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More than money: closing the NHS quality gap

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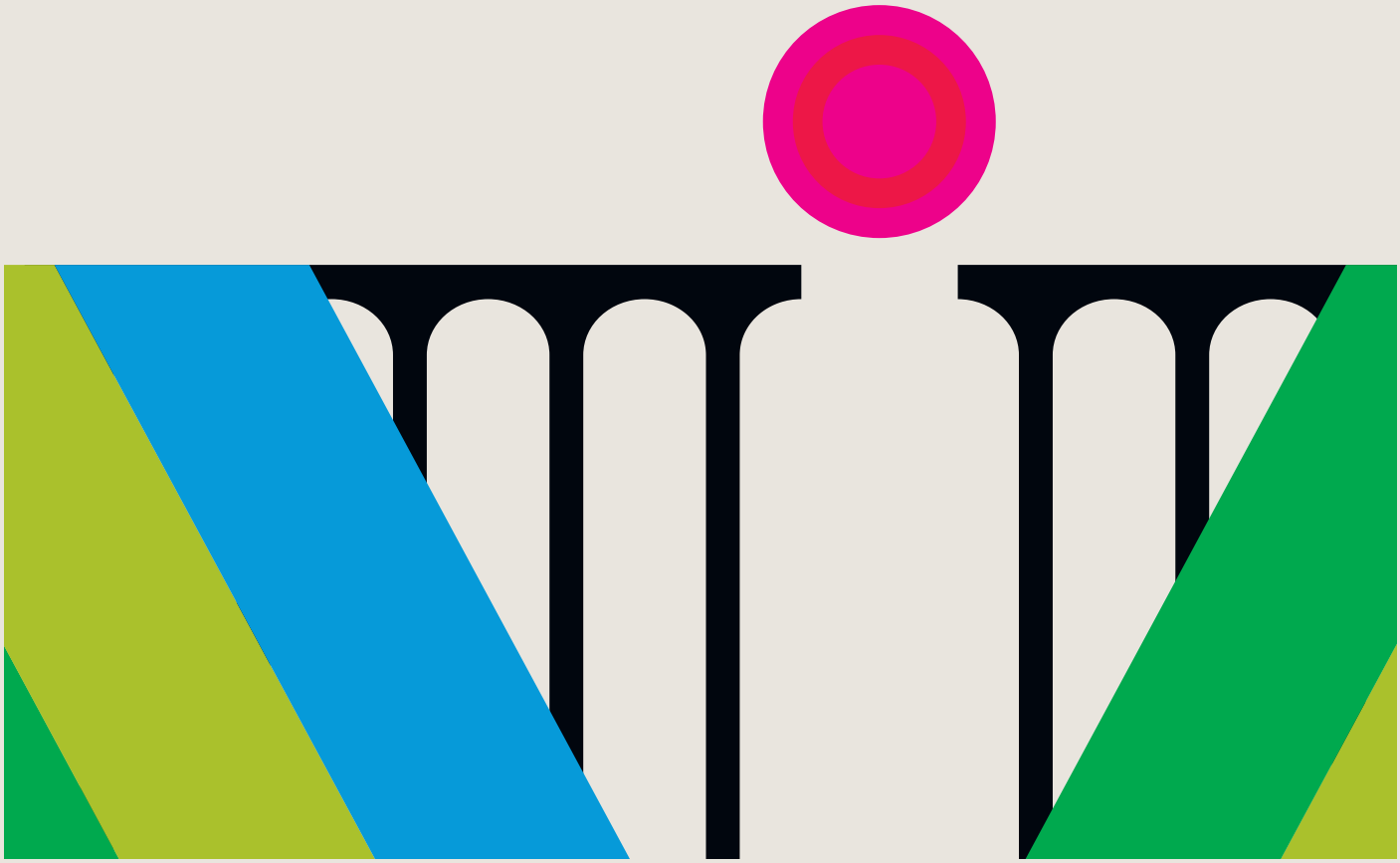

Policy analysis

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About this report

That the NHS faces a significant financial challenge is well known and much discussed. This 'financial gap' has been projected to reach £30bn by 2021. This is due to the disparity between the pressures on the NHS and the projected resources available to it.

This report explores what the financial gap means for quality of care. It draws on three specific pieces of work to help explore the issue:

1. **A workshop with NHS and foundation trusts on how they are likely to react to financial pressures.** A group of 25 senior NHS leaders considered how a hypothetical financially challenged trust could achieve financial balance while maximising quality, and the impact of these decisions on patients and service users.
2. **A scan of available evidence about how six other countries have dealt with austerity.** A study focused on six countries (Denmark, the Netherlands, Ireland, Spain, Portugal, Canada) and examined the most common health care policy responses to financial pressures and their impact on cost and quality.
3. **An analysis of options available to the NHS for closing the financial gap.** A summary and discussion of proposed ways to close the financial gap through productivity savings or other methods of reducing costs, drawing on a number of recent reports.

We present this report as a contribution to a complex and contested topic and a prompt for further discussion and analysis.

Acknowledgements

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Key points 1

The NHS in England is four years into what is projected to be the longest period of austerity in its history. Spending growth has averaged just 1.3% between 2010/11 and 2013/14, a stark contrast to the rapid growth in the previous decade, where spending growth in the NHS averaged over 6%.

The scale and urgency of the financial challenge currently facing the NHS pose risks to the quality of care it provides. This is because estimates of the potential savings from productivity improvements – changes that save money while maintaining or improving quality – are insufficient to close the financial gap. This gap is projected to reach £30bn by 2021 (if NHS funding continues to grow broadly in line with inflation).

Countries such as Ireland, Spain and Portugal have responded to severe constraints in health funding by using a range of nationwide 'supply-side' measures, such as cutting wages and restraining prices for health care, and 'demand-side' measures, such as increasing user charges or restricting access to services.

In England many of the same supply-side measures are already being used. However, there are limits to these nationally applied options, in particular how much longer NHS pay can be constrained. Any benefits from increasing user charges are likely to be outweighed by a detrimental impact on equity of access to care.

At the same time as addressing the financial challenge facing the NHS, there is an ongoing challenge to improve health care quality – that is to close the gap between what the NHS should deliver and what it actually does deliver.

Despite many successes in recent years – for example reductions in health care acquired infections and improvements in 30-day survival rates – there still remains much to do to. High quality care is not consistently delivered across England: for example, an unacceptably high number of people are avoidably harmed in the course of receiving health care. We are also starting to see quality get worse in specific areas such as access and mental health.

Shortfalls in quality of care are not isolated to times of financial crisis, and there have been examples of poor quality during times of plenty as much as constraint. However, the current financial pressures make the task of closing the gap between what the NHS should deliver and what the NHS is capable of delivering, even more difficult.

If the population of England wants to maintain quality of care and the comprehensive nature of the NHS in the short to medium term, what is needed is a set of changes that speed up efficiency, alongside ongoing additional funding. The amount of extra money needed will depend on how effectively and quickly change can be delivered, and it is crucial that the mechanism for how funding is distributed to providers of care works to incentivise, not distract from, delivering changes.

As such, the primary implication of the financial challenge is the need to change how care is delivered, not how the NHS is financed. Changing how health care is funded would not reduce the imperative to become more efficient. Each of the six countries reviewed in our evidence scan have tried to increase efficiency in response to austerity – and through similar means, despite very different funding models.

Across the Organisation for Economic Co-operation and Development (OECD), health care is funded and organised in many different ways but no one 'type' of health system appears to outperform another. The variations in performance within each 'type' of health system are greater than those across them. Debates and analysis about how health care across the UK may be better financed are wholly legitimate. Yet these are different to debates on how to meet health care needs within available resources most effectively, which is the key question at hand and needs to be addressed regardless of the system of financing.

There are a range of opportunities available for the NHS to become more efficient. Analysis by Monitor estimates that total recurrent productivity gains of £10.6bn to £18bn could be achieved by 2021, representing opportunities to 'close' between 35% and 60% of the £30bn funding gap.

There is also a growing consensus across a range of different stakeholders that the way to care for patients better, and potentially achieve greater efficiency, is more coordinated care across different settings, more care provided outside of hospitals, and a greater role for patients through self-management and shared decision making. These changes are complex, not least because the evidence underpinning these measures is variable.

The complexity of the changes required means that they are unlikely to be delivered quickly. Instead there needs to be sustained support in the short to medium term and across different levels of the NHS. Close attention also needs to be paid to reducing unnecessary barriers to new providers who may offer innovative fresh approaches to NHS-funded care, benefiting patients.

Our work with NHS trusts and foundation trusts and the international case studies examined in this report both highlight the tension that exists between managing performance in the short term and delivering longer-term change.

With such strong pressures to maintain performance in the short term, achieving long term change requires specific, dedicated support.

Three forms of support needed to close the quality gap:

- **Systematic improvement support for providers:** The key bodies within the health care system should support providers of care in implementing improvements to services, both within their own organisation and working with other providers to deliver integrated care. Such support might include building skills in basic management, change management, improvement skills and analysis, all with the objective of improving quality and efficiency.
- **Targeted resources:** Two types of funding are needed: first a 'transformation fund' to allow new services to be introduced and existing services to be improved; and second, as the financial gap cannot be closed by productivity alone, ongoing additional funding is also required.
- **Political openness and support for change:** Political support is critical for the changes needed both in the short and medium term. A start would be a new candid dialogue between politicians and both the public and NHS about the challenges, and why significant change is needed now.

Introduction 2

The financial pressures facing the NHS* in England are widely known and have been extensively discussed. The Nuffield Trust has calculated that there will be a shortfall in funding of around £28–34bn by 2021.[1] NHS England's own estimates place this 'financial gap' at £30bn, also by 2021.[2]

This report looks at the implications of the financial gap for quality of care, using the definition of quality as:

- care that is clinically effective – not just in the eyes of clinicians but in the eyes of patients themselves
- care that is safe
- care that provides as positive an experience for patients as possible.[3]

We use the concept of a 'quality gap' to refer to the gap between expectations of what should be delivered and what the NHS is capable of delivering.

Quality and money: the NHS context

Cost pressures on the NHS are projected to continue to grow at 4% a year. A growing and ageing population, rising incidence of chronic conditions and increasing input costs (principally pay) are all increasing pressure on the NHS.[1] However, funding is projected to grow by an average of only one-tenth of this, 0.4% in real terms (ie, adjusted for inflation) in 2014/15 and 2015/16.[4]

The disparity between cost pressures and funding growth is contributing to a rapid deterioration of NHS finances in England. The number of NHS and foundation trusts recording a deficit rose by 50% in 2013/14, to 66 from 45 a year earlier,[5] with the whole NHS and foundation trust sector slipping to a £100m deficit in 2013–14.[6,7] Only 36% of NHS and foundation trusts are confident that they will be able to meet their financial targets in 2014/15.[8] Financial problems are not restricted to secondary care: for example, general practice is coming under increased strain,[9] with predictions of rising numbers of consultations amid reports of a declining share of the overall NHS budget, and challenges in meeting the growth required in numbers of new GPs entering the service.[10]

* This report focuses on the NHS in England. However, the issues it highlights are relevant to the NHS across the United Kingdom.

According to evidence from QualityWatch (a joint project between the Nuffield Trust and the Health Foundation), the NHS has so far broadly maintained quality during the funding squeeze, albeit with significant variation between local areas. For example, health care acquired infections, screening for venous thromboembolism and 30-day survival rates[11] have all seen significant improvements over recent years. The King's Fund quarterly monitoring report also shows some optimism about patient care: in June 2014, 73% of NHS and foundation trusts thought that care in their area was the same or better over the previous year, up from 66% in July 2013.[12]

But cracks are starting to appear, particularly in access,[13] where providers have increasingly struggled to hit performance targets relating to accident and emergency (A&E) and 18 week maximum wait time for treatment. The national target for A&E, that 95% of patients are seen within four hours, has not been met by major units since July 2013.[14]

The 62-day wait for first cancer treatment from GP referral target was missed in the final quarter of 2013/14 for the first time since it was introduced, and has continued its decline into 2014/15.[14] In addition, there are signs of pressure within mental health services where, particularly for younger people and urgent care, it appears capacity is unable to keep up with demand. From 2008/09 to 2012/13, the number of mental health beds available decreased by 17% (from 26,448 to 21,949).[15]

There is limited evidence from NHS history about the implications for quality of continued austerity, not least because the NHS has never before experienced a comparable funding squeeze. The tightest previous four-year period in the last 50 years for the NHS was between 1975/76 and 1979/80 when there was a real increase in NHS spend of just 1.3%. However, the current limited growth is expected to continue beyond the initial four-year period. The historical evidence that does exist is mostly anecdotal, pointing to a 'silent erosion'[16] of quality during previous times of constraint. Given the wealth of information we now have available on quality of care, there is no longer any prospect of quality slowly and quietly declining unnoticed in the way that may have been the case during previous periods of austerity.

How can NHS providers respond?

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MORE ➲
The full write-up of the event – *Can the NHS maintain quality without additional resources?* – is available at www.health.org.uk/publications/can-the-nhs-maintain-quality-without-additional-resources

In August 2014, the Health Foundation and the Foundation Trust Network held a workshop with senior representatives of 25 NHS and foundation trusts – acute, mental health, community and ambulance – to explore the likely effects of the financial gap on the quality of care they provide.

Key findings

- **Financial constraint can be a key driver of transformational change.** New models of care – preventative services, coordinated care and better use of technology – are necessary to improve quality of care and efficiency. The financial challenge can provide both an opportunity and a threat to the ability of the system to make changes at the scale or pace required.
- **There is a commitment from NHS providers to protect clinical quality and safety at all costs.** Participants wanted to prioritise clinical outcomes and safety, and found it difficult to accept options that might reduce quality even when all efforts to improve productivity had been exhausted.
- **Difficult choices need to be made both politically and at local health economy levels.** Participants acknowledged that current activities to achieve efficiency savings will not go far or fast enough, in which case quality of care will be at risk in the immediate future.
- **To achieve faster change, collaborative leadership and effective management will be needed.** No service exists in a vacuum. This is true within provider organisations, but particularly across the whole health economy where leaders will need to work together on system-wide solutions.
- **It is vital that national regulatory and policy frameworks enable and support local change.** This includes effective, proportionate and risk-based regulation, appropriate payment mechanisms, and pump-priming investment to support the immediate costs of change. Providers may then wish to seek other forms of support locally to free management time ('headroom') to focus on more medium-term changes, to build management capability where needed, and to ensure effective, objective methods to evaluate progress.

Participants at the event were provided with a hypothetical case study of an acute–community NHS foundation trust with a turnover of £280m, predicting a £4m deficit in 2014/15 rising to a £30m deficit in 2015/16. They were asked to set out how they would achieve financial balance for the trust; running a deficit was not allowed in either year. Participants were then asked how those external to their organisation could help them meet this challenge, and what they would do if additional resources in the form of 'new money' became available.

Overall approaches to reducing the deficit

There was a strong commitment to safeguarding quality of care. Participants were clear that they needed to pursue 'quality-positive' or 'quality-neutral' measures in the first instance, with a belief that there was more that the fictional trust could do to achieve greater efficiency savings. However, participants acknowledged that some areas of quality may be at risk if the hypothetical provider's focus was concentrated on short-term imperatives to prioritise certain areas and away from a more rounded view of the organisation's performance.

'I am sorry, I just can't sign up to that [compromise quality in order to avoid a deficit]… I would rather overspend than do that.'

Director of Finance, Acute Trust

There was a common theme that, to maximise quality overall, the hypothetical organisation would need to decide which aspects of quality it would look to prioritise. However, this was set within a wider debate about whether in reality boards would feel willing or able to take active decisions which have a negative effect on specific areas of quality. Most participants felt that the more likely scenario was that quality would decline in a less predictable way through a series of indirect changes and unintended consequences.

Participants were clear about how difficult a challenge closing the financial deficit was, stressing the need to be completely open with patients, staff and their boards. There was a consensus that the best way to minimise any negative impact on quality was to work collaboratively with partners within the local health and care economies. There was a discussion about the need for individual organisations to also be honest with themselves as to whether they were sustainable in their current form.

Participants agreed that the challenge for the hypothetical trust was not just about meeting financial balance in the two years they were asked to consider, but making those changes 'stick' for the long term. Without sustainable change, the trust risked putting off problems for later, or merely shifting the problems on to wider services in the local health economy.

The need for short-term efficiencies and longer-term 'transformative' change were not felt to be mutually exclusive; rather both were needed if quality was to be maintained now and into the future. However, participants felt that there was a risk of the short-term priorities crowding out the opportunity to focus on more sustainable solutions.

Responses to financial challenge: short term

Efficiency savings that were perceived as having less of an immediate risk to quality of care were top of many participants' lists, with improved use of IT and reductions in back office functions commonly given as examples. Others targeted longer-term investments such as IT projects, estates and infrastructure development, research and training. While it was acknowledged that these decisions might have an adverse impact on quality in the medium to long term, people felt they were less likely to directly impact patient care in the short term.

Participants thought it unlikely that efficiency savings alone would be enough to close the funding gap, whether within the hypothetical trust or more widely in the real NHS. Therefore, measures that would either directly or indirectly affect the quality of care may need to be considered. During the course of the discussion it became clear that each of these options was likely to raise politically sensitive choices in the real world.

'There is no way to achieve financial balance without the wage bill going down.'

Chair,
Acute Trust

First, maximising the efficiency of the workforce was a consistent theme, as the overall wage bill represents the bulk of provider expenditure (ranging from 60% to 85% of total trust budgets).[17] A number of opportunities to increase efficiency were identified, such as adjusting skill mix, reducing the use of agency and bank staff and updating Agenda for Change conditions (the standardised system of grading and pay bands within the NHS[18]) to become more flexible. However, it was noted this would be politically volatile and could have a negative impact on quality if staff morale declined, recruitment or retention became more difficult and staffing levels altered.

Second, it was suggested that some areas of quality might be compromised in a bid to prioritise clinical outcomes and patient safety. Participants felt that access and patient experience would be more likely to be at risk during a period of financial constraint. While some individuals gave examples of specific actions they would consider taking in order to reduce the deficit (Figure 1), the group found it difficult to agree on which areas they would be content to see taken forward. Unsurprisingly, participants had different views on the relative value and impact of such choices, emphasising that these are not simple decisions to make.

Figure 1: Actions participants might consider taking to reduce the hypothetical trust's financial deficit*:

Short-term actions perceived to present less of an immediate risk to service quality:	Short-term actions that participants thought were not 'quality-neutral' but could be considered if pushed:	Short- to medium-term actions that individuals suggested may support wider changes in how care is delivered:
• reduce bank and agency spending (where possible) • shelve estates or capital investment projects • reduce research spending • reduce or share back office support staff.	• prioritise access targets by clinical need (eg allow some 18 weeks referrals to slip in non-urgent cases) where this did not impact on safety or outcome • de-prioritise hitting mixed-sex accommodation targets • reduce hours of access where clinical outcome and patient safety were not compromised • reduce training budgets for non-essential development • drop some mandatory or regulatory targets not seen to add value to a particular service.	• invest in primary care and other preventative measures – including introducing GPs in A&E and other means of working more closely with primary and social care • recruit and train care coordinators in the community • consider projects that enhance the use of community-based support, eg 'discharge to assess' schemes (home-based, multidisciplinary ongoing needs assessments) • access to electronic single patient records • patient ownership of own medical record • explore how and if seven-day services could improve patient flow and potentially release efficiencies for particular services.

* *These are examples given by individuals and do not necessarily represent the consensus opinion of the whole group.*

'If we work together we can achieve a transformation in how care is delivered.'

Chief Executive, Acute Trust

Responses to the financial challenge: long term

Participants' preferred response to austerity, both for the fictional trust and more widely, was to make transformational change to services to achieve a more efficient health service beyond short-term fixes. A key theme was integration, working across different providers and commissioners in a local health economy to take a whole system approach to reforming services. Complete patient pathways would need to be improved to ensure people received the most appropriate care for their needs, in particular preventing avoidable emergency admissions and facilitating swifter discharge processes. Many participants viewed constraint as an opportunity to stimulate innovation and provide the impetus for change. However, there was recognition that these longer-term actions may be unlikely to solve the short-term problem, as savings would take time to deliver and even then, the evidence base for the impact of some of the proposed new models of care is still emerging.

Participants were clear that the transformational change needed would be hard to achieve, and would need specific support. This support fell broadly into three areas:

- Financial resource to support transformation – for instance to allow for a period of double running of existing services while new services are being established.
- Significant support for improvement capacity and skills within the system – including facilitating greater partnership working among providers and commissioners.
- Consistent messages from all within the health system at both local and national levels to ensure 'system rules' and ways of working were helping not hindering change.

How the system could support change

Participants felt that there were a number of additional factors that could prevent them from carrying out sustainable change. They described a lack of headroom, or thinking space, to make decisions about the future of their organisation, with the political cycle, short-term contracting and one-off non-recurrent funding for short-term priorities all cited as barriers to longer-term thinking.

Overall, participants felt that collaborative, local leadership was needed to drive the necessary changes, working together with partners for mutual benefit and, where appropriate, pooling risk. Participants suggested the system rules, for instance some payment mechanisms, were currently not designed to incentivise cross-organisation working. Some participants spoke of a feeling of exclusion from strategic decision making across their areas, perceiving that there was a lack of an appropriate forum to bring together partners across both commissioning and provision. There was a general view that reform of some of the system rules was necessary, yet this was coupled with a clear view that further extensive structural reform would be deeply unhelpful in meeting such a difficult operational challenge.

What can we learn from other countries?

4

MORE ➲
The full evidence scan, *International responses to austerity*, is available at www.health.org.uk/publications/international-responses-to-austerity

To learn from international experience, we commissioned an evidence scan (a rapid review of the available empirical evidence) of the responses to austerity of six countries: Canada, Denmark, Ireland, the Netherlands, Portugal and Spain. The work was conducted by a team of researchers at ICF International, led by Dr Jo Ellins. This section summarises their conclusions.

Key findings

- **A narrow range of options have been pursued.** In responding to austerity, the six countries reviewed (Canada, Denmark, Ireland, the Netherlands, Portugal, Spain) sought to pursue a relatively narrow range of options. These generally aimed to blend a mixture of short- (often cost-cutting) and long-term (for instance redesigning how services are delivered) measures.
- **Mechanisms for monitoring the effects of very significant reforms were poor.** Countries have limited evidence to be able to show whether quality of care or population health more generally has been affected.
- **The financial crisis presented both a stimulus and a barrier to health system reform.** It was seen to have strengthened the case for change. However, increasing demands on staff risked reducing capacity for delivering such change.
- **Short-term measures were more likely to be implemented than longer-term reforms.** Short-term measures, such as increasing user co-payments and decreasing workforce salaries and pharmaceutical prices, have been more dominant than attempts at longer-term reform. However, these short-term measures are unlikely to be sustainable in the long term.
- **Successful reform strategies have been based on strong central leadership and constructive engagement.** Reflections on success in Canada and the Netherlands in particular reinforced the crucial role of political and health system leaders in driving and shaping reform.

The global financial crisis, which started in 2007, has been one of the most severe economic recessions on record and its impact is still keenly felt today. In response, governments worldwide have made cuts to public spending. While health has been relatively protected compared to other sectors across most OECD countries, expenditure on health has typically been cut, frozen or its growth has slowed.[19]

In the appendix to this report, Figure A1 summarises the principal measures the six case study countries took. Figure A2 summarises the impact broad groups of measures had on quality and cost, as well as their sustainability.

The six countries examined and their health systems are diverse. They have also been affected by the financial crisis in a variety of different ways. However, several common themes emerged from the analysis of the evidence reviewed.

Countries pursued a narrow range of measures

Overall, countries pursued a relatively narrow range of responses, with efforts at cost saving and containment largely focused on a handful of strategies targeting areas such as user co-payments, workforce salaries and/or working conditions and pharmaceutical pricing. Most countries sought to blend measures to achieve immediate or short-term cost savings with some elements of structural reform, most notably restructuring hospital services.

Major changes are being made without any programme to monitor or evaluate their impact

None of the countries examined appear to have put in place mechanisms to monitor and/or evaluate the impact of the budget cuts or austerity measures that have been implemented. In effect, major policies are being enacted – many of which do not have a strong evidential basis – without any commitment to understanding their impact on service access, delivery, quality or outcomes, or on population health more generally. Some high-level indicators of system performance (eg waiting time data, activity data) are available, although these are of limited value in tracing the specific impact of austerity measures and problems of attributing cause and effect are rife.

Financial crisis presents both a stimulus and a barrier for health system reform

The findings from the scan suggest that the recent financial crisis has brought the issue of reform to the fore, strengthening the case for change and providing an opportunity to open up debate to a wider audience. Several countries intensified or extended existing processes of reform, while others introduced measures that might – in other conditions – have been unacceptable or considered too sensitive to pursue.

Politically it is more important to have short-term successes than to prepare for long-term gains.

Clemens and colleagues[20]

However, the financial crisis does not necessarily make the process of agreeing and implementing reform easier. This remains politically challenging, and often highly contentious, whether there is perceived to be a 'burning platform' for change or not.

The evidence gathered indicates that financial crisis also creates barriers to bringing about change on the scale that is required. A key issue is that the task of balancing budgets places increasing demands on staff and managers at a time when the workforce may be contracting. These increasing demands reduce capacity for, and may intensify resistance or apathy towards, longer-term system redesign and reform.

Short-term measures to control costs have been more prevalent than efforts at structural reform, yet are unlikely to be sustainable

For those countries that have had more defined 'austerity' responses (Spain, Portugal, Ireland, Canada), immediate financial stability and longer-term financial sustainability have been pursued simultaneously. This is particularly true for Portugal, where it is clear that key aspects of the austerity programme are seeking to address long-standing problems within the health system. Portugal also had conditions imposed as a result of a bailout from the Troika (the European Commission, the International Monetary Fund and the European Central Bank), which included substantial cuts to public expenditure; under a legal obligation to comply, the case for change was potentially increased.

In practice, however, across all the countries reviewed, short-term measures have been dominant, or have been far more likely to be implemented. Such measures include wage restraint (ranging from freezing salaries through to wage cuts of 5–30%, either in individual professions or right across the public sector), increasing user co-payments, changes to pharmaceutical pricing and service reductions (eg limiting opening hours) or closures (eg wards or beds). This situation, of course, may reflect the longer timescales involved in planning, designing and implementing structural reform. Equally, it might suggest that actions to cut costs have taken priority over longer-term goals. Whichever of these is correct, there is a risk that short-term cost saving measures have to be traded off against service quality and provision.[21]

As the wider literature shows, the emphasis on 'quick fixes' is evident in policy responses to austerity generally,[21] as well as in relation to strategies for hospital reform[20] and pharmaceutical policy.[22] For example, an analysis of strategies for European hospital reform in times of economic crisis led Clemens and colleagues to conclude that:

'evidence from previous crises suggests that reductions in expenditure growth have always been only a temporary fix and that health spending growth resumes as soon as economies begin to grow again.' [20]

Reductions in expenditure growth have always been only a temporary fix

Clemens and colleagues[20]

Some evidence of this is also provided by the Canadian case study, which looked at Canada's response to a financial crisis in the early 1990s – earlier than the other countries studied. For example, the workforce reductions made in Canada during the 1990s were subsequently reversed from 1999 onwards – once the country was out of recession – and the size of the clinical workforce has grown steadily since then.[23]

Successful reform strategies are based on strong central leadership and constructive stakeholder dialogue and engagement

A clear message emerges from both Canada and the Netherlands about the importance of openness and honest debate, as well as broad and ongoing stakeholder consultation and engagement. In no small part, the successful implementation of structural reform in these countries seems to be linked to the willingness of political and health system leaders to front up reform processes and engage in a genuine dialogue with professionals and the public.

The need for engagement is also evident in what has happened in Spain, although here its importance is arguably demonstrated by its absence. Spanish austerity measures have been resisted in some cases and subverted in others, such as reports of clinicians identifying themselves as 'conscientious objectors', vowing to continue to treat undocumented immigrants who had been excluded from access to services.[24] Opposition has been driven not only by the content of the changes, but also by the way they have been enacted, which influenced how they are perceived. For example, in Spain, resistance came from the clinical workforce in particular, based on views that some of the proposals lacked evidence or were being imposed in a top-down, unilateral manner.

The evidence assessed in the scan does suggest a number of factors that appear to enable longer-term structural reform. These include:

- whether there was already a clear vision and strategic direction for system reform in place beyond the imperative caused by the financial crisis
- the severity of the financial situation and scale of the need for immediate cost savings
- willingness and ability to make investments in alternative provision to support transformational goals (such as hospital restructuring)
- political preferences of the ruling party and influence of external bodies (such as the Troika)
- the extent to which proposed changes are grounded in (or are perceived to erode) the values and principles on which the health system is based.

What also comes through from the Canadian experience is the need for national leaders, including politicians, to lead the case for reform. Summing up the lesson from the major restructuring of the hospital sector achieved in Ontario and Saskatchewan, Thorlby asserts that:

'Although each province adopted very different approaches, central drive and strong leadership were key features in both cases. This was underpinned by an awareness that local organisations, left to themselves, were unlikely to reform services, however strong the plans or the financial imperative.'[25]

Central drive and strong leadership were key features

Thorlby[25]

The case study countries provide some, limited, evidence about the impact of austerity measures on costs and quality of care

Disentangling the effects of multi-component austerity packages is highly challenging. Attempts to do so will always run into concerns about attributing cause and effect over a long period of time, in systems that are highly dynamic and which operate within wider contexts that are ever changing. Accepting this caveat, the evidence scan did identify some indications of the early impact of particular strategies and approaches that have been taken (for details see Figure A2 in the appendix). This evidence should be treated as tentative, because for many of the studies concerned the period of analysis was relatively short, and therefore longer-term outcomes are still unknown.

How can the financial gap be closed?

5

There have been a number of recent proposals put forward for how the NHS might close the financial gap. This section summarises and discusses these proposals.

Key findings

- **There are significant opportunities for productivity savings in the NHS.** These have been estimated at £10.6bn to £18bn by 2021 and include making existing services more efficient, ensuring care is delivered in the most appropriate settings and developing innovative new models of care delivery.
- **The chances of effectively delivering productivity savings depends on the capacity and capability organisations have to manage change.** Chances of success are increased with committed leadership, staff ownership, effective use of information, and strong partnership working.
- **Selling unnecessary estate could help the NHS raise revenue, with the value of underused estate estimated at £7.5bn.** However, this would be a one-off saving, and there are reasons to doubt whether such a figure is achievable.
- **Pay restraint has already been one of the major contributors to savings realised by the NHS over the past four years.** However, there are questions about whether this can continue in light of rising private sector wages, and concerns over the possible consequences on recruitment and retention.
- **User charges have been proposed, for example charges to see a GP.** While this may have the potential to raise revenue, it would be highly likely to have a detrimental impact on equity.

Opportunities for sustainable productivity savings

Providers at our workshop told us that they would need to exhaust every avenue for productivity savings in their organisation before they could contemplate any of the more controversial options for addressing the financial challenge. Similarly, 76% of the Nuffield Trust's Health Leaders Panel thought that productivity savings could be achieved without harming patient care.[26] Analysis by Monitor estimates that total recurrent productivity gains of £10.6bn to £18bn could be achieved by 2021.[27] This would represent 35% to 60% of the funding gap, a very significant proportion. This is broken down further in Figure 2.

Figure 2: Opportunities for NHS recurrent productivity gains by 2021[27]

Improving productivity within existing services	Delivering the right care in the right setting	Developing new ways of delivering care
Options include: • measures to reduce waste and running costs • improving procurement • reducing length of stay in hospital • collaborating better with social services • redesigning clinical roles • avoiding procedures or drugs of low clinical value. Taking 2010/11 as a baseline, it is estimated that these plans could yield gains of £6.5bn to £12.1bn by 2021.	Many patients could enjoy better outcomes at lower cost to the NHS if their care was delivered in a more appropriate setting. For example, increasing care in the community for the millions of people who live with one or more long-term condition could both improve their experience as patients and reduce costly hospital visits. Similarly, concentrating resource-intensive specialist care in centres of excellence could improve the standard of care and capture economies of scale. The evidence suggests that reconfiguring services and integrating care effectively across providers could yield productivity improvements in the region of £2.4bn to £4bn by 2021.	It is estimated that introducing innovative models of care to services in primary and secondary care could deliver £1.7bn to £1.9bn of productivity gains by 2021. As gains from innovation are by definition unknowable, such gains could be significantly bigger.

A number of other studies have reinforced the potential for significant productivity gains across the NHS. These studies have looked at similar areas to those covered by Monitor, meaning the savings identified should not be seen as being additional to those set out above.

The King's Fund report, *The NHS Productivity Challenge*, estimates a total of £5.9bn could be saved through a range of clinical improvements such as reducing length of stay, increasing day surgery rates and reducing unnecessary emergency admissions.[28] Implementing NICE guidance on potential savings, compiled for the Quality Innovation Productivity Prevention (QIPP) programme, could achieve savings of £2.2bn.[28]

In 2011, the National Audit Office estimated potential savings of around £500m could come from better coordinated procurements of goods and services across the NHS.[29] The NHS Shared Business Service has been working to achieve savings of around £224m by 2015 through productivity within support services such as finance, payroll and procurement.[30] However, a more recent report by the Department of Health and NHS England set a more stretching target – to achieve savings of around £1.5bn by 2015/16.[31]

Delivering sustainable change

Knowing where changes can be made to deliver productivity savings is part of the challenge, but the really hard work comes in considering how to deliver them effectively. Lessons from research into improvement projects in health care tell us that a wide variety of factors can help or hinder change, many of which rely on those delivering the change being supportive but also willing to own the change as it happens.[32] Broadly speaking, this requires:

- committed and supportive leadership
- ability for staff to own and lead change
- effective use of information to measure and support improvements
- partnership working across patients, service users and carers, professions and organisations.

Perhaps most importantly, improvement requires a large amount of skill and energy to drive it forward, navigate the challenges along the way and sustain focus. Providers at our workshop with the Foundation Trust Network told us that short-term imperatives can often divert focus away from longer-term goals and both are competing for the same resources. Dr John Øvretveit, in his report for the Health Foundation *Does improving quality save money?*, also picked up a lack of time, skills and motivation to undertake sustainable change in the face of other, more urgent demands.[32] This is reinforced by the House of Commons Health Select Committee in their assessment of the QIPP savings to date. In the committee's view, an overemphasis on individual provider-driven change, rather than a systematic and joined up approach to more transformational change, is putting the delivery of further savings at risk.[33]

Providers need support, both financial and non-financial, in order to make changes which both improve quality and release savings, but they cannot do this on their own. Øvretveit's work points to the need for incentives to be aligned across the system and for costs of investing in interventions and developing provider improvement capacity to be spread over time and between providers and commissioners. Investment in skills and behaviours which support improvement are also critical. A review of the international evidence on hospital productivity improvements by Rumbold and colleagues identified a particular need for high calibre general and clinical managers, who are equipped with the skills and confidence to work collaboratively between different professional and managerial groups within organisations, coupled with an openness to review and change local practice.[34]

Further options: Selling estate, pay restraint, user charges

Selling estate

The NHS estate is estimated to be worth a total of £31.2bn[27] and further savings are possible from rationalising its use. A 2013 report by EC Harris found that, while improvements had been made in recent years regarding the use of estate, the amount of wasted or underutilised space in the NHS in England is still the equivalent of London's Hyde Park.[35] The report estimated that if all organisations adopted best practice in facilities management and procurement and reduced still further the scale of unused space, the savings could yield £2.3bn annually.

Monitor estimates the one-off cash gain of selling underused estates across the acute and mental health sector as £7.5bn.[27] However, there are questions about how easy this figure would be to realise in practice. Long-term private finance contracts, the practical difficulties of selling off parcels of property on hospital sites and the costs of modernising estates all point to the risk that the gains could be much less than estimated.

Pay restraint

As demonstrated by the six international case studies in our evidence scan, wage restraint is frequently one of the first options used to reduce costs. While some countries (eg Portugal) froze wages, others (eg Ireland, Spain and Canada) also made reductions in health sector wages, ranging from 5–30%. These reductions either targeted specific professions (eg consultant doctors in Ireland) or were introduced right across the public sector. The NHS use of wage freezes over the past four years has, along with reducing the Payment by Results tariff, made up most of the 'QIPP' savings generated.[36] Furthermore, the Nuffield Trust has calculated that if salaries were only to grow in line with inflation, rather than returning to their historical average growth of 2% a year, the funding gap could be reduced by £8bn by 2021.[1]

Although the exact impact of continued pay restraint is as yet unknown, there are warnings around the negative repercussions of holding back wages, for example the attrition of staff and low morale, which are also likely to have a knock-on effect on quality.[1] So far, wage restraint has not appeared to lead to a large recruitment and retention problem in general.[28] However, it was implemented at the time when the UK's economy was at its weakest. Now the economy is improving the Office of Budget Responsibility has forecast an increase in pay rises across the UK. Restraining NHS wages while they are growing in other sectors could impact on NHS recruitment and retention. There are also questions about how sustainable wage restraint is; it can often be followed by periods of catch up with their trend level in subsequent years.

User charges

From the international case studies in our evidence scan, Spain, Portugal and Ireland all increased user charges considerably. A number of proposals have also been made for charges in the NHS in England. These include:

- a £10 charge to visit the GP, see a practice nurse or other primary care professional, or have a GP telephone consultation, potentially raising between £1.2bn[37] and £3bn annually[38]
- removing the blanket exemption from prescription charges for those aged over 60, restricting free prescriptions for older people to those on pension credit, potentially raising around £1.5bn annually[38]
- a £10 per month NHS 'membership fee', potentially raising up to £1.2bn annually.[39]

Such estimates generally do not take into account administration costs, bad debt from unrecovered charges, and the potential impact on behaviour change (eg reducing necessary as well as unnecessary demand), particularly the subsequent avoidable costs from delayed access to care. Therefore there are questions about the effectiveness of such charges as a revenue raising source. Nevertheless, such estimated revenues are not insignificant, and overall the UK has a low level of total private expenditure on health[40] and a low level of direct charges compared to the rest of the world.[41]

However, any implementation of new charges, even with very careful protection mechanisms, would be likely to have a detrimental impact on equity and health.[42] The experience from our international case studies shows that user charges can present a major barrier to accessing care, with disadvantaged groups most likely to be affected. In Portugal, following significant increases in the user charges, the proportion of those reporting unmet health needs who cite affordability as the main cause has risen from 49.9% in 2006 to 69.8% in 2011.[43] This suggests that charges can be a blunt tool for demand management, drawing little distinction between necessary and unnecessary activity. Equally, with public opinion split on the use of increased taxes to fund the NHS,[44,45] the appetite for further charges or fees is likely to be limited.

Discussion 6

Significant financial challenge is woven into the fabric of the NHS's history. It was present in its infancy, when the first user charges were introduced in 1952.[46] It appeared with Barbara Castle's so-called 'document of despair' in 1976,[47] which saw capital expenditure halved. Margaret Thatcher's 1988 NHS review followed on directly from the stock market crash on Black Monday the year before. Even during the 2000s, which saw the most prolonged funding increase in NHS history, more people saw lack of resources as the biggest problem facing the NHS than any other issue.[48]

So how is this time different? Isn't the NHS always requiring more money, yet somehow managing to get through? Two things stand out: the scale and the urgency of the current financial challenge. To date it has been possible to recycle money around the system to cover those parts needing a helping hand (effectively an opaque system of pooling financial risk). That risk pool – the wiggle room – has largely gone; the Department of Health's underspend on its total budget in 2013/14 was £305m, barely a fifth of what it was the year before.[49]

At present, there is political consensus that the NHS needs to continue to deliver the same or improved quality of care and breadth of service. If current trends continue, with no additional money and no shift in NHS productivity, this is unlikely to happen. The financial gap needs to be closed, and a combination of additional resources and increases in productivity are the tools to do it. Failure to do so poses a significant risk to the quality and safety of care, with the cracks already being seen having the potential to develop into a significant quality gap.

With no additional funding in the short term, significant savings would need to be made quickly. Our international case studies have illustrated the relatively narrow range of options other countries have reached for when faced with the same immediate challenge. Input costs were slashed: in particular pay and staffing levels were reduced and much lower prices agreed for pharmaceuticals. Access to services was also reduced, either through restricting the 'offer' of services available, or through increasing user charges.

However, it was striking that none of the countries examined appear to have put in place any mechanisms to monitor or evaluate the measures introduced. In the absence of hard and fast evidence on what will impact on quality, real-time measurement and evaluation should be used to assess the impact of change and make sure that steps are taken to mitigate against negative impacts during, not after, the event.

Our workshop with NHS and foundation trusts illustrated the types of unappealing actions providers would need to consider if required to achieve financial balance next year. This included decreasing the staff bill (reversing a trend of increasing numbers of staff following the Francis Report), reducing capital expenditure, reducing training and research budgets, allowing waiting times to grow, and having to prioritise which service areas and dimensions of quality would be protected at the expense of others.

Is this what lies in store for the NHS in England? Constraining pay has already been used, to considerable effect. However, at a time of increasing private sector wages, it is questionable whether continuing to hold wage costs down – or considering further reductions – will be sustainable without significant retention and recruitment issues. The latest Pharmaceutical Prices Regulation Scheme agreed in November 2013 will continue to make a contribution through restricting growth in pharmaceutical costs, although there appears to be little appetite to push prices down beyond this. Implementing additional user charges is very unlikely to receive political backing, and experience in our international case studies highlights both a harmful effect on equity of care as well as a lack of success in raising significant revenue.

However, the NHS is yet to exhaust the productivity savings available to it – and by a big margin. Such savings would not fully close the financial gap (meaning additional resources would still be required to maintain NHS services of similar quality and scope) but would potentially fill between 35% and 60% – a significant contribution.

The financial challenge therefore emphasises first and foremost the need to deliver a more efficient health service. It is wholly legitimate to debate and analyse whether the NHS needs a different financing model, particularly with demand for health spending (as a proportion of GDP) likely to continue to grow in England. However, achieving greater efficiency and quality on the one hand and how best to finance health services on the other are fundamentally different questions. Even with a different financing model, the question of how to improve efficiency would remain, as is the case in all health systems across the globe. Too great a focus on changing ways of financing health care risks distracting from the harder issue of how to achieve greater efficiency while maintaining or improving quality.

In order to make efficiency savings which are also sustainable and deliver the care that patients need, the clear message we heard from NHS and foundation trusts was to meet the financial challenge through major transformation of care across a whole health economy.

The ideas presented by providers in the workshop chimed with a broad consensus of what the NHS should look like in the future, seen through proposals put forward by the Integration Pioneers, a number of Better Care Fund plans, and whole system blueprints such as those for London[50] and Liverpool.[51] Common themes from all these sources are shown in Figure 3.

Figure 3: Proposals for NHS transformation

- A focus on integration across care pathways (for instance avoiding duplication of home visits by different agencies)
- Greater investment in capacity outside hospitals including primary care, community services, social care and nursing homes
- Learning lessons from previous service changes, for example the opportunities of greater specialisation where this can improve clinical outcomes
- Multidisciplinary teams providing seven-day services
- A primary goal of supporting wellbeing, including through prevention
- Workforce development including new roles or different ways of working
- Self-management and shared decision making
- Integrated information systems supporting joined up care
- Supporting research, innovation and use of technology to support quality and efficiency

Large-scale change of this order does happen in the NHS, sometimes unnoticed and frequently impressive. But it requires time to achieve it. For example, productivity levels in A&E services over the past 10 years have improved substantially. In England, to accommodate the number of A&E attendances in 2012/13 at the same level of occupancy as in 2003/4 would have required building an estimated 25 additional major A&E units, yet the number actually decreased slightly over that period.[52] Similarly the proportion of available beds in the NHS has declined by around 40% since the late 1980s,[53] despite a vast increase in numbers of patients treated. This shows that the NHS as a system can change significantly. The question on the table now is whether it can change at a speed, and over a prolonged period of time, to match the squeeze in financial resources available to it. This would be a feat that health systems right across the OECD would find challenging and has never previously been achieved by the NHS.

To accelerate the transition to a more productive health service, NHS and foundation trusts told us the ingredients they need are the time and headroom to focus on transformative change, coupled with investment to establish new services and support from national policies. There was a request for far greater openness from national leaders that the status quo was unsustainable, with rapid change a necessity rather than an option. The current political focus on safety is important, and chimes with the area trusts were keenest to protect. However, while understandable, particularly at this stage of the electoral cycle, a strong emphasis on putting resources and management focus on the maintenance of access targets was seen to be unconstructive.

So what needs to happen?

We suggest three forms of support are needed:

- Systematic improvement support for providers.
- Targeted resources.
- Political openness and support for change.

Systematic improvement support for providers

Providers of NHS care, including but not restricted to NHS and foundation trusts, are now facing a task of unprecedented difficulty. Their chances of success will be far greater if there is systematic and rapid sharing of learning, best practice and improvement methods, coupled with access to further support as required.

At present there is no explicit strategy for how providers are assisted in taking change forward beyond a focus on commissioning, regulation and competition in order to generate impetus for improvement within providers autonomously. While this structure of incentives can generate change, it is unlikely to be sufficient in terms of the scale or speed now needed across the whole NHS, particularly in supporting the rapid adoption of models that have been shown to work. These incentives should not be discontinued, especially given the importance to delivering change of innovative new providers who are able to bring fresh thinking to the NHS. Closer attention on how to reduce unhelpful barriers to new entrant providers would help.

More fundamentally, further thought should be given to the level and form of additional support for NHS providers in the short and medium term. This support should be developed with providers, as well as with those cross-provider bodies (such as networks) that are already working to support providers in improvement. Areas of support could include:

- building skills in change management
- supporting people to learn and make best use of evidence-driven improvement methods
- improvement in basic management processes
- reorientation of ways of working towards person-centred care
- informatics and analysis to support real-time measurement of improvement
- facilitating clinical engagement in change
- supporting changing roles within the skill mix and distribution of the workforce
- appropriate sharing of financial risk.

The exact form this improvement support should take needs careful consideration, as does the vehicle through which is it delivered, for example a voluntary network of providers (as being examined in the Dalton Review*) or possibly coming from an existing supra-provider group such as an Academic Health Science Network cluster. When thinking about the form of support, it is important to learn lessons from the NHS's chequered history with improvement support organisations, such as the rapid establishment and abolition of both the NHS Modernisation Agency and the NHS Institute for Innovation and Improvement.

Targeted resources

Our work with NHS and foundation trusts, and the evidence from our international case studies, has highlighted the importance of dedicated resources in enabling large-scale change. A transformation fund for the NHS is needed to allow new services to be introduced and existing services to be improved, as well as developing the type of improvement support set out above. Without such a fund it is difficult to see how providers would be able to find sufficient resource within existing budgets to drive long-term change. Given such a transformation fund would be likely to be fixed term (representing a 'one-off' cost), one option would be whether it could be linked to 'one-off' ways of raising revenue, such as selling surplus NHS estate.

As productivity savings will not be able to close the financial gap alone, maintaining the quality and breadth of the NHS will also need extra ongoing resource, in addition to the transformation fund. The amount of extra resource needed will depend on how much and how quickly the NHS can increase productivity. However, without careful consideration the mechanism for distributing any extra resources may disincentivise providers from making the changes needed to become more productive. As such, and with the proportion of trusts in deficit increasing rapidly, thought should be given as to whether there are new ways to distribute NHS resources and manage financial risk across providers.

For the NHS to need not one but two extra forms of financial support is exceptionally challenging, especially given the hardships in other areas of the public sector. It is of course legitimate to argue that there are other more worthy candidates for additional public spending, or that the NHS should not require extra resource both for ongoing running costs and to support transformation. However, the alternative is to risk a decline in the quality and safety of NHS-funded care and a reduction in access to, or the breadth of, services that the NHS covers. Without resources specifically earmarked for transformation, there is a risk that the NHS will be unable to become more productive, and the bill for additional running costs only gets larger.

* Sir David Dalton, chief executive of the Salford Royal NHS Foundation Trust, was asked by the Secretary of State for Health to conduct an independent review into new options for providers of NHS care. Sir David will examine the potential benefits that different forms of organisation can offer the NHS as well as the barriers to introducing them. http://consultations.dh.gov.uk/nhs-policy-and-strategy/daltonreview/consult_view

Political openness and support for change

There is a chasm between political rhetoric about what the NHS should deliver and what it is likely to be able to deliver, both in the short and long term if the political choice remains to keep funding levels only rising in line with inflation. Candour with the public about this choice, as well as its consequences, is lacking across all three main political parties. A new narrative needs to be established which is consistent with the severity of the challenge faced. This narrative needs to make clear the need for further productivity savings alongside more transformational change. In areas of the public sector that have faced (and will continue to face) sustained cuts such narratives have been developed, and these have contributed to galvanising change and setting the framework for leaders across the country to take hard decisions. This needs to happen for the NHS. The narrative needs to address quality and cost in tandem, rather than viewing them as separate issues.

With the financial position deteriorating fast and some key areas of quality reducing, the ingredients for a crisis in the NHS are starting to assemble. It is possible to foresee a crisis of finance or quality, or both, occurring in the NHS within the next 18 months. With it, and particularly in the year of a general election, would inevitably come debates as to whether the NHS is sustainable.

However, such a crisis is entirely avoidable. The funding levels at present are political choices. While most agree that the NHS can and must become more productive, and propose some broad service models that might achieve this, most also agree that it is unrealistic to expect that a service of such complexity can change to the extent and pace that the current period of austerity would require without additional support.

The change needed in the NHS is not to its underlying principles of care provided free at the point of need, funded by general taxation; rather change is needed to **how** care is delivered. Strong leadership, particularly from but not restricted to politicians, together with careful use of additional resources (both financial and non-financial) and support for providers in taking forward improvement, can mitigate potential quality issues in the short term, and help to build a more sustainable NHS in the future. Four years into austerity, these forms of support are not in place. This needs to change, now.

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Appendix 8

Figure A1: Summary of case studies and countries' principal responses

Country	Context	Principal features of response
Ireland	• GDP fell in 2008 (by 3%), 2009 (7%) and 2010 (0.4%) • Real term spending on health per capita fell by 8.7% between 2008 and 2012	• Workforce reduced including through recruitment freeze and early retirement. Biggest reductions in general and support staff and nursing (cut of 1,605 WTE nurses) • Substantial salary cuts, including starting salaries for consultants cut by 30%; GP income reduced in the region of 23% • Introduced new charges, including across range of service for those without medical cards (two-thirds of the population) • Capital spending reduced by 26% • Sharp reduction in pharmaceutical prices, including price of off-patent medicines reduced by 20% in 2007, 15% in 2009 and a further 40% in 2010 • Expansion of primary care teams and an increase of 25% in community care packages
Spain	• GDP fell in 2009 (by 3.74%), 2010 (0.32%), 2012 (1.4%) and 2013 (1.2%) • Regional health budgets fell by an average of 5% between 2010 and 2012	• Salary cut of 7.1%, reduction in holiday entitlement and increases in working hours; 75% cut in training budget • Undocumented migrants and adults aged 26 and over who have not made social security contributions excluded from receiving all but basic emergency care • Closure of continuing care centres and out-of-hours primary care services in some regions; deepest cuts made in Catalonia, where hospital departments, beds, operating theatres and outpatient centres were closed • Introduced new charges and co-payments, mainly for medicines; older people on higher incomes now pay 10% of the cost of medicines, others pay between €8 and €60 per month depending on their pension • Pharmaceutical prices reduced by 25% for generics and 10%-16% for branded products; 500 drugs of 'dubious therapeutic value' de-listed

Country	Context	Principal features of response
Portugal	• GDP fell in 2009 (by 2.9%), 2011 (1.3%), 2012 (3.2%) and 2013 (1.4%) • Public expenditure on health care reduced in real terms by 8.2% in 2011	• Significant increases in user charges for medicines and services, although retaining financial incentive for people to access care in primary settings; exemption threshold raised, increasing the proportion of the population exempt from charges from 45%-50% to 70% • Cuts of between 3.5% and 10% to the salaries of public sector employees earning over €1,500 per month; freezes on promotion and career progression; reduction in overtime; recruitment and replacement freeze • Target to reduce hospital operational costs by 15% between 2011 and 2013 through further acute sector reconfiguration • Extensive focus on pharmaceutical expenditure including reductions in prices, reimbursement and state subsidies • New system to monitor prescribing patterns and feedback data to individual doctors, as well as introduction of prescribing guidelines
Canada	• 6% real term reduction in GDP per capita between 1990 and 1992 • Average 0.2% reduction in real term health budget between 1991 and 1996	• Extensive reconfiguration of the hospital sector, including closures, mergers and centralisation of services; resulting in a 27% decrease in staffed beds in short-term care units between 1986 and 1994 • In Ontario, between 1990 and 1999 the number of hospitals reduced from 225 to 150 and 28,800 beds were closed • Moves to shift services in community settings including cuts to hospital budgets and inpatient care • Workforce reduced and salaries cut, including 5% wage cut in Ontario and Alberta
Netherlands	• GDP fell in 2009 (by 3.67%) and 2012 (0.46%) • Health spending reduced by €5 billion	• Reductions in eligibility for long-term care, and exclusion of specific services (eg basic mobility aids, IVF) from mandatory coverage • Mandatory deductibles increased from €170 to €350 between 2008 and 2013; co-payments introduced for long-term care and physiotherapy • Extension of market mechanisms, including extension of free pricing from 10% to 70% of all defined packages of care • Ban on for-profit hospitals lifted in an effort to attract private investment • Public tendering for drugs introduced • Comparative information published on website to support consumer choice
Denmark	• GDP fell in 2008 (by 0.54%), 2009 (5.8%) and again in 2012 (0.28%). • Health spending has slowed since 2008, with a small (2%) real term decline in expenditure between late 2009 and mid 2011	• Rate of salary increases slowed, redundancies made in some regions • Eligibility limited for certain procedures and surgeries (eg. gastric bypass), reimbursements restricted for dental care • 5% cut in medicine prices in 2010; promotion of generics and parallel imports • Initiatives to improve continuity of care, including pathway coordinators and incentivising GPs to act as care coordinators for groups of patients with chronic illness • Restructuring of acute care, with national plan to reduce number of hospitals accepting acute admissions from 42 to 20 by 2015, supported by a DKK40bn (around €5.4bn) investment fund for building, expanding and renovating hospital facilities

Figure A2: Summary of impact of measures on costs, quality and sustainability

Measure	Impact on costs	Impact on quality	Sustainability
Altering workforce pay, benefits and working conditions	Given staff salaries account for 42.3% of public expenditure on health, wage restraints could be an effective short-term measure to constrain or reduce health spending. Evidence on the cost savings achieved through wage restraints is, however, limited. In Ireland, a reduction in staff salaries of between 5% and 15% produced cost savings of €659m in health. Staff may need to be recruited and/or trained post-recession, with associated costs. If this happens, cost savings may be short lived.	Some anecdotal evidence (eg from Portugal, Canada and Spain) of a decline in staff morale and concerns about impact of staff reductions/ shortages on quality and safety of care. In several countries there have been temporary increases or upward trends in waiting times, with a possible (unconfirmed) link to staffing shortages.	Evidence from previous economic recessions (eg Canada) suggests short-term wage restraints are lifted once economic recovery is underway thus costs are saved only temporarily. Little evidence that countries have pursued longer-term workforce strategies, such as role substitution or changing skill mix.
Priority setting and rationing	Evidence not yet available. Changes to coverage have generally been marginal and not affected core services so cost savings are likely to be limited. The Spanish government estimates that €500m will be saved each year from excluding undocumented migrants from health coverage (although the possibility of there being knock-on costs cannot be discounted).	No evidence found. Impact on quality will be highly dependent on the measure concerned and whether the aim is balancing budgets (eg relaxing waiting lists targets) or improving efficiency (eg health technology assessment to support prioritisation).	This is likely to depend on the particular measure concerned. Evidence not yet available for the case study countries.
Cost sharing	The Portuguese experience suggests that user fees generate very little additional revenue for health systems, even where they are substantially increased, and are not effective as a means of encouraging more rational health-seeking behaviour (although they may lead a reduction in service use per se). Evidence from both Portugal and Ireland shows they can substantially increase out-of-pocket costs for patients.	Evidence from Portugal, Ireland and the wider literature shows that user fees can present a major financial barrier to accessing care and vital medication, with poorly served groups (eg low income, the elderly) most affected. For example, the proportion of Portuguese people reporting unmet health needs who cite affordability as the main cause has risen from 49.9% in 2006 to 69.8% in 2011. Likely to be increasing inequity in access to care.	Unclear whether, in those countries that have introduced or increased user fees, this is a temporary cost saving measure or permanent policy. This may ultimately depend on emerging evidence of their impact, eg on equity and access to care.

Measure	Impact on costs	Impact on quality	Sustainability
Changing modes or models of care	Evidence not yet available – outcomes are only likely to be seen over a longer-term period. Wider evidence on the economic impact of care closer to home and service integration is mixed, and varies according to the particular approach taken and local contextual factors. Some evidence of reductions in inappropriate admissions and length of stay, especially when payment systems are redesigned.	Evidence is not yet available. Wider evidence base points to benefits, especially for certain groups (eg frail older people, people with multiple long-term conditions). Highly integrated primary care systems that support continuity of care are associated with better patient experience.	Changing models and modes of care is a long-term strategy for health system reform, not a short-term measure.
Changing care providers' structure, ownership and/or payment	Evidence from Canada, Portugal and Denmark suggests that anticipated cost savings from hospital restructuring are not achieved, and in the short term restructuring may increase costs and create diseconomies of scale. In Ontario it was estimated that restructuring costs were $3.8bn, against a target of $1bn of savings in hospital operating costs. A similar picture emerges from the wider evidence base about hospital mergers failing to achieve anticipated cost savings, at least in the short term.	Likely to depend on the form that restructuring takes, but concrete evidence is limited. Wider evidence base supports centralisation of some clinical services for improving patient outcomes (eg stroke or cancer); purely administrative mergers are less likely to improve quality. Evidence from several countries of temporary increases or upward trends in waiting times, with possible (unconfirmed) link to hospital and bed closures.	Mixed – likely to depend on the original rationale for restructuring, and the extent to which a strategic (rather than purely geographical) approach is taken. In Canada, some evidence of hospitals de-merging post-recession.
Reducing the cost of medical goods	Evidence from across several countries (eg Ireland, Portugal, Spain, Netherlands) suggests that significant cost reductions have been made from pharmaceutical pricing reforms. Pricing controls led to reductions in overall pharmaceutical expenditure of €434m in Ireland (between 2009 and 2014), of 17.8% in Spain, and of 20% in Portugal. In the Netherlands, public tendering for pharmaceuticals generated €355m of savings in 2008 alone.	No evidence to suggest that the reforms have had a negative impact on quality. Access to medicines appears to have been affected by increased user fees in some cases (see cost sharing above).	Responses so far have tended to be quick pricing measures, with no fundamental changes to reimbursement systems; this reflects a wider pattern in pharmaceutical policies implemented in response to the financial crisis. Uncertain whether the pharmaceutical industry will seek to negotiate more favourable terms once economic recovery is underway.
Regulation, monitoring and/or accountability measures	Evidence not yet available for the case study countries. Main function of performance assessment is to benchmark and improve quality, not directly save costs.	No impact as yet reported from case study countries. Wider evidence suggests that performance assessment can drive quality improvement, but only when certain factors are in place (eg information must be able to inflict reputational damage by being reliable, published, widely disseminated and understood by the public).	Systems for performance assessment of hospitals (and other providers) are a long-term strategy for quality improvement, not a short-term measure.

About the authors

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Richard Taunt is Director of Policy at the Health Foundation, leading a team responsible for the Foundation's work in policy.

Richard joined the Health Foundation from the Care Quality Commission, where he led the Commission's regulatory change programme. Previously, Richard held a number of roles within the Department of Health, including as head of the NHS Policy and Strategy Unit, and the lead civil servant on the parliamentary passage of the Health and Social Care Act 2012. Richard has also been an adviser on strategy and policy on areas including quality and efficiency (where he led the establishment of the NHS Evidence QIPP library – evidence.nhs.uk/qipp), primary care and health service reform, as well as working on health and care at the Treasury and Cabinet Office.

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Natalie Berry joined the Health Foundation in August 2014 on secondment from the Department of Health, where she is a Senior Policy Adviser.

Natalie has held a number of roles in policy and legislation within the Department of Health. These include the development of Quality Accounts policy following publication of *High Quality Care For All*, supporting the Nursing and Care Quality Forum in their first report to the Prime Minister, and leading the development of the joint DH / NHS England strategy *Transforming Primary Care*. Natalie also worked on NHS reform during the parliamentary passage of the Health and Social Care Act 2012 and served as Private Secretary to Rt Hon Jeremy Hunt MP, Secretary of State for Health. Natalie is in the final stages of a Master's degree in Health Policy at Imperial College London.

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