care Services:

- Freed-up clinician time, reduced costs, and improved services.

- Clinical professionals, rather than being at the apex of the system, act as support within a wider system of 'self-treatment' (home care), self help networks (Jennings, Miller and Matema, cited in 74).

- Blurring of traditional professional demarcations in health, for example telemedicine challenges traditional identification of the care provider and the setting of care.

- Changing organisations and institutions, including the location and design of hospitals.

- Improved patient access to information, which is currently controlled by the health care system. New systems may be designed for patients to hold and store medical information.

- New training and education needs for professionals and other health care workers.

- Information services such as NHS Direct may stimulate demand for health care services, as unmet demand is revealed.

For Policy Making and Management:

- Resource allocation. Diverting funds from clinical services to information systems in order to achieve benefit in the long term.

- Central planning within a devolved health system. Linking local providers and IT systems to central information systems.

- Greater openness within the health system and in how it interfaces with the public and patients.

Recommendations

For Health

- It is important that policy for information technology and communication is focused on the patient or users in terms of how they can be better informed and make better use of health care Health is playing 'catch-up' to other service industries such as banking, supermarkets and shops in terms of using information technology as a tool for consumers. Strategies should therefore be focused with the end consumer of health in mind.

For Health Policy Care Services

- Evaluate the full costs and benefits of new technology m information and communication. For example, telemedicine has increased cost implications in terms of doctor time since there is one doctor with the patient and also one doctor in a remote location[8]. Obviously there are more factors involved, and more cost and time benefits to be included, but all factors should be included in evaluating the overall implications of technological developments.

- Develop Performance Indicators on information and communication.

For Policy Making and Management

- View informanon technology in an integrated way across the health sector rather than being separated from both clinical and managerial issues.

- Share information and learning on IT from European policy making because of economies of scale in IT developments.

- Link capital investment and investment realisation so that the system is able to reap the benefits from investment.

- Ensure appropriate regulation of information and communication systems, including patient rights to privacy in terms of personal, medical information.

- Include informanon, communication and IT skills in the training and education of health professionals, particularly the management of information, and communication skills for dealing with patients and sharing information with them effectively. Give more training about information to medical undergraduates. (75).

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[8] I am grateful to Graham Lister for making this observation.

Regulation

There is increasing concern with regulating the provision of pubhc services. Regulation is one of the primary functions of government when public services are decentralised, devolved, and being provided through public/private mix. Regulation involves monitoring, scrutiny, and action in the form of sanctions on the regulated. Regulation can be undertaken by many different groups, and for different reasons. Regulation in health is concerned with value for money (National Audit Office, the Audit Commission), administrative process (complaints procedure, Ombudsman) and increasingly performance (Patient's Charter, NICE, professional bodies, public inquiries). There is also extensive regulation within health services themselves, professional regulation, which includes many professional bodies such as the General Medical Council (GMC) and the UKCC. Finally, there is legal regulation of certain services provided within health.

Government regulation of the health sector, like other public services within the UK is increasing in its overall level, and diversifying in form.

Trends

increasing level and scope of government regulation throughout public services

regulation within health moving from a focus on finance and administrative process towards a concern with performance

new regulatory bodies at the national level in health who are concerned with health outcomes

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Current Policy

Current policy is made up of:

- Financial. The Public Accounts Committee reviews public expenditure. The National Audit Office is the financial regulator for central government, investigating value for money. The Audit Commission investigates the use of resources in the health service and local government.

- Procedural. The parliamentary ombudsman investigates complaints made against the health service. If a specific case warrants it, there may be a pubhc inquiry set up to investigate a particular case of alleged malpractice, or maladministration. There are currently two high profile pubhc inquiries being held, one into BSE, and one into deaths of heart patients at Bristol Royal Infirmary. The public inquiry process is lengthy and expensive, with the detailed accumulation of evidence and witness statements from key people involved in a case.

- Performance. The Patient's Charter set performance targets primarily for waiting within the NHS. Performance has been the focus of the current Labour government's white paper on the NHS (61) and a subsequent Performance Assessment Framework (76). Health Authorities will ensure that local purchasing arrangements lead to health improvements set down in Health Improvement Programmes. The Commission for Health Improvement will be a statutory body at national level that will ensure that these local systems set up to monitor and improve clinical quality are in place. It will have the power to undertake local reviews, for example on NHS Trusts, from 2000. Most recently, the government has announced performance indicators as part of its Performance Assessment Framework, incorporating performance indicators and clinical indicators (77, 78).
- Legal: Regulations concerning medicines and pharmaceuticals. There are also legal regulations concerning the provision of certain services.

- Professional: Through statutory authorities such as the GMC and the UKCC, with whom professionals have to register in order to practice. The GMC has been high profile recently due to the disciplinary procedures being brought against surgeons in Bristol.

Implications

For Health Policy:

Possibility of collecting evidence on:

- patient outcomes

- patient access to information
- patient complaints

Having the ability to observe trends and act on them, leading to improved accountability mechanisms.

For Health Care Services:

- An increase in bureaucratic burden and litigation as a result of more available published information on outcomes and a greater openness about failures in treatment and care.

- Improving standards of care and increased uniformity of standards of care.

- Increasing pressure on health professionals, professional bodies and managers to improve performance, with increase in complaints, more assertive patients, and high profile internal regulatory failures.

- Increases in the number of complaints about health care services.

For Policy Making and Management

- Increasing resources devoted to regulation within health. Policy has yet to be implemented on new performance arrangements for clinical procedures and hospital outcomes, but it is likely that policy will become increasingly complex on this issue. It could provoke resistance from powerful interest groups within health, and it will require strong co-ordination between the various bodies responsible for regulation, the policy makers and those who are regulated so as not to make accountabilities more confuse**d.**

Recommendations

For Health Policy

- Use regulatorv' mechanisms to accumulate relevant data on health outcomes across the UK. Contribute to international comparisons and benchmarking using health outcome data.

- Ensure the public's confidence in the NHS. which is high.

For Health Care Services

- Secure the support of the key constituencies that will be involved in increased regulation namely the patient, the population and the health care system (79: p. 40).

For Policy Making and Management

- Establish an ethical regulatory framework that sets out individual and community rights.

- Explore the possibility of 'no fault' compensation.

- Evaluate the costs of regulation within health.

Health Professionals

"Decide on roles for professionals, and how best the NHS can value them "

Health professionals are subject to increasing scrutiny in the health care system. Health professionals have been influenced by changes that have sought to make public services more like the private sector; they have expenenced an erosion of their traditional status, particularly in the acute hospital sector, and a decline in professional autonomy. Managerialism with explicit cost and performance measures continues to present a challenge to professional groups and the way that they work. Regulation of the professions, the implementation of both clinical guidelines, and performance measures are likely to put added pressure on health professionals. As a result, surveys of groups of professionals show increased levels of dissatisfaction, low motivation, changing attitudes, sickness, absenteeism and general levels of stress. There is currently a shortage of nurses in the UK health service and a shortage of doctors for some specialties. Caring has traditionally been central to the health professions, but recently there is felt to be a decline in the importance of caring. It has been lost in many reforms of the NHS, where managerial and financial positions are valued more highly man 'hands on' patient care (71).

Trends

increasing challenges to health professionals including the erosion of professional autonomy, the growth of management in the health service, and increasing regulation or professional activities

increasing signs of stress, dissatisfaction and low motivation among some groups of professionals

increasing problems with traditional workforce planning in health including current shortages in nursing and a shortage of doctors for some specialties

demographic effects on the health workforce, including ageing of the nursing workforce

shifting roles from doctors to nurses and other health professionals in primary and secondary care settings

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Current Policy

In September 1998 the NHS announced its Human Resources Strategy, *Working Together: Securing a Quality Workforce for the NHS' (SO).* The document outlines the values of NHS staff as fairness and equality, flexibility, efficiency and partnership. Greater collaboration between health and social care is planned (81). The Scottish Office also released its first ever Human Resources Strategy in April 1998, *Towards a New Way of Working: The Plan for Managing People in the NHS in Scotland* (82).

Traditionally professional groups have held privileged positions within the health service. They have been able to organise themselves into a powerful professional network, which largely recruits its own members; controls supply, and are self-regulating. Increasingly, this is changing. The managerial reforms in the 1980s and early 1990s asserted the primacy of the manager. Today in 1999 there is increasing desire to regulate and control professional groups externally.

The NHS has always planned the supply of doctors and nurses on the basis of advice and evidence from advisory committees. The number of training places that are made available can determine supply. The success of thus professional workforce planning is mixed. The Department of Health recently decided to increase the supply of doctors by 20% over a five-year period. The NHS currently uses foreign-trained nurses and doctors to fill gaps in supply. At the beginning of 1999 the government announced a recruitment drive for nurses to deal with nursing shortages. Nurses were awarded pay rises above rate of inflation in 1999.

Professionals are increasingly encouraged to work in multi-professional groups centred on the patient and the care that they receive.

Implications

For Health Policy:

• Moving doctors away from direct contact with and treatment of patients, which is what they were trained to do.

For Health Care Services:

- In the future patients may be 'further' from a medical professional because of the use of nurses and now telephone services as replacement first contacts for patients.

- Increased labour shortages, which will have to be filled using overseas doctors.

- Role substitution in health care services, with more interventions performed by nurses, and other technicians (12).

- Changing professional roles from doctors to nurses could facilitate the shift of activity from hospitals to primary care and community care settings.

- Change in the role of general practitioners from treatment to the management of chronic conditions particularly in treating for older patients (12).

- Changing education and training of professionals with less rigid demarcation between the professions and some elements of generic training (12).

- Possible link between rise in complaints as caring falls in health care services. Negligence claims against general practitioners rose 13-fold between 1989 and 1999, from 38 to 500. Compensation awards and settlements also rose. (83, 84)

Recommendations

For Health Policy

- Role shift from doctors to nurses and other health professionals should be supported if patients get seen quicker, get better treatment and show improved outcomes. Team care has been shown to lead to improved outcomes. In addition to benefits of team care, it has also been shown to lead to poorer care at greater cost, for example. Bristol cardiology, recent maladministration of anaesthetic in theatre. It is also hard to evaluate.

For Health Care Services

- Reflection and planning concerning training the future NHS workforce to meet the right future needs.

- Ask the question, what should the future role of the health professional be, in order to begin thinking about specific measures.

- Introduce flexibility and choice in career patterns.

- Take care of the health care workforce (85).

- With a proper valuation of caring. asses and plan what a health professional wants to be in the future. This involves resolving the tension that exists today between the scientific, and the moral basis of care. Kitson (71) suggests that for nursing, this could be achieved in the future through a system that promotes health and well being rather than treating illness. We could see. for example, practice nurses running community health programmes and being supported by other health professionals, including doctors and nurses. PCGs are a possible organisational mechanism for achieving this change, but so far only a handful are likely to be headed by a nurse. Health Action Zones may allow nurses to take more of a lead role in planning health care.

For Policy Making and Management

- Investigate alternatives to the current systems of workforce planning.

Location of Care

"Evaluate locations on the basis of need and appropriate care "

There is increasing questioning of the traditional demarcation between primary, secondary and tertiary care and the various functions mat these sectors performed. Today, with the hospital sector remaining the largest and increasing concerns to improve efficiency within health care provision, there is a drive to relocate care from hospitals to primary, community and specialist care centres. Technological developments and role substitution amongst staff are driving the provision of certain services towards primary care. At the same time technology and specialisation are demanding fewer, larger hospitals to carry out more specialist functions. There is continuous questioning of where care should be located. Increasingly care follows the patient, rather than the functional organisation of the hospital, its departments, and its medical staff, which traditionally determined where services took place. More treatment takes place at primary care settings; nurses and nursing practitioner at the primary care level undertake more treatments; and increasingly mixed 'teams' provide care around a patient and their condition.

Trends

increasing use of substitution within health care; changing the location of care, introducing new technologies, and changing the mix of staff and skills in order to achieve efficiency gains

shift from secondary to primary care as a result of changes in patient management, improvement in clinical techniques and the development of new technology, and efficiency incentives to reduce lengths of hospital stay

contraction of inpatient care with reductions in inpatient beds, and reductions in average length of hospital stay

blurring of traditional boundaries between sectors within health care

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Current Policy

Current policy towards the location of care has been driven by efficiency improvements. With an assumption that primary care and day care are more efficient than inpatient care, there has been a drive to close beds, and reduce inpatient stays in order to improve efficiency. Policy has also focused on enhancing the 'appropriateness' of hospital care, which reduces admissions and the demand for hospital beds. Finally, there has been a shift in the overall perspective of hospital service configuration so that policy is increasingly focused on the network of services, and hence the experience and outcomes for the patient, as they pass through various care settings.

Implications

For Health Policy

• Improved outcomes.

• Care settings more suited to needs of the patient.

• Patients may find some services more accessible at their primary care centre and some less accessible because they are only provided at a regional centre.

For Health Care Services

• Continuous assessment and change of service configuration, which has to be planned and implemented.

• Staff recruitment and training in a changing system. Staff need to be retrained to take account of new technologies, become more specialised, develop new skills as services change.

• Withdrawal of some services and the extension of others.

• Cost implications of changing hospital use, including capital, particularly in the short term. At least 30% of the costs of hospitals are associated with buildings and other fixed facilities (25: p. 230).

• Higher demands on management and planning of services, particularly at the strategic level. With changing service configurations, and more complex networks of service provision, the need for an overarching perspective is enhanced in order to evaluate costs and benefits from change. Running an increasingly

efficient service using complex organisations like hospitals also means that there is reduced room for error in planning terms, which means mistakes will be more costly to the system as a whole.

For Policy Making and Management

- Need for strategic planning, management and evaluation.

- Need for improved information on costs associated with hospitals, including utilisation costs.

- Greater role in accumulating and disseminating information throughout the health care system, so that decisions on reconfiguration can be informed at the local level. Information also needs to be supported by systems, including IT systems to link the networks of organisations providing services.

- Ensuring primary care structures are able to cope with increased role in health care provision, including planning tools, management tools, information systems, staff, technology, and infrastructure.

Recommendations

For Health Care Services

- Greater evaluation of the lessons and drivers from change in hospital systems, using international experience. Change in hospitals has been a feature of almost all health care systems in the world in the last twenty years, and many have involved hospital closures. Along with other lessons from this report is the need for policy to learn from international experience. Hospital reform is one of those areas could benefit from shared lessons. (25: p. 231).

- Focus on hospitals rather than hospital beds in substitution measures because of the fixed resources tied up in hospitals (25: 230-1).

- Categories for improving the efficiency and appropriateness of hospital care can be identified as the following (25: chapter 6):

    payment systems

    quality of care strategies

    management techniques

    clinical performance strategies

- Some of these areas are covered elsewhere in this report. Examples of clinical performance strategies include the following, which usually involve substitution:

    shifting to day case treatment

    improving the appropriateness of admissions

    expediting the discharge of patients

    applying utilisation review techniques

- Barriers to improvements in hospital care include the lack of evidence in the following areas: economies of scale in hospital planning; the relationship between quality of outcome and volume of work; lessons from management theory on what constitutes 'good' hospital management. There is an assumption that the effect of new technology means larger, fewer, more specialised hospitals supported by primary care centres as the only possible model for the hospital of the future. (25: p. 227-8).

For Policy Making and Management

A strategy for strengthening hospital policymaking includes:

- responsibility for change at both government and hospital level

- financial and managerial targets for the hospital sector including efficiency incentives for managers and clinicians

- learn from good practice

- a clear budget for the hospital sector, with appropriate financial targets

- ensure policies allow for innovation and encourage the search for efficiency

- an integrated set of targets

(25: p. 231-2).

WHO defined four strategic elements of primary- health care in the Declaration of Alma-Ata, which are:

- at the core of the health care system, with secondary and tertiary care as supporting levels

- an intersectoral approach to health policy, including lifestyle and environmental determinants

- community and individual responsibility and participation

- redistribution of resources away from hospitals and towards primary care

(Cited in 25: p. 232-3).

PART THREE

REFERENCES

Burden of Disease
Efficacy
Effectiveness
Performance and
Benchmarking
Quality
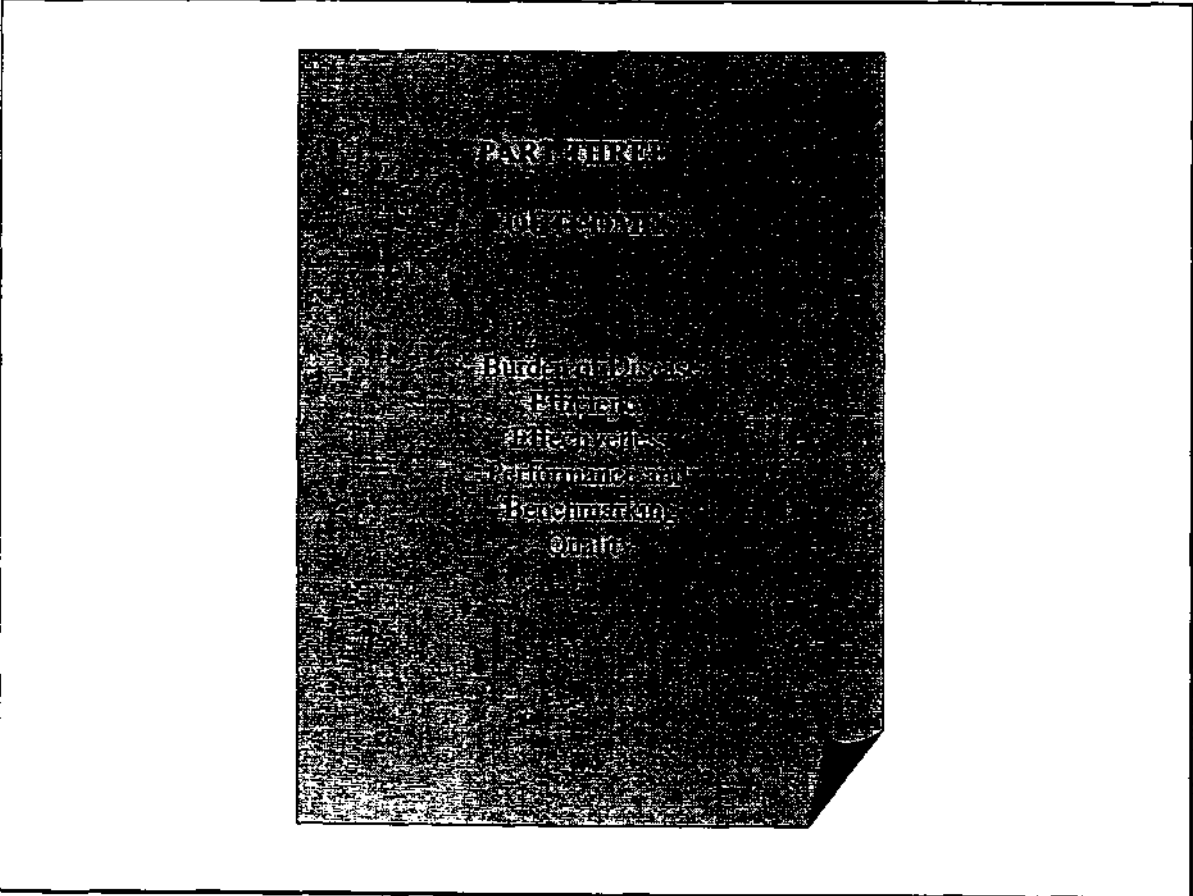
Burden of Disease

"The burden of disease will be felt predominantly in older people with chronic diseases"

The overall burden of disease has shifted from the young to the old and from communicable to chronic diseases. Deaths from respiratory diseases are increasing. There are adverse trends in smoking and in obesity, which will both be important determinants of future disease patterns in the UK. Increases in depression are predicted, one of the most common reasons for visits to the doctor. Conditions such as diabetes and conditions of the central nervous system are gaining in importance. The burden of disease differs for different racial, gender, social class, and age groups. For example, suicide is one of the biggest killers of adult men aged 18-24.

The burden of disease is shifting in terms of conditions and age groups. However, it remains firmly on the poorest in society who have worse outcomes than other groups whichever age or condition is considered.

Globally, the burden of disease projected forward to 2020 has been calculated in a study commissioned from the World Bank and the WHO, which quantifies the burden of disease in terms of disability -adjusted life years (DALYs) (86). The top ten causes for 'established market economies' are (given in order, including whether the burden is likely to increase or decrease in 2020): ischaemic heart disease (increasing), unipolar major depression (same), cerebrovascular disease (increasing), road traffic accidents (decreasing), alcohol use (decreasing), osteoarthritis (increasing), tracheal, bronchial and lung cancer (increasing), dementia (increasing), self-inflicted injuries (increasing), congenital anomalies (decreasing). WHO Europe has set itself the following targets for 2020: improving mental health, reducing communicable diseases, reducing noncomunicable diseases, reducing injury from violence and accidents (2).

Trends

shifting burden of disease from young to old and communicable to chronic disease, although continued threat of new and recurring infectious diseases

increasing incidence of cancer mainly due to the ageing population

increasing trends in obesity with the proportion of adults aged 16-64 who are obese rising from 13% to 16% for men 1991/2 to 1996 and 15% to 17% for women (30)

increasing proportion of children aged 11-15 who are regular smokers, from 10% in 1990 to 13% in 1996 (30)

increasing mental illness, including depression

Current Policy

Health care services are provided for the whole population. Individual treatment takes place for diseases, and ill health. Public health measures are targeted through campaigns, local units and focused on life style and education. In a recent speech, the Director-General of the World Health Organisation, Dr. Gro Harlem Bnmdtland, emphasised the need to set priorities in health. In order to do so, Dr Brundtland spoke of the importance of examining the distribution of disease, health inequalities, the need to evaluate and compare country performance, and the relevance of anticipating future trends in health. In comparison with Germany, Greece and the Netherlands the UK comes second in terms of death due to heart disease, second in death due to cancer, second due to suicide and third due to infant mortality. However, our overall performance would be reduced if respiratory diseases were included in the comparison.

Implications

For Health Policy:

• What does it mean to be healthy?

• Life style factors affect health.

• The health of older population is a future concern, for example there is an increase in the incidence of cancer for older people.

• Threats of infectious diseases and antibiotic resistance will affect health.

• Smoking, depression and suicide (young men) are problems for the health of young people.

For Health Care Services:

• Services will need to be organised and planned to deal with burden of disease, for example, the incidence of depression, which is the second most common reason why people visit their doctor.

For Policy Making and Management:

• The limited success of policy making is reflected upon, illustrated by the fact that the poor remain the hardest hit by disease and ill health.

Recommendations

For Health Policy

• Health policy should target the burden of disease and the UK should look to benchmark itself against other countries in terms of its performance in tackling the overall burden of disease.

For Health Care Services

• Strategic planning requires intersectoral approaches and ways of working together. Develop national and local policy agreements on shared working.

For Policy Making and Management

• Demographic trends are difficult to influence. However, policy needs to be aware of demographic trends. Obesity, smoking, and depression are likely to place a burden on health care services, and on the health of younger people. Health care services need to be planned to anticipate these changes in patterns of disease.

Efficiency

"Apply the fullest measures of efficiency"

Efficiency is an economic measure of productivity or the relationship between inputs and outcomes in the health system. Efficiency gains within the health service have recently been concentrated at the micro-economic level, to improving the performance of organisations. Efficiency may be considered in the following areas: management, health outcomes, quality initiatives, the appropriateness of care, restructuring of services, and human resources. (25: chapter 6).

The UK has seen reductions in bed numbers and average length of stay in hospitals, but waiting lists remain high. Demand for health services is increasing at a faster rate than efficiency improvements can be materialised.

Trends

decentralisation of management to local purchaser and provider organisations

increasing focus on health outcome measures, for which location of care, treatment, and management of human and financial resources are contributory factors that require individual assessment and review

efficiency measures drive increasing processes of substitution within health services

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Current Policy

Efficiency has traditionally been defined in fairly crude output measures in health, for example bed numbers, waiting lists, and activity rates. Policy has previously been focused on containing and constraining inputs into the health system, meaning cost control, or economising, rather than improving efficiency. Strict input controls remain in health services, together with an emphasis on cutting waste, particularly in non-essential services. Hospitals are expected to generate a 6% return on capital employed. Decentralisation of purchasing and providing decisions continues, with new purchasers operating with a population of approximately 100,000 rather than the local authority populations of approximately 400,000. The government has recently introduced quality and information as two national strategies that have implications for efficiency. Other strategies include enhancing the capacity of primary health care, Research and Development strategies to ensure effective, evidence-based treatments, and a focus on human resources.

Implications

For Health Policy:

- More appropriate treatment for conditions in terms of technology, human resources and location of care, which may lead to improvements in length of stay, support systems and recovery time.

- Local management of services that are accountable and responsive to local needs.

- Enhanced role for primary health care, which may include the loss of local district hospitals, in favour of primary health care in combination with more specialist centres (25: p. 203). Reconfiguration of services may mean reduced access to certain services, in terms of increased travel to specialist services that were previously housed within district hospitals.

For Health Care Services:

- Enhanced role of performance and assessment within health services, which includes the introduction of systems to support performance such as information systems and quahty measures.

- 'Substitution' in health care: the reorganisation of staff, skills, equipment, information and facilities in order to achieve improved clinical, financial and patient-related outcomes. Substitution encompasses:

    moving the location of care (primarily a shift out of hospital care);

    the enhancement of primary care, and increases in self-care;

    introducing new technologies, for which staff will have to be trained to use;

    a changing mix of staff and skills, for example, nurse practitioners replacing GPs for certain functions;

(25: p. 214-217; 87).

- Increased pressures on staff within the health service to deliver efficiency improvements. Hancock, Rafferty et. al. illustrate how increased activity in hospitals has not been matched by increases in nursing resources, putting extra strain on nursing staff (88).

For Policy Making and Management

- Reduced control for the centre, with increased decentralisation, although monitoring and assessment at the national level are increasing. Assessment is increasingly focused on outcome and performance measurements, in addition to the financial accountability that local units have towards the centre. Clinical governance arrangements will further increase the capacity of the centre to monitor efficiency improvements at the level of the individual organisation.

- Increased demand for national strategies to support efficiency improvements such as Health Technology Assessment (HTA) and the Research and Development Programme (R&D), in order to provide evidence on the effectiveness and appropriateness of treatments.

- Increased demand for role of the centre in co-ordinating information across services, so that knowledge can be shared.

- Possible trade-off between reduced access to local services and improved overall outcome from the reconfiguration of hospital services, although supplementary policies, such as improved travel arrangements may enhance overall improvements (25: p. 209-210).

Recommendations

For Health Policy

- Support HTA, Quality and R&D programmes to improve standards across the NHS. Link R&D strategy to commissioning so that purchased services are supported in terms of effectiveness (25: p. 205).

For Health Care Services

- Introduce effective information systems within the health service, in order to improve consistency, and to provide important strategic links for increasingly dispersed locations of care.

- Use purchaser arrangements to encourage substitution, co-operation and co-ordination across organisations. Link resources to outcomes rather than inputs. (25: p. 217). With PCGs as local purchasers, these incentives may be in place, although information sharing will be paramount with such devolved levels of purchasing.

- Use substitution to improve the efficiency and appropriateness of inpatient hospital care, which typically consumes 45-75% of the overall health care resources. Strategies within hospitals include: incentives to reduce length of stay, improving the appropriateness of admissions, expediting the discharge of patients and applying utilisation review techniques. (25: p. 223-6, see also Location of Care).

For Policy Making and Management

- Link initiatives that are intended to improve efficiency so that there are incentives to integrate and provide appropriate treatment, and fewer opportunities for distorted incentives or manipulation. Make the role of the centre to monitor improvements, in order to provide an overall perspective on decisions that individual organisations are making, including spreading knowledge and encouraging co-operation (25: p. 226).

- Place a higher priority on providing a full evaluation of efficiency in health services, so that decisions on reconfiguration, the introduction of new technologies and staff substitution are fully informed. Evaluate the full cost implications of change (25: p. 226).

Effectiveness

"Improving effectiveness means doing better with your money"

The UK health system has moved from an integrated model of provision, to a separation of purchaser and provider. More autonomous NHS Trusts provide services purchased by local authorities and GP fundholders. With the establishment of PCGs and their counterparts in Scotland, Wales and Northern Ireland, in 1999, the health purchasing function has become further devolved, with each group responsible for a population of around 100,000. Within this complex system containing a diverse set of incentives, resource allocation mechanisms are increasingly important for maintaining central control of expenditure and achieving improvements in institutional efficiency. (25: p. 141).

In terms of European comparisons, the UK is described as a 'good example' of a mixed payment system for providers and that adjustments on capitation to account for socio-economic deprivation, and target payments for reaching certain levels of preventive coverage appear to have been effective (25: p. 161).

Trends

use of alternative resource allocation mechanisms to hierarchical control such as service agreements throughout the NHS

performance related payment systems for providers increasing in scope and diversity

reform of hospital payment methods from budgeting to service agreements that will increasingly be tied to outcome measures and overall service objectives

innovation in mechanisms for allocating capital for health, including private finance (Private Finance Initiative, PFI) and redistribution of capital through changing locations of care

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Current Policy

The internal market in health replaced hierarchical organisation, including payment systems and resource allocation, with contracts. Those contracts have been replaced by longer-term service agreements. PCGs are allocated funds on a weighted capitation formula, and are set to purchase services from provider units, primarily acute, community and mental health NHS Trusts. Performance-related payment mechanisms are increasingly being introduced into the NHS and will be driven at the national and the local level.

Implications

For Health Policy:

- Improved health outcomes.

- Reduced health inequalities due to targeted payments.

- Greater consistency m health outcomes with performance measures.

For Health Care Services:

- Increasing awareness of resource issues amongst health professionals, particularly PCG leaders.

- Devolution of resource allocation decisions to the local level.

- Changing incentives and behaviour of health professionals (although difficult to predict the outcome of economic incennves on behaviour of GPs, cited in 25: p. 161).

- Resource allocation is more explicitly linked to overall health improvement objectives, with a greater monitoring of clinical outcomes.

- Diversification in local service practice and organisation, such as Health Action Zones.

For Policy Making and Management

- More effective allocation of scarce resources.

- Increased external scrutiny of resources used by organisations set against performance objectives, leading to increased internal resources within organisations being devoted to monitoring and reviewing performance to meet external targets.

- Changing mechanisms of external control and accountability focused on outcomes rather than throughputs.

Recommendations

For Health Policy

- Accumulate and disseminate from the centre evidence and advice on effective treatments and interventions.

For Health Care Senices

- Allow decision making to be taken at the local level.

- Objectives for reforming hospital payment methods:

  Improving cost containment mechanisms (including cost effective provision of pharmaceuticals)

  Enhancing service quality

  Achieving community-wide access

- Address difficulties relating to achieving objectives:

  Dynamic nature of the hospital system

  Financial pressures from technological advance

  Growing expectations of patients

For Policy Making and Management

Recommendations for allocating capital for investing in health:

- Match investments and capital. For example, if a technology allows diseases to be prevented, or treated more effectively in outpatient settings, the former inpatient facilities should be closed, reduced, or reallocated, with investment made in the outpatient settings or preventive measures.

- Investments should promote 'high technology', which is defined for these purposes as: 'a genuine understanding of the disease mechanism ... so that it is possible to cure the illness in question completely, or even prevent it'; examples include vaccination, antibiotics.

- Maintain an appropriate capital stock over time through by balancing capital investment and operational spending. A crude indicator of mis-match may be low occupancy rates in hospitals.

- Stimulate the critical examination of existing patterns of capital allocation.

(25: p. 196-202).

Performance and Bench-Marking

"Decide where the UK wants to be in health terms, and measure progress towards it"

Performance and bench-marking involves deciding where the UK wants to be in health terms, identifying what strategies are needed to achieve this, and finding appropriate means to assess progress. It means developing a system of assessing performance in health, both in terms of health service indicators, and national health outcomes; and comparing performance against other developed nations.

Health targets are included in public health papers that have been established for England, Wales, Scotland and Northern Ireland (1, 3, 4, 5). International benchmarks compiled by organisations such as WHO, OECD are at developmental stages.

Trends

increasing concern with organisational performance in health in terms of clinical outcomes, replacing traditional concerns with finance and administrative process

increasing use of national health targets

increasing desire to link health care funding to improved health outcomes

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Current Policy

Our Healthier Nation has set national targets to be achieved by 2010 for: heart disease and stroke (reduce deaths by one third); cancer (reduce under 65 death rate by one fifth); accidents (reduce by one fifth); and mental health (reduce death rate by one sixth) (1). *Towards a Healthier Scotland* (3) has 7 'headline targets' including heart disease, cancer, smoking, teenage pregnancy, and alcohol misuse.

Performance indicators in the Patient's Charter currently judge performance within the health service, where the key indicators are waiting lists for treatment. The government is committed to reducing waiting lists, although they are currently at peak levels throughout the history of the NHS. Broader indicators of national performance have been set out by the current government under the following headings: health improvement; fair access; effective delivery of appropriate care; efficiency; patient/carer experience; health outcomes of NHS care. (76). These broad headings indicate a shift towards outcome measurement. The National Institute for Clinical Excellence (NICE) launched in April 1999 is designed to provide evidence-based guidelines on treatment (37). The Department of Health's annual report for 1999 announced that it will report annually to the public on the following: achievements, effectiveness, quality of service, efficiency and relating outputs to inputs with the first interim report planned for autumn 2000. The Patient's Charter set performance targets primarily for waiting within the NHS. Today, health authorities will ensure that local purchasing arrangements lead to health improvements set down in Health Improvement Programmes. The Commission for Health Improvement will be a statutory body at national level that will ensure that these local systems set up to monitor and improve clinical quality are in place. It will have the power to undertake local reviews, for example on NHS Trusts, from 2000. In June 1999 the government published its first set of performance indicators as part of its Performance Assessment Framework, incorporating both performance indicators and clinical indicators (77, 78).

Implications

For Health Policy:

- Performance targets work to ensure poor performance is eradicated, making health outcomes from treatment equal across the country. International benchmarking on performance places UK performance in an appropnate international context. For example, comparing UK to Germany, Greece and the Netherlands, using four crude indicators of health outcomes, we find that the UK comes 2nd for death due to heart disease, 2nd for death due to cancer. 2nd for death due to suicide, and 3rd for infant mortality, using current OECD data. Including death from respiratory diseases brings down UK performance.

For Health Care Services:

- For patients, improvements in performance could bring potentially better services, services based on evidence and best practice that are available throughout the country, shorter waiting times and rights to treatment if the treatment has proven outcomes.

- For professionals the changes mean more evidence based treatment, which will have training implications. Professionals will face more explicit measures of their performance, they will be judged against their peers, and will have to take steps if they are found to be under-performing.

For Policy Making and Management

- Purchasers will have a more explicit basis for decisions to purchase. There may be some potential conflict between clinical/financial decisions on whether to provide a treatment or service that will need to be resolved.

- For government: There are funding implications from evidence based medicine. The commitment to reducing waiting lists has already affected government funding of services.

Recommendations

- There is a further test of national performance and that is bench-marking UK performance against that of other EU and developed countries according to key indicators, such as those developed by OECD (89,90).

For Health Policy

- As the OECD acknowledges, health outcomes depend on a number of factors beyond the health care system. Improving health outcomes is a wider responsibility than that of the Department of Health; a fact that the UK government has itself recognised. However, benchmarking outcomes can serve as an evaluation of policy, particularly if data can show performance over time. Health outcome indicators may highlight where we are neglecting health issues, and prompt us to ask the question why we differ on performance against some indicators when compared to other countries, and what can policy do to improve the situation.

For health care services

- Evaluating policy in terms of benchmarking and performance will help direct health care services to the areas of greatest need. Comparable indicators that *evaluate* rather than simply *measure* the activity of health care services are currently difficult to find. The UK has one of the lowest spends on health as a percentage of GDP in the EU, but performs satisfactorily on many general indicators, which suggests that we are performing well. However, we need more measures based on outcomes rather than activity levels.

For Policy Making and Management

- The new performance framework set up by the Labour government represents a shift from indicators based on waiting times to overall health outcomes. The emphasis in current government policy seems to be firstly, in making improvements over time, for example, in the targets set in the public health paper, *Our Healthier Nation;* secondly, in bringing local providers up to national performance standards. International benchmarking provides an additional measure of performance that is the evaluation of policy making that compares UK performance not only over time, but also across alternative systems and alternative policies over time. In this way. using common indicators, we could make an objective assessment of UK performance on an international basis.

Quality

"A better deal for patients ... which you could measure "

Quality can be defined at three levels of performance: of the health sector, of organisations within it and of a specific clinical intervention. There are different measures of performance, for example, economy, efficiency or effectiveness. There are also different constituencies to whom quality is to be delivered, such as individual patients, the patient population, or the system as a whole. (79: p. 18). The concept of quality has moved from referring to detailed process measures within health care to some kind of outcome measures in terms of healthy individuals or overall health policy.

Trends

increasing concern with achieving consistent high standards of service across the NHS

increasing interest in outcomes rather than process measures of quality

increasing concern with measurement, comparisons and evaluation within health services

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Current Policy

The current Labour Government has articulated quality in many proposals for reform of the NHS. 'Top down' policy on quality includes the following:

- A commitment m *The New NHS, Modem Dependable* (61) *and A First Class Service* (91)

- The extension of National Service Frameworks along the lines of the Calman-Hine framework for cancer services

- Two national organisations, the Commission for Health Improvement, and the National Institute for Clinical Excellence (which comes into effect in April 1999)

Performance frameworks are likely to be managed at the regional level. At the level of health care organisations, measures will include clinical governance and peer review, and quality management, which could include hospital performance tables on indicators like mortality.

'Bottom up* changes are expected in terms of the development of guidelines for practice, and developments in professional values and ethics. (79: p. 28).

Implications

For Health Policy

- Improved health outcomes.

- Improvements in the regulation of health care services and the identification and elimination of failures in outcomes.

- More openness about procedures, so that patients can make better-informed choices about care. Hospital league tables may follow similar developments in public services like education.

For Health Care Services

- Services become more responsive to patients as consumers.

- The goal of the quality agenda is to improve the overall performance of the health care system - for the individual patient, for the patient population as a whole, and for the system itself.

- Greater need for regulation in health care services.

- Increased prevalence of evidence based treatments.

- Increasing self-regulation of health professionals, particularly doctors, and also regulation by external bodies.

- Increased pressure on those working in heath services, particularly medical professionals. There may be objections or resistance among some professional groups about the practical implications of quality measures.

- Increased responsibility for organisational heads throughout the health care services, particularly hospital chief executives.

- Resources for implementing the quality measures will be taken from existing budgets, so resource allocation decisions will need to be taken at the service delivery level.

For Policy Making and Management

- Guidelines on treatment at the centres of national government departments.

- Re-balancing of the current domination of cost measurements in health services (79: p. 16).

Recommendations

For Health Policy

- The public needs to be informed about, and involved in, the quality agenda.

For Health Care Services

- Ensuring appropriate and clearly communicated mechanisms of accountability within the health sector. Clinical governance suggests that in the future senior managers in an organisation will be responsible for clinical performance in their organisation, but will they also be accountable to parliament on this issue, as they are for financial considerations?

- Allocating human resources required to operationalise quality and ensure support from all constituencies of the health care workforce.

- The development of the internal market in the UK health sector showed how little information was generated by the health care system about what it does, why it undertakes particular functions, and what they all cost. The internal market drove the development of that information in financial terms; the quality agenda appears to demand the same amount of information on more complex matters such as performance. Investment in information search on quality needs to be accounted for.

For Policy Making and Management

- Some priorities:

    Clarify assumptions regarding professional self-regulation versus government regulation

    Develop incentives within the quality system.

    Operationalise the new system of clinical governance

    Develop a strategy to increase capacity in the health service (79)

- Establish international collaboration in shanng knowledge, agreeing standard methods, and disseminating information as in the Cochrane Collaboration (25: p. 212).

- Link policy and practice decisions to continuing assessment in order to improve health outcomes, which means long term strategies on assessing the value of interventions and using the information systematically in decision making, and also developing a research infrastructure and mechanisms for implementing its results. (25: p. 213).

Conclusion

So, what are the lessons from undertaking this assessment of health policy? An overall assessment is difficult because there are so many issues involved mat to summarise often means to oversimplify what are in reality highly complex subjects. The policy recommendations made in the report should not be taken to mean that there is one 'right' way to progress in health. If anything, the assessment shows that there are a series of underlying tensions within health policy that mean simple solutions are likely to fail. Some of the key tensions are listed below in Figure 5, although it *is* not an exhaustive list

What is interesting about the series of tensions that have been drawn out; is that they often represent tensions between common opposing forces; that is the forces of individualism versus the forces of collectivism. Alternatively, they represent tensions between 'macro' and 'micro' policy issues in health. They illustrate that health policy is often concerned with resolving tensions between a desire for collective good on the one hand, and moves to bring services closer to individual choice on the other. The debates are not unique to health but appear in many government functions. However, health has unique resonance in people's lives; it is both a uniquely 'public' good on the one hand and an intensely private, individual matter on the other. It raises issues of access, equality, equity, and social justice.

These tensions often stem back to the political traditions of collectivism versus libertarianism, which Greenleaf uses to describe the whole of British political tradition (cited in 92: p. 26). With Ubertarianism comes the basic importance of the individual, limited role for government, awareness of the dangers of concentrating power, and the rule of law. Collectivism represents public good, social justice and positive government Such tensions are not new. Today, they are both to be found within the policies of all of the major political parties in die United Kingdom. They represent many of the tensions within modern health debates. The pace of technological, scientific, organisational and political developments in health simply make these tensions more acute.

So, for example, developments in genetics could change the focus of health towards preventive population measures, whilst at the same time highlighting debates about the rights of individuals to determine their own lives, to live their lives freely, and to have the right to refuse treatment or behavioural change. The drive towards national information technology networks in health, which can be used to monitor population health and aid research, crystallises debates about individual patient rights to privacy in terms of their own medical records. There is rising technical expertise in health along with a reduced ability to communicate respectfully with individual patients. There is increasing therapeutic potential in health, but at the same time, increasing strain on the workforce within health services. The individual experience of work for health professionals in the health service is shown to be deteriorating. Many more examples of tensions can be found.

Health policy increasingly operates within these tensions. Each component is desirable - by somebody, and to some extent. It is possible that shifts and trade-offs between these tensions will increasingly determine policy. An example can be illustrated with food safety policy, which has raised its public profile in the last ten to fifteen years. In response to the collective decision making that took place in banning beef on the bone there was a negative reaction from the public, and a consequent desire to exercise freedom of choice in terms of what was eaten, despite the risk that it might be infected with BSE. In contrast, with genetically modified foods the public debate has put pressure on the government to take positive collective action on behalf of experimentation with genetically modified crops, which has been followed by the banning of products from large retailers and suppliers.

Shifts within the tensions will become increasingly commonplace, as there are developments in drivers such as scientific advance, globalisation, information technology and demographics. The consequences for policy and policy making are that instead of rational choices, a more constrained model of policy making emerges where compromise, collaboration, co-operation, and consultation are likely to characterise decision-making. In some areas policy might be a compromise on certain tensions, in others, there may be more acute difference or explicit conflict between opposing forces.

Two points should be added here. One logical conclusion of this thinking on health policy in terms of the resolution of a series of increasingly diverse tensions, is that reaffinning values can resolve the tensions. In some areas of policy that may be true. In others, it is the support for compering value systems that give rise to the tension. It is not even that on one issue a particular value system is adopted which is different to that on

another issue - the values will change over time, and often be equally desirable on a single issue.

Tensions also need to be placed in the more varied social, economic and political context than can be described here. The context of debates in health may shift within the next ten to fifteen years and this will have consequences for the various tensions. Such shifts may eliminate tensions, or escalate the gaps between them. Despite this, health policy has to be set within the present climate. The futures exercise has shown that these tensions will have to be addressed by policy makers - either through decision making on behalf of the electorate, or through more explicit public debate on what possible solutions to the tensions might be.

Figure 5 Tensions in Health Policy

Drive for public and preventive health measures across the population	*Increasing commodification, and individual responsibility for health and health issues*
Health indicators	*Treatment indicators*
Universal coverage	*Consumer choice*
Societal factors affecting health	*Behavioural factors affecting health*
Central managerial controls such as governance and performance evaluation	*Localities' part in priority setting and decision making*
National IT networks used to record and analyse patient information	*Individual rights to privacy with respect to medical records and patient information*
Increasing technical expertise	*Reduced ability to communicate respectfully with individual patients*
New knowledge facilitating preventive strategies in society	*Individual right to refuse treatment*
Global prevention strategies against communicable diseases	*Individual freedom of movement*
Increasing therapeutic potential	*Health workforce under pressure*
Global health measures	*Role of nation state in making health policy*
Sustainable public finance through universal taxation	*More heterogeneity in health financing, including opportunities and incentives for individuals to opt out of public treatment, or to provide top up funds*
National population measures	*Targeting of health policy towards specific sub-population groups*
Informed and assertive patients	*Time pressures on health professions, which reduce contact with patients, and time for professionals themselves to be informed*
Complex scientific and technological processes of manufacturing, process and treatment	*Demand for assurances on public safety issues*
Concentration of specialist expertise and equipment in smaller number of larger centres	*Diagnosis, treatment and monitoring taking place outside hospital, including self-diagnosis and*

	home care
Scientific and technological discovery	*Systematic evaluation of health interventions*
Globalisation and Europeanisation; policy shifts upwards	*Devolution and decentralisation; policy shifts downwards*
Containing overall government health expenditure	*Rising public expectations about what health services should deliver*
Inter-sectoral approaches in health, which require a central, strategic lead	*Devolution and decentralisation of policy decisions*
Monitoring and assessment at UK and national level	*Reduced control for central departments*

In order to build on the identification of emerging tensions within health pohcy, a summary of pohcy recommendations from the report is presented in Figure 6.

Figure 6 Summary of Recommendations

ISSUE	POLICY RECOMMENDATIONS
DETERMINANTS	
DEMOGRAPHICS AND AGEING	Reform pensions
	Develop a statement on individual rights of older people
	More research on the disease profile associated with ageing
	Integrate health and social care
	Develop policy for older people
	Consider expectations of older people
	Integrate policy and planning for the health and welfare of older people
	Develop broader quality of life indicators for older people
GLOBALISATION	Assess the protection of public health
	Address threats to health from globalisation
	Explore IT for global health
	Provide education and training for health professionals dealing with new diseases
	Provide education and training for professionals dealing with borders
	Enhance the UK role in international and global agencies
	Balance global and local interests
	Develop inter-ministerial committees to co-ordinate health policies
	Focus international aid on capacity building
	Construct a regulatory framework to deal with the marketing practices of foreign companies in the UK
TRENDS IN DISEASE	Develop an appropriate mix of individual and population based measures
	Improve research on common and increasingly prevalent diseases
	Benchmark the UK internationally on performance in tackling disease

improve education and training on mental health

Be aware of demographic trends

Develop intersectoral working on tackling disease

Develop an improved approach on dealing with risk

Assess preventive disease strategies

Learn from international experience on tackling disease

PUBLIC EXPECTATIONS   Develop standards in patient information

Provide effective public disclosure on public health issues

Train professionals to deal with increasingly informed patients

Give more time to doctors to review clinical information on patient conditions

Keep aware of international trends in consumer issues

TECHNOLOGY   Link health technology assessment to health outcomes

Investigate the impact of technology on health inequalities

Plan for technological development in resource allocation decisions

Plan investment in new technology

Investigate the socio-economic impact of new technologies and include it in evaluation

Develop an 'early warning system' for new health technologies

SCIENTIFIC ADVANCE AND NEW KNOWLEDGE   Link evaluation of scientific advance to health outcomes

Evaluate the impact of genetic developments on health care services

Develop genetic awareness amongst the population

Develop an ethical framework to evaluate scientific advance

Respond to changes in public attitudes to scientific advance

Develop further the systematic evaluation of scientific advance

ENVIRONMENT   Consider the environment at individual and community level

	Develop an integrated health policy to include environmental factors, for example in reducing inequalities
	Develop improved understanding of, and communication of risk to the public
	Develop a single classification of risk terminology
	Adopt a broad understanding of risk that includes social as well as medical risk
LIFESTYLE	Explore new ways to reach groups on lifestyle messages
	Focus on child health
	Develop interagency working to tackle the root causes of ill health
	Establish regular audits of policy to monitor and improve performance
POVERTY AND RELATIVE DEPRIVATION	Tackle the root causes of poverty
	Collect data and set benchmarks for health outcomes and test progress internationally over time
	Target health expenditure to poor health outcome areas
	Redistribute health care resources towards tackling inequalities
	Gather information on inequalities such as poor access to health care services
	Make inequalities relevant to the public and to policy makers
INTERVENTIONS	
DEVOLUTION	Maintain UK targets for public health indicators
	Develop an appropriate role for the Department of Health, England after devolution
	Sustain means of policy learning from alternative systems
	Establish 'policy villages' to ensure consistency of health policy
	Establish governance structures, including the role for regional agencies
	Establish a standing conference on devolution in health to aid planning
USER INVOLVEMENT AND EMPOWERMENT	Develop strategies taking account of barriers to and benefits of public participation
	Provide staff development to support user and citizen involvement

Change structures to involve user groups

Include social science and user perspectives in professional education and training

Develop models of engaging users and citizens about health service and health policy issues

EU INSTITUTIONS   Use the EU and Europe as a benchmark for performance on health

Compare health services in order to improve policy learning

Develop EU policies on health and health care

Take advantage of information sharing and dissemination between member states

SERVICE DELIVERY   Link indicators of service delivery to health outcomes

State organisational roles and objectives clearly

Assess role substitution and changing settings of care

Increase flexibility in role substitution and changing settings of care

Assess education and training to meet the requirements of changing health services

Decide on role of centre(s) and ensure compatibility with local approaches

FINANCE   Link expenditure to outcomes so expenditure is directed to areas which will have greatest impact on agreed objectives

Improve assessment and evaluation, including health technology assessment

Maintain the principal of equity

Give more attention to long-term planning in health

Fully evaluate PFI and consider pessimistic long-term scenarios

Consider alternative options to the current system of financing, such as voluntary health insurance

PRIORITY SETTING   Promote consistency

Use information technology to inform patients about priority setting

Look at successful international priority setting measures

Use a priority setting system that assesses need

Debate priority setting at UK level

LEADERSHIP AND GOVERNANCE

Link leadership and governance mechanisms to outcomes

Provide motivation and incentives for NHS staff

Develop clear lines of accountability in the devolved health system

Allow flexibility in local arrangements

Specify objectives of developments in leadership and governance arrangements

CARING

Build in caring to formal health costs

Include caring more explicitly in the health system as promoting health and well being

INFORMATION AND COMMUNICATION

Focus information policy on users

Evaluate fully the costs and benefits of new technology

Develop performance indicators on information and communication

View information technology in an integrated way across the health sector

Share policy learning in information at the European level

Ensure proper regulation, including patient rights to privacy

Develop information and communication training for health professionals

REGULATION

Use regulatory mechanisms to improve consistency of health outcomes

Maintain and ensure public confidence in NHS

Secure support from key constituencies involved in improving regulation systems

Establish an ethical framework that sets out individual rights and community rights

Explore the possibility of 'no fault' compensation in health

Evaluate the costs of regulation within health

HEALTH PROFESSIONALS   Evaluate role shifts on the basis of improved patient outcomes

Initiate reflection and planning on training the future NHS workforce

Reflect on the roles of professionals

Introduce flexibility and choice in career patterns

improve measures that take care of the NHS workforce

Investigate alternatives to current systems of workforce planning

LOCATION OF CARE   Establish international policy learning on changing hospital systems

Focus on hospitals rather than hospital beds in substitution measures

Develop efficiency improvement strategies in hospitals

Develop more evidence on relationships between location of care and outcomes, including economies of scale in hospital planning

Pursue evidence-based redistribution of resources away from hospitals and towards primary care

OUTCOMES

BURDEN OF DISEASE   Develop international benchmarking on improvements in tackling disease

Develop intersectoral working on reducing levels of disease

Use trends in disease to plan health care services

EFFICIENCY   Link R&D strategy to commissioning

Develop effective use of information systems

Use purchaser arrangements to encourage substitution, co-operation and co-ordination across organisations

Improve efficiency and appropriateness of inpatient hospital care

Use central departments to monitor efficiency improvements

Link resources to outcomes rather than inputs

EFFECTIVENESS   Accumulate and disseminate from central departments, evidence and advice on effective treatments and interventions

Allow decision making to take place at the local level

	Improve hospital payment methods
	Develop a long-term strategy for allocating capital for investing in health
PERFORMANCE AND BENCHMARKING	Use international health outcome measures to benchmark the UK over time
	Develop more outcome measures and work to improve the measures
	Evaluate policy in terms of performance and benchmarking
QUALITY	Inform and involve the public in the quality **agenda**
	Ensure appropriate and clearly communicated mechanisms of accountability
	Allocate human resources to operationaiise quality measures, including incentives
	Invest in information search on quality measures
	Establish international collaboration - sharing knowledge, agreeing standards, disseminating information
	Set appropriate priorities for developing quality in the health sector
	Link policy and practice decisions to continuing assessment in order to improve health outcomes

It is a challenge to try and draw together the various issues that have been highlighted, in this report. The project was not intended to start with a policy statement and provide evidence for it, but to attempt to present a systematic overview of health issues for 2015, and from that assessment or 'environmental scan' to draw some policy implications and policy recommendations for the UK.

The aim was not to present a finished body of work. The project is intended to be ongoing, in amassing, analysing and commenting on growing evidence about the state of UK health, and the picture of future health issues that is emerging. This paper is for consultation and your views are welcomed.

In the light of this process, the project aims to influence policy on the basis of available evidence and analysis. The most immediate task in that respect is to decide where the UK would like to be on an international scale, in health terms and what the strategies might be needed in order to get there. Single targets tend to be set for health gam, but it is also important to set up an assessment and review process so that the UK can be examined in policy terms, perhaps 3, 5, or 10 years down the line. The government has set overall targets such as eliminatmg child poverty over a twenty-year period. More discernible progress steps to that overall target are needed in order to evaluate policy.

The analysis shows that there are gaps in policy; gaps in objectives, gaps in benchmarks, gaps in available evidence. The policy recommendations in each of the areas highlighted in this report attempt to address those gaps.

With a relatively new government that has set itself some long-term objectives in health, many policies are new

and address new issues. So, in some areas 'current policy' points out new policies that are addressing some difficult issues in health, such as persistent health inequalities. It is hoped that policy will benefit from the independent scrutiny of progress in these areas over time. The time horizon of this work means that policy recommendations are addressed to government in its general sense. Health is a long-term issue, transcending government and organisational boundaries. The agenda needs to be tackled in order to improve the health of the UK population.

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