Can the NHS cut costs without substantially damaging the quality of health care?

In a forthcoming King’s Fund/BMJ debate Rebecca Rosen and Paul Corrigan will argue that the NHS cost cutting that will occur over the next few years does not inevitably mean that the quality of care it provides will suffer. John Appleby and James Owen Drife are not so sure.

The NHS spends £100bn (€113bn; $153bn; 2009 figures) a year. It spends this money through a series of financial relationships, some of which are contractual or organisational ones, such as those between commissioners and providers. Other financial relationships are between individuals and organisations, such as contracts with medical staff.

This money flows round the system through these relationships, and we can develop them to gain better value for money. In 2010 we are well placed to use incentives to improve health outputs without increasing resources.

In a pre-reformed NHS one of the abiding ways in which inefficiency was incentivised was that if a hospital ran out of money in January it would get a winter allowance to ensure that it survived the year. Those hospitals that worked hard to keep within their budget were not rewarded with extra money, whereas those that had spent their budget before the end of the year were—an odd way to encourage value for money.

In any healthcare organisation improving value for money is difficult. It means discussing and changing the way in which medical professionals work. Some form of incentive structure has to be in place to encourage institutions to do this hard work.

One way to encourage efficient behaviour is for real consequences for inefficiency to exist—and positive consequences for efficiency are also needed. Why should an organisation work hard to improve their financial position by 10% if someone takes that money at the end of the year? This is the rationale behind foundation trusts. An organisation having the autonomy to keep the resources that they create through greater efficiency is a good incentive for efficiency. The equivalent for primary and community health organisations—that is the right to keep the finances that they create through efficiency—will have an impact on all providers.

Although technical efficiency affects how an organisation develops value for money by bearing down on costs, allocative efficiency has an impact on the way in which resources are used. An improved allocative efficiency is developed when the system allocates the resource for treating the patients to that part of the health system that provides the best value for money in the system.

Allocative efficiency needs incentives to work across organisations to maximise care in the most efficient locations. At the moment the tariff is primarily used to pay an organisation for the work that it does. A tariff is being developed that encourages the creation of a patient pathway, and places the greatest surplus to be made by keeping people away from expensive care.

An example is long term care. It has been estimated that about half of the cost of diabetes care comes from complications and emergency admissions—both of which require admission to hospital. Obviously people with diabetes must know that they can go to hospital when they need to—however expensive that treatment is. The patient and the system as a whole, however, do not want patients to be regularly admitted as emergencies. It disrupts the lives of patients, and is expensive to the system. So the patient and the healthcare system need a patient pathway that encourages as much self management as possible. When the patients feel they cannot manage themselves a strong and fast primary care intervention should exist to keep them out of hospital.

A tariff is being developed that looks at the cost of a year’s diabetic care, and which encourages the provider who is managing that year to keep the patient out of hospital. Seventy five per cent of the NHS’s expenditure is spent on long term conditions, and so it is the management of those conditions that provides the biggest opportunity for using a tariff that will incentivise allocative efficiency. Paul Corrigan management consultant and former director of commissioning, NHS London, London corriganpauld@yahoo.co.uk

**In 2010 we are well placed to use incentives to improve health outputs without increasing resources**

**YES**
NO

It would not be credible to argue that, in a multibillion pound business, opportunities to improve efficiency do not exist, or that any reduction in the costs of production will inevitably lead to corners being cut and quality of care suffering. But the productivity challenge for the NHS is daunting.

Belt tightening starts this year for the English NHS with a real rise in funding of just 1.6%. This will be the smallest increase for 14 years and around a quarter of the average annual real increases since the turn of the century. In 2011-2 the prospect is for a slight real reduction in NHS funds through to 2012-3 and possibly beyond.

Pressures to do more, and do it to a higher standard, will be unabating, hence the Department of Health’s planning assumption that the NHS in England needs to find productivity improvements valued at between £15bn (£17bn; £23bn) and £20bn by 2013-4 to meet these pressures.

Being more productive is not about saving money or making cuts. These are not ends in themselves. The point will be to get higher volumes of higher quality care without spending more. Some parts of the NHS will be pressurised to do the same, if not more, at lower cost. The prices paid to hospitals will be frozen in cash terms over the next few years, putting pressure on hospitals to reduce their costs.

But this incentive carries a risk that hospitals may behave in other ways. Faced with the prospect of making a loss on a service where costs rise above the tariff price, one decision could be simply to stop production. Costs (and losses) are cut, but so too is the service, potentially reducing local access and hence quality for patients. Another decision could be to subsidise loss making services from more profitable areas of activity. Services carry on, but there is no productivity gain, merely a drain on surpluses.

For evidence of when a risk to quality turns to reality for a hospital under financial pressure, the Francis review of care from the Mid Staffordshire NHS Foundation Trust provides the most recent and distressing catalogue of management, clinical, and information failures.

For commissioners in primary care trusts the prospect of frozen budgets but increasing demand will prompt greater efforts to decommission relatively low value care in favour of high value care. Nothing wrong with that perhaps; the costs of low value care are cut and overall productivity (bang per buck) is improved. But the trade-off between relatively low and high value care may also be a trade-off between one group of patients and another. If an aspect of a quality health service is also equity, then here is an example of a trade-off between efficiency and equity. The net outcome—allowing for one patient’s welfare to be traded off against another’s—could be a reduction in quality; it depends what values are placed on the loss of equity and the gains in efficiency.

In a budget of billions it should be possible to squeeze more value from every pound without, at a minimum, sacrificing the quality of care. But the NHS is poor at measuring quality, and what goes “unobserved” can be at risk when the (misplaced) focus is on what gets measured—savings.

John Appleby chief economist, King’s Fund, London W1G 0AN
j.appleby@kingsfund.org.uk

Competing interests: None declared.

Cite this as: BMJ 2010;340:c1959

YES

We face a tough financial climate. We don’t know exactly how much we’ll need to save across the NHS, although the amount will be substantial. But it is not inevitable that cost cutting will reduce quality for two reasons.

Firstly, much activity has no value in the NHS so it can be cut without detriment to clinical outcomes or patient experience. NHS “better care better value” metrics highlight opportunities for this. Up to £0.5m (£0.56; $0.76) of savings are still available in most hospitals by reducing preoperative bed days. Potential to save millions of pounds exists, and more than 10% of bed days could be saved by reducing length of stay by 25% towards the mean value for matched patients.

Crump estimates that up to £3bn can be saved by tackling this kind of variation in the delivery of care. So, doing what we currently do, but doing it better, will make a good start towards the savings needed in the NHS, but it won’t be enough. The cuts we need will require a transformation of the way we work. We must look to the best health systems in the world for ideas.

Former chief executive of the Mayo Clinic, Denis Cortese, was surprised when he discovered, on the basis of an evaluation of performance, that Mayo delivers excellent clinical care at lower cost than many other health systems. (Cortese D, personal communication, 2010.)

He attributes Mayo’s success to its focus on the best interests of patients through integration and coordination of care. Integration ensures they connect the whole organisation so everybody knows everything about each patient and receives evidence based prompts about best practice. Coordination of services around patients and their carers—particularly when they leave hospital—is achieved through team work and by allocating a coordinating doctor and nurse.

Much activity has no value in the NHS so it can be cut without detriment to clinical outcomes or patient experience.
This improves communication, makes it easier for patients, and reduces duplication and waste.

The techniques that underpin integration and coordination are not rocket science. Mayo has used system engineers to design efficient processes of care since 1901. The NHS Institute’s “Productive” programmes aim to introduce similar techniques in the NHS. Mayo also excels at data integration, linking all clinicians through a single electronic record. We’re not there yet, but some primary care trusts have developed data systems linking GPs, community services, and hospitals, so we know data integration is possible in the NHS (Burke C, personal communication, 2009.)

Mayo also makes selective use of financial microincentives to change and improve clinical practice for selected conditions—as we do with the GP quality and outcomes framework. Finally, it minimises incentives to over treat. Cortese concluded that using this combination of methods, Mayo Clinic utilisation rates are 30-35% lower than other systems, and they are not an exception. The Commonwealth Fund Commission on high performance health systems describes other high performing health organisations using similar techniques, many of which are used in the NHS.

These institutions evolve over years and we have little time before the financial axe falls, so we need to move fast to get some ingredients in place. Firstly, we need medical leadership, which is a key feature of all these organisations. Their boards typically include leaders, and for the first time in the history of the NHS, the head of the board took a greater interest in the running of the trust (as it did in the past, didn’t we? Who needs a system that only gives bad news?)

Secondly, to improve quality and continuity of care and reduce duplication and waste we need rapid development of data linkage systems. Thirdly, we need novel governance and accountability arrangements that can blend professional and patient expectations to set reasonable goals for the turbulent near term future. This will require effort and innovation, but high performance health systems show us the rewards available if we get it right.

Rebecca Rosen senior fellow, The Nuffield Trust, London W1G 7LP rebecca.rosen@nuffieldtrust.org.uk

Competing interests: None declared.

Cite this as: BMJ 2010;340:c1967

For NHS clinical staff, cutting costs is a way of life. When I was a final-year student in 1970, extra beds were squeezed into the middle of the wards. When I was a consultant in the 1980s, the financial formula was simple: your department’s budget is the same as last year’s, minus 2%. Through good times and bad this mantra has never changed, except that “department” is now “team.”

So my first reaction was that the coming lean years will make little difference. Writing this article, however, made me face facts. Eighteen per cent of government spending goes on health—second only to work and pensions (28%) and ahead of education at 13%. (Why do politicians talk of “schools and hospitals” when it should be “hospitals and schools”?) Only 6% goes on defence. In the post-election crunch, health cannot escape cuts.

The NHS costs about £100bn (€113bn; $153bn; 2009 figures) a year, a sum big enough to be meaningless to me. The budgets of our local primary care trust (a mere £1bn) and acute trust (a cosy £873m) are easier to understand. Half of the trust’s money goes on doctors, nurses, and scientists; a quarter on drugs and clinical supplies; 10% on ancillary staff, administrators, and managers; and another 10% on the buildings. When cuts come, sacking ward clerks and privatising cleaners won’t avoid the need to stop replacing doctors and nurses.

In the cycle of boom and bust, what fluctuates most is forward planning. The good years brought us a new cancer wing, and the subsequent chill meant the cancellation of a women’s and children’s hospital. When times are hard women’s services are an easy target. My psychosexual clinic disappeared as soon as I retired last year. Anger about child abuse is cheap, and so are services for its lifelong victims, but they don’t figure among NHS quality targets.

Lack of planning means future problems. In 15 years’ time there will be a million more pensioners, who are the biggest users of NHS services, but services won’t be ready for them. Current changes in society are already damaging care. With excessive working hours now illegal, rotas are impossible to run without relying on locums. Agencies are sending out desperate emails even before cuts begin to bite.

Quality is measured in different ways by three different groups—officials, patients, and clinicians. In the good years, official targets were met by throwing money at them. Consultants were paid to do extra operating lists. Taxis were hired to deliver appointments when deadlines loomed. Now that such extravagance is impossible targets will be modified and the quangos which assess them quietly abolished. We got along without audit in the past, didn’t we? Who needs a system that only gives bad news?

Patients measure quality by the kindness of staff. You used to get sympathy if you made it obvious that you were rushed off your feet but were doing your best. This generally worked if you already knew the patient. Today’s doctor, usually an unfamiliar face, doesn’t get off so lightly, and today’s patients sometimes have the temerity to expect an efficient service.

But the people who truly measure quality are the clinicians. In today’s maternity services, senior midwives and doctors have to comfort younger colleagues reduced to tears by the disparity between what they want to do for patients and what they can do. This is just one example of the human cost of the bland phrase, “efficiency savings,” that we shall hear so often in the coming years. Does all this amount to substantial damage? After 40 years of “minus 2%,” I think so.

James Owen Drife is emeritus professor of obstetrics and gynaecology, Leeds General Infirmary, Leeds LS1 3EX j.o.drife@leeds.ac.uk

Competing interests: None declared.

Cite this as: BMJ 2010;340:c1966

References are in the versions on bmj.com