Welsh Liberal Democrats
Democratiaid Rhyddfrydol Cymru

Consultation:

The Future of our Healthcare

Autumn Conference 2012

Conference Hall,
1.15 p.m.

This paper has been published for a Consultative Paper for debate at the Welsh Liberal Democrats' Autumn Conference.

Not all of the questions asked by the consultation will become party policy and no question or statement should be taken as being Welsh Liberal Democrat policy unless it has been approved by Conference.

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Published and promoted by R Thomas on behalf of Welsh Lib Dems, both at Blake Court, CF10 4DW.

THE SCALE OF THE CHALLENGE

In recent years, evidence from a wide range of sources has demonstrated that there will be significant challenges for the Welsh NHS in future years. These can roughly be summarised as an ageing population, technology will change and expectations of the NHS will continue to rise. An increasing body of evidence lays out the scale of the challenge facing Welsh politics over the medium- and long-terms.

Analysis from *Five- year Framework*

The five-year framework is the government's plan for improving the NHS over the medium-term. It is notable for identifying a projected deficit of up to £2 billion over the next five years.

Health Outcomes	
1. Outcomes are poorer than peers	• Age standardisation death rates are higher than in England. • Cancer mortality is falling but lags behind international rates
2. The chronic disease burden is severe	• One-third of Welsh adults (~800,000) have at least one chronic condition • 57% of adults are overweight or obese
3. Big inequalities in health and healthcare	• The most deprived segment of the population is 50% more likely to have a limiting long term illness
4. An ageing population is stretching resources	• The number of people aged 75+ will increase by 75% by 2031 • Continuing healthcare spend has increased 27% a year since 2003/4 (£75m - £248m)
System performance	
5. Hospital capacity is strained by suboptimal use	• A 999 call is 30% more likely to lead to a hospital admission than in the best English regions • Occupancy rates are consistently >90% versus an 85% recommended limit
6. Other resources also used less efficiently than they could be	• OP follow-up DNA rates are twice as high in some areas than in the best • Wales prescribes 22 items per person versus 16 in England • If Wales were to reduce its emergency length of stay to target, it could save ~£90m
7. Access challenges persist	• During 2009/10, no Health Board met the A&E target of 95% of patients in less than 4 hours
8. Key costs are rapidly rising or consistently high	• Continuing care costs increasing at 27% annually since 2003/4 • Prescription costs are higher than England or Scotland
Financial health	
9. The current system is unaffordable	• Costs have grown at 5% a year for the last five years and Wales is projected to face a £1.3bn - £1.9bn gap in the coming 5 years • Annual cash growth in NHS funding in Wales has lagged behind growth in England over the last five years and will do so in 2010-11.

SOURCE: WAG, NHS Wales Finance final budget reports, StatsWales

Analysis from *Understanding Wales' Future*

Understanding Wales' Future is a presentation prepared for the Welsh government about the long-term challenges facing all Welsh public services. It draws on a series of statistical sources. This is the summary of the slides on health care.

We rely on the NHS more than in England as fewer people have private medical insurance. Our NHS spend per capita is high compared to other European nations, including the UK average.

Life expectancy is increasing, although at a lower rate than the EU average. However, this growth is not equal. Life expectancy is increasing the most for the least deprived in Wales. As a result, health inequality (the gap between when the poorest die and when the richest die) is projected to rise.

All things being equal, this should lead to more people being treated for illnesses. There would be a rise in the prevalence of age-related illnesses, and dementia is specifically cited as an example. However, things are not equal and healthy life expectancy is rising. It is not known if this will continue but it could mean that the direst predictions about an ageing population's effect on the public health are too pessimistic. As a result, it is unclear if the NHS use is related directly to age or to the two years before, at whatever age that may occur.

Lifestyles of today's young people suggest that their lifestyles may be getting healthier. Incidences of regular alcohol consumption, cannabis use and regular tobacco use has fallen amongst 15 year-olds in recent years, although remain high compared to European averages. However, there is no evidence of a fall in sexual activity amongst 15 year-olds and this also remains high compared to European averages. We are also much more likely to be obese than other European nations and there is no clear sign of improvement – although there is a fall amongst girls there is also a rise amongst boys. Adult obesity is also rising.

Mental health also has a rising cost on the NHS and even though sickness absence is falling there is a rise in people who are off from work for mental health issues.

Analysis from IPPR report *The Long View*

The Long View is a report from the Institute for Public Policy Research think-tank. It is a short document designed to begin debate on addressing long-term challenges. It outlines the things we know and do not know about what challenges will confront public services in the future. Although it is a UK-wide report, it is applicable to Wales.

The known knows: Life expectancy will rise and the media age will also rise from 39.7 in 2010 to 42.2 in 2035. The numbers of over-85s will more than double, and the number of over-100s will increase eightfold by 2035. It also points out the economic growth (and thus financial health) will be affected as economic power shifts eastwards to China.

The known unknowns: We do not yet know how an ageing population will affect the health of the population, and whether out ill-health will be contained to the final few years of life or we will live in poor health for longer. We are also unable to predict how the productivity of the civil service will change, given that outcomes have not risen as quickly as investment in recent years.

The unknown unknowns: We do not know what technological or behavioural changes will occur in future years.

The report also highlights claims by the (independent) Office of Budget Responsibility that predict that health spending increases from 7.4% of GDP now to 8.5% in 2030/1 and 9.8% on 2060/61. Spending on long-term care will rise from 1.2% to 1.5% to 2%. Tax revenues will not rise by a proportionate amount.

Analysis from the Office of Health Economics

The Office of Health Economics is a research body. As part of a report to the Association of the British Pharmaceutical Industry they calculated the likely cost of drugs over the next several years.

On a UK-wide basis, the cost of branded medicines is firmly under control and flattening and spend is predicted to rise alongside inflation, but less than other NHS costs.

In the future, loss of exclusivity is projected to yield over £3.4bn of cumulative savings to the NHS between 2012 and 2015, due to rapid genericisation.

By 2015, new branded medicines launched between 2012 and 2015 will account for less than 2% of the total medicines bill. This underlies the issue in the UK of slow uptake of innovative new medicines.

UK branded medicine prices are already amongst the lowest in Europe and the UK is one of the lowest-spenders on medicine in Europe. Although it is marginally higher in Wales, there has been a tendency towards using older, less effective medicines.

Summary

The Welsh NHS already faces tougher circumstances than in England, and its outcomes are poorer.

Life expectancy is rising which will lead to more people in those age categories where illnesses are more prevalent. It is not yet known how much impact this will have on health care costs, but it is likely that they will rise. Life expectancy will not rise equitably.

In some respects, our lifestyles are improving, but our lifestyles are still worse than in the rest of Europe.

Health spending needs are likely to outstrip inflation, and increases in tax revenue in the short-, medium- and long-terms. The cost of medicines *currently being prescribed* will remain relatively affordable. We are not able to predict the long-term costs of new medicines with certainty. Individual LHBs regularly underspend on their medicine budgets.

Q1: Which of these trends do we think are most likely to have a significant impact on the finances and service provision of the Welsh NHS?

THE GOVERNMENT'S RESPONSE

The government has moved decisively towards the reconfiguration of services as part of its drive towards modernising the NHS in Wales. Each Local Health Board is likely to approach this in slightly different ways. However, we expect that most areas in Wales will see the concentration of specialist services in a smaller number of facilities. In some cases there is a strong clinical case for this, in others the case may be entirely financial.

We have always believed that the government is able to find greater efficiency savings in the NHS than it believes. For example, we have regularly called for more stringent investigations into the claims of money being misspent in the NHS and have continually campaigned against issues such as wasted prescriptions, ambulances queuing outside hospitals or the overuse of locum doctors.

However, we have also stated that reform of the NHS may be necessary in order to prepare it for future challenges. The party has so far balanced its repose to the government, accepting that there may be cases for reconfiguration in some areas but not in others. We should be prepared to refine our position on this.

Q2: How do we wish to respond to government proposals to re-configure the health service? We need to consider the balance between maintaining local services and driving up clinical standards in specialist services?

OUR EXISTING POLICY

In our 2011 manifesto, we argued that "moving NHS resources into preventing ill health or the need for medical treatment in the first place has two benefits: people live longer and healthier lives and the NHS saves money." Some of our policies were designed specifically to reduce costs, others to provide improvements to services that were more suitable for the modern health service. For example, prominent policy pledges that would have re-structured the health service included:

- Establishing an Office for Health Spending to act as ongoing, independent and expert assessor of the effectiveness of NHS expenditure. It will be required to monitor rigorously how each LHB and Trust spends its budget, holding them accountable to an agreed set of outcomes. With its assistance, Ministers must ensure that NHS funds are used to optimal effect.

- Spending money on preventing the need for hospitalisation. Early intervention is better for patients and, when elderly people enter hospitals, their stays often become lengthy and debilitating. So we will invest in projects to reduce the number of elderly people suffering slips and falls by preventive measures and ensure swift home treatment when they do occur.

- Making sure that hospitals are seen as the last resort – prevention and community treatment should be where most healthcare takes place. We will prioritise investment in community facilities to ensure that people get better treatment and at a lower cost.

- Improving collaboration between social care and the NHS. We will promote joint projects with a single management and budgeting structure to commission and deliver social and community care. We will also encourage the establishment of social enterprise provider models to match the best in Britain.

Given the likely response from the government (outlined above), we need to consider to what extent these policies will be applicable up to the next election and beyond. We have stressed the need to reduce hospitalisation by either preventing illness from arising in the first place and also in providing better care earlier.

Likewise, removing barriers between health and social care will improve the quality of service for people who are in receipt of social care or are currently bounced between the two.

As the population ages, there will be a greater need for social care provision for the elderly. This is also likely to be an increased need for primary care. We have long-argued that social care should provide dignity and independence for people who receive services. We have often also emphasised the need for greater proportions of care to be provided either in the individual's own home (where appropriate) in smaller-scale local hospitals and care homes.

Some key policies which re-enforced this included:

- Ensuring more people had access to direct payments or an equivalent
- Joint-budgeting between the NHS and social-care to reduce the number of patients being shuttled between the two
- Developing an agency to loan money for people to improve their homes so that they can stay there in the future, with the money being repaid when the home is later sold

Finally, in a consultation document in 2007, we asked,

> "It is clear that, to be successful, the NHS and Social Services Departments will have to work very much more closely together, probably in jointly managed teams. Is there a case for following the Northern Ireland model and integrating social care into the NHS?"

We have in the past considered a placing the NHS and social care into the same body in order to ensure greater collaboration between them.

Additionally, one of the expected costs of medicines and technologies for the NHS in future years will be the cost of new medicines and new technologies. In the years before budgets began falling, Local Health Boards regularly under-spent on their medicine budgets. As well as this, the cost of drugs which are currently being prescribed by the NHS will fall as their patents become invalid and generic replacements are developed. However, new medicines that are developed are increasingly expensive.

In the past, we have proposed to streamline the various procedures (NICE, the All-Wales Medicine Strategy Group and formularies) to reduce costs but also to provide a more equitable access to medicines across Wales.

Finally, we have regularly discussed the need to create healthier lifestyles and pursue investment in prevention. These will require investment today for which the health service will not recoup investment for decades, and then in an indirect way. As well as this, promoting health and well-being is often a "soft" issue which means it can be difficult to target government intervention easily – new laws and funding streams can only contribute towards changing behaviour, they do not achieve it immediately.

Q3: How much of this policy do we wish to retain and which areas do we think we need to expand on to ensure that our policy is relevant by the time of the next Welsh general election?

ISSUES WE NEED TO CONSIDER

The party needs to consider the way in which it believes that the health service should be structured in order to ensure that we can provide a clinically safe service to every citizen. This will be influenced by the current financial problems, but also by the long-term squeeze that will occur on the health service as a result of the trends that we have outlined in this document.

The challenges facing the NHS and the scope for savings are likely to change continually over the next few years. Given that assessing these challenges and scopes is currently the prerogative of the NHS itself (and often subject to pressure from the government), we should consider how we can develop an objective method for analysing any potential reforms. We should consider whether or not we wish to consider retaining our policy to establish an Office for Health Spending to independently analyse areas where reform could be made, and savings found. We estimated that this cost £300,000 per annum.

Q4: Is this the best model for ensuring value for money and ideas for efficiency are developed for the Welsh NHS?

Welsh Liberal Democrats have always considered that community-based services should be maintained wherever there is a clinical case for that service to remain. However, for some services, especially acute care and specialist services, there is evidence that clinical care can be approved by concentrating expertise at a smaller number of sites. The party should consider if that is something that we would support. It is unlikely that this would lead to hospital closures, but it would lead to downgrading of services. We should consider which sort of NHS services we consider to be appropriately delivered in a local community and which we believe could be more effectively delivered more remotely from some patients.

Q5: What should the structure of community services look like across Wales and which services are best provided there?

The relationship between the NHS and social services is also crucial. We should consider if we can continue to improve services through greater collaboration and if so, how we can best ensure this collaboration is effective. Our policy so far has been to drive collaboration by using a series of funding measures and structural incentives to encourage closer working. This has included creating single sources of funding for patients and encouraging joint-appointments between local authorities and the NHS. We should consider whether we still believe that this is sufficient to deliver the scale of improvement that is needed or whether we wish to consider a different model whereby health services and social services are delivered by the same provider. If we propose a different model, we should consider whether we believe health services should be delivered at a more local level, or social services by the NHS.

Q6: What is the best way to ensure health and social services can be integrated more closely and are we prepared to consider a single provider as is the case in Northern Ireland?

Welsh Liberal Democrats believe that democratic accountability and public scrutiny of improves the quality of public services and therefore we must ensure that any significant changes to the delivery of health and social services must take this into account. Currently, health services are held accountable to the National Assembly and local authorities are responsible for scrutinising the work of local social services. If social services to continue to move towards a more regional basis, local authorities may well lose the ability to effectively hold social services in their area to account. If we choose to move towards greater

regionalisation or a national model for social services then we must consider how we can maintain democratic oversight of this essential public service.

Q7: Which bodies should have democratic oversight of health and social care providers and how do we ensure that this oversight is meaningful?

We are likely to see a difference in the number of illnesses and medical conditions that we will need to be treated. Hopefully, lifestyle-related conditions will decline in prominence, but we will certainly see an increase in the age-related condition. This is likely to see a shift in how medicines and technologies are used by the NHS. As a result, we are likely to see new medicines and technologies being used that could be more costly to develop and more costly to prescribe. We should consider what priority we attach to provision of these treatments and how we will pay for them as other health service costs rise.

Q8: How can we find additional resources for new technologies and, if resources, are limited, how do we decide which are most worthy of investment?

We also know that hospital visits are more costly for the NHS and can provide less effective care for the patient than earlier interventions. Some of this work can be done by encouraging healthier lifestyles, but we should also consider if we can use the social services to provide greater preventative care and if this would be facilitated by greater collaboration. We should also consider if there are any models that would establish these early interventions more effectively, such as the “Camden Clinic” we promoted in our last manifesto.

Q9: What would be the most effective way of preventing hospitalisation and instead promoting reduced need or earlier intervention?

Finally, health service costs are likely to rise at above the rate of inflation, and against predicted growth in government expenditure, over the next few decades. Additionally, the Welsh government has little scope to increase its budget. We ought to consider what proportion of the budget we believe the NHS should be receiving in future years. For the financial year 2012/3, “health and social services” (which does not include direct spending by local authorities) cost £6.5bn out of a total budget of £15.1bn. We have also endorsed the government broad headline reductions in the budget for this group of expenditures. Do we consider this to be adequate in the short-term and if not, how would we pay for any additional increase. The Welsh budget is, essentially, fixed so any increase in expenditure on the health service would need to be drawn from elsewhere. We should also bear in mind that investment in other parts of the budget can have a benefit to health services. For example, investment in improving housing can reduce the number of people who are admitted to hospital for conditions relating to dampness or coldness in poor housing. We should consider whether or not we want to explicitly fund such projects as part of our programme to improve health condition in Wales.

Q10: Which other services contribute to reducing ill health and do we want to increase resources to them in order to reduce later costs in the NHS? If so, how do we find the up-front funding required?