

Looking ahead to 2020: economics, health care policy and pharmacy

In this fourth article in a series leading to a consultation among members about the Royal Pharmaceutical Society's Pharmacy 2020 project,

Clive Smee, former chief economic adviser at the Department of Health, looks at economics and health care, particularly in England

The central economic problem for any society is how to reconcile the conflict between people's almost limitless desire for goods and services, and the scarcity of resources available to produce these goods and services. Economics has been defined as the study of how society decides what, how and for whom to produce. Looking ahead to 2020, what can be said about the drivers of what (and how much) the pharmacy profession will produce, how it will be produced and for whom?

Pharmacy is an important component of the health care sector and their futures are intertwined. In considering each of the "what" (including how much), "how" and "for whom" questions it is, therefore, appropriate to look first at the drivers for the health care sector as a whole and then to turn to the probable influences on the pharmacy sub-sector.

What will be produced at what cost?

Health care services In the past seven years, the health services in the UK have enjoyed the biggest increase in resources in their history. Between 2000 and 2007, NHS funding increased by around 7 per cent per annum in real terms raising total health expenditure from 7.3 per cent of GDP to about 9.2 per cent. Although there continue to be pressures from health care's long-term cost drivers — new pharmaceuticals and other technologies, rising public expectations and demographic changes — these rates of growth cannot and will not be maintained.

"Securing our future health: taking a long term view" (the Wanless review, 2002) was the most authoritative forecast of the need for health care funding. It assumed that after 2008 the required rate of increase in NHS expenditure would fall to between 3.2 and 4.3 per cent per annum in real terms, about the rate of increase from 1954 to 2000. The lower rate of 3.2 per cent could be achieved by the "full engagement" of society in responsible health choices. This is assumed to require a major expansion in self care and in public health. Even at these lower rates of increase, Wanless projects health care costs rising to 10.6 per cent of GDP by 2020.

The UK, like many other countries, funds its health services from a combination of tax, social insurance and private insurance. A major slowing in the rate of increase in tax funding, as seems almost certain, might in theory be offset by a growth in private insurance or private out-of-pocket payments. But history suggests the offset is likely to be small.



Moreover there is a fairly broad consensus among commentators and the main political parties that tax remains the most efficient method of revenue collection, the most effective way of controlling expenditure and the most equitable way of sharing health risks.

It seems reasonable to conclude that up until 2020 the increase in health service funding will depend primarily on the buoyancy of tax revenues, and hence of the economy, and on the priority governments give to health relative to education, the environment, security and defence, and the other demands on public budgets. Even on the most optimistic assumptions over most of this period resources are likely to be much tighter than they have been over the past five years.

Aware of these pressures the Government is attempting to manage demand for publicly funded health services through investing in self care and prevention, and to move health service resources away from the most expensive part of the health care system — the hospital — into primary and community care. Pessimists will point out that such shifts, particularly the latter, have been on the agendas of both major parties for the past 25 years with, in general, only limited success. Optimists can retort that the present plans are more robust, better informed, more adequately funded and supported by stronger incentives.

Anticipation (and experience) of tighter resources can also be expected to strengthen the drive for evidence-based medicine and policies. The establishment of the National Institute for Health and Clinical Excellence in 1999 marked political acceptance of the need for health interventions to be not just clinically effective but also cost-effective. The role of NICE has already expanded enormously from the appraisal of new technologies to the appraisal of existing technologies and from health service interventions to public health interventions. As resource constraints drive wider recognition of the need for prioritisation and for maximising value for money in health care, the role of NICE (or any successor organisations) can only expand. Services that cannot be shown to offer value for money will be increasingly targeted

for scrutiny and possible contract exclusion.

Greater public consciousness of safety and quality is another trend that is affecting public expectations of health care services. Increasing information on health care outcomes is highlighting unacceptable levels or variations in quality and safety. Addressing these may require investment up front but in the longer term this could reduce overall health care costs.

Pharmacy How far will the trends expected to affect health services in general also have an impact on pharmacy? Historically the growth of community and hospital pharmacy has been closely tied to the growing role of pharmaceuticals in health care. Pharmaceutical expenditure was 12.8 per cent of total UK health expenditure (public and private) in 1980 and 15.8 per cent in 2004. Although the number of pharmacists under contract to the NHS has barely risen in recent years there has been a sustained increase in the number of prescriptions dispensed per pharmacy, from 42,500 in 1994 to 65,100 in 2004, according to the OECD, the Organisation for Economic Co-operation and Development. However the rise in pharmaceutical expenditure was not reflected in a similar rise in dispensing fees: between 1994 and 2004 pharmacy income from dispensing fees fell from 18 per cent to 12 per cent of total expenditure on general pharmaceutical services, according to the Office of Health Economics, though this may have been offset by a rise in income from margins.

Will trends in pharmaceutical expenditure buck the expected slow-down in the growth of overall health service expenditure? In the 1990s they did, but it is possible that the 1990s will come to be seen as exceptional. Since 2000 pharmaceutical expenditure has been growing more slowly than total health expenditure. In Australia it has recently been argued that growth over the next decade or so could be much slower because of government action to achieve large price cuts in pharmaceuticals, the introduction of higher co-payments, a decline in block busters and growth concentrated in products (eg, oncology products) that are not dispensed via community pharmacists. In the UK only the second of these factors would seem to be currently ruled out by Government policy.

Other Government policies may offer pharmacy, particularly community pharmacy, opportunities to escape from the tighter constraints on health service expenditure as a

whole. A raft of recent Government policy statements has identified opportunities for pharmacy to expand its role in self care and public health. Other statements have urged it to play a larger role in the planned build up of "closer to home" primary and community services. Moves in both these directions have been supported by the new community pharmacy contract. While the development of new services or "products" has so far been relatively slow there are already reports that fees from medicines use reviews (MURs) are making a significant contribution to pharmacy profits.

How far pharmacy can exploit these new opportunities will depend on a number of constraining factors. Some, such as opposition from GPs and the ignorance of primary care trusts, may be difficult for the profession on its own to overcome. Others, such as the current lack of evidence on the effectiveness and particularly the cost-effectiveness of many potential advanced and enhanced services, are more within the profession's control provided it is willing to sponsor the necessary evaluation and research. The action required is now urgent: viewed through the eyes of primary care trust commissioners the profession starts at a major disadvantage relative to the services of traditional suppliers for which there is often much better information on value for money.

How will it be produced?

Health care services Since the founding of the NHS the bulk of health service provision has been through public monopolies or through highly regulated private providers. Direction and control has been centralised at the national level. Competition has generally been discouraged between providers and between professions. In some sectors, including pharmacy, the public has always enjoyed choice but for many services it has not been encouraged or even permitted. Remuneration systems have been linked primarily to hours of work and skill level, and have usually avoided explicit links to performance. Where there have been links to individual productivity or performance the link has invariably been to activities or outputs, not to quality of service or outcomes.

Beginning with the Conservative's "internal market" in the 1990s there have been halting steps towards giving market incentives a greater role in the NHS, both in the "product" market and in remuneration systems. The current Government believes competition, or at least contestability, and choice can make an important contribution to improving service access, quality and efficiency. The private sector has been allowed into service areas that were previously public monopolies and patients have been offered choices across an increasing range of suppliers, public and private. Some of the barriers or distinctions between professions are also being broken down: prescribing is a good example.

In the labour market the new GP contract amounts to a major experiment in tying remuneration to quality of care. In order to en-

sure that authority is based on the best-quality information, commissioning decisions are being decentralised (formally at least) in England to PCTs and practice-based commissioners.

This new organisational paradigm is still not fully worked out. Some elements will doubtless work better than others but, looking ahead to 2020, it is difficult to see a reversal of the trends towards more contestability and choice in service markets, more overlap between professions, more emphasis on quality and outcomes in remuneration systems and greater decentralisation in commissioning.

Pharmacy Through a series of policy papers, the 2005 relaxation of entry controls and the new contractual framework for community pharmacy, the Government has signalled that it is changing the organisational arrangements for pharmacy in ways that mirror the changes in other parts of the health sector. The intention has been to make community pharmacy services more accessible and patient friendly, to enable pharmacists to offer an improved range of services and to make better use of pharmacists' skills and expertise.

It is early days to judge how well these objectives will be met. The relaxation of entry controls has clearly had consequences that were not anticipated: in January 2007 ministers asked for a review to ascertain how PCTs could be given the power to ensure there are adequate pharmacy services in deprived and rural areas. The new contractual framework appears to have been a greater driver of change with progress reported on repeat dispensing of prescriptions, the expansion of MURs and the growth of local enhanced services. Nevertheless progress has generally been slow and early evaluation points to few innovative services and little change in relationships with GPs or integration with primary care. However, the contract can be expected to continue to evolve, particularly in the direction of linking payments to quality of care (similar to the quality and outcome framework for GP remuneration).

In the longer term the new contractual framework offers community pharmacies a much richer range of business alternatives than they have enjoyed in the recent past. In particular they can choose to remain as dispensers or they can move into the supply of a range of primary and community care clinical services that have normally been associated with doctors, nurses or public health specialists (when they have been provided at all). The choice may be assisted by continuing downward pressure on the dispensing fee as the Government tries to ensure that pharmacy delivers the same year-on-year efficiency gains as it expects from the rest of the NHS.

These choices could well lead to different ownership structures. Independent ownership of community pharmacies has been declining rapidly. Between 1990 and 2005–06 the percentage of community pharmacies in con-

tract with the NHS that were independently owned fell from 66 to 43 per cent. Some forecasts see this figure falling to 25 per cent by 2015. Should pharmacists retreat into a narrowly defined drug supply role this trend could be accelerated. On the other hand those pharmacists who choose to focus on extending their clinical roles could see their independence strengthened as they work either on their own or with family doctors or in primary care organisations.

New delivery technologies present another challenge to the organisation of community pharmacies. The development of integrated IT systems is clearly essential for inter-professional working. Optimists in the profession will also see the internet, mail order, telephone consultations, medical help lines and interactive video consultations as complementary services that provide patients with increased choice. Pessimists may view them as direct competition. Either way most of these "new" technologies are likely to be much more in evidence by 2020.

For whom will it be produced?

Health care services The market for the NHS will remain the whole population. But the Government has signalled that it wants to do more to tackle inequalities and improve access to community care, to improve prevention services and to give more support for people with long term needs

Pharmacy With 94 per cent of the population visiting a pharmacy every year and more than a fifth of people reporting that they would like to receive information and advice on health from their pharmacist in the future, community pharmacists should be well placed to respond to the Government's signals. The new contractual framework and the local pharmaceutical services scheme provide incentives and mechanisms for reaching those least active in self care: the most elderly, the deprived and those from ethnic minorities. However expanding outreach to these groups will not be easy and may require a reversal of recent trends: a recent Mintel lifestyle survey found that the proportion of the public consulting a pharmacist when suffering a minor ailment fell from 40.5 per cent in 1994 to 39.4 per cent in 2004. In the absence of a good evidence base pilot projects are needed to identify the best way to make progress.

Conclusion

The slowing of the growth of health service expenditure from 2008 will present all health service with significant challenges. But the Government's strategic responses of encouraging prevention and self-care and moving services "closer to home" provide major new opportunities for pharmacy. Increased attention to safety is another opportunity. The new (and evolving) contractual framework should supply the incentive to respond to these new market opportunities. But the evidence base still needs to be tackled.