Value for money in the NHS

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Can the NHS cut costs and meet rising expectations?

Although all the major political parties pledged to protect the NHS from spending cuts, after a period of unprecedented growth there is the prospect of a three-year real-terms funding freeze, or close to it. This would be the most austere period for the NHS in over thirty years. Even with funding held constant, rising demands from an ageing population, together with higher public expectations driven by clinical developments, mean there is likely to be a substantial "funding gap" to be met by improvements in productivity and efficiency. The NHS Chief Executive estimates that savings of around £15-£20 billion will be required by 2013-14 simply to maintain the quality of care on offer.

The parties have pledged to protect funding but demand will continue rising

Productivity is rather a crude measure of value for money in the NHS, calculated by comparing inputs and outputs. There are questions about what is and is not measured, and about how to place a value on the outputs of healthcare. When the Office for National Statistics (ONS) reported that productivity in the NHS had fallen by 3.3% between 1995 and 2008 many argued that this did not reflect improvements in quality of care, waiting times and patient experience. Despite these limitations, the ONS figures highlight the scale of the challenge the NHS faces in trying to increase productivity.

EFFICIENCY SAVINGS

The main political parties and think tanks have highlighted a number of opportunities to cut costs in the NHS while protecting frontline services. These include cutting "back office" management, limiting staff pay and pensions, selling assets, rationalising procurement and drugs purchasing, and re-aligning the NHS IT programme. There are also a number of wider policy debates about value for money in the NHS.

COMPETITION OR COLLABORATION

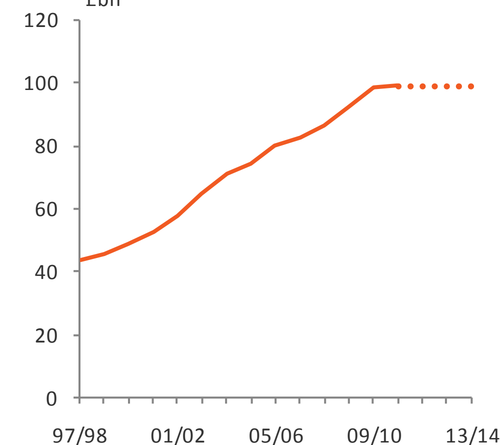
The purchaser-provider split in the NHS in England is intended to enable competition between providers, decreasing costs and increasing quality and innovation. Studies exist citing both improved and harmful outcomes of competition. Some commentators have argued that increased patient choice and competition from independent, voluntary and community sector providers will improve efficiency and clinical quality. Others have countered that competition creates wasteful overcapacity and prevents co-operation.

PREVENTION AND PRIMARY CARE

There have been repeated calls for a shift in care from hospitals to the community, with more services delivered in GPs' surgeries and patients' homes, particularly in the treatment of long-term conditions. Arguments for early intervention and care "closer to home" often highlight the savings from avoiding hospital admissions, as well as the benefits for patient care. Similarly, although prevention of illness is seen as desirable for its own sake, the cost implications of obesity, smoking and alcohol and drug abuse have pushed public health up the political agenda.

A freeze in NHS spending would follow unprecedented growth since 1997

NHS net expenditure, England, real terms, £bn



If the NHS provides more care in community settings and reduces the use of hospital services, then there will need to be substantial reconfiguration of services, yet proposals to close or downgrade local hospitals are often deeply unpopular. And while prevention may be a cost-effective way to extend years of healthy life, this does not necessarily mean it is ultimately cost-saving.

IMPROVING CLINICAL EFFICIENCY

As NHS funding tightens, another option is to try to target resources on clinical interventions that optimise health outcomes and to identify procedures that can be made more efficient. The King's Fund has suggested money could be saved by reducing the length of stay in hospitals and using lower cost drugs.

There are already a number of programmes in the NHS aimed at improving quality and productivity, such as "productive ward" procedures to help nurses spend more time on patient care. It has been suggested that the National Institute for Health and Clinical Excellence (NICE) focus more effort on stopping ineffective practices. However, the experience of NICE has shown that making judgements on the cost-effectiveness of interventions can be highly controversial.

DECENTRALISATION OR CENTRAL CO-ORDINATION

There is a tension between national co-ordination and local decision making in the debate about value for money in the NHS. Should the NHS attempt to enforce top-down best practice? Or will innovation and efficiency only come from local decision making and accountability, with an acceptance of locally varied, diverse provision? Is it possible to reconcile these tensions? Arguably the NHS currently employs a mix and match approach, using competition and promoting cooperation, combining central co-ordination and local decision making.

Given the financial challenges facing the NHS it will be vital to find the right balance in all these issues to achieve value for money.