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PERSPECTIVES ON HEALTH CARE REFORM IN THE U.K.: A DIALOGUE WITH SECRETARY OF STATE FOR HEALTH ANDREW LANSLEY

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P R O C E E D I N G S

DR. MCCLELLAN: Good afternoon, everyone. Welcome to the Brookings Institution. I'd like to thank you all for coming today.

I'm Mark McClellan. I'm a Senior Fellow here in Economic Studies and the chair of the Engelberg Center for Health Care Reform here at Brookings, and we're very pleased to have with us today the Secretary of State for Health for the United Kingdom, Andrew Lansley.

Minister Lansley is currently leading some important efforts in the U.K. to address the rising costs of care while improving quality of care through a major set of health care reform proposals in the United Kingdom.

The efforts that are being undertaken in the U.K. are starting from a health care system that is quite different in terms of its financing, in terms of its structure, in terms of its organization from the system here in the United States, but the underlying challenges that the U.K. system is facing are very familiar to Americans as well.

We're facing rising health care costs. The ongoing global economic pressures have increased the need to address the efficiency of health care in our system, as well as elsewhere, and we are also facing some real opportunities and real public concerns about improving the quality of care.

Here, as in the U.K., there have been many calls and many opportunities identified for delivering care more efficiently—not just more efficiently, but delivering higher quality care, and you're going to hear some about that from Secretary Lansley in a few minutes as well.

So this event today gives us a unique opportunity to learn about how the United Kingdom is pursuing its challenges. And what I would expect to be, as we head more into the future and growing concerns about how to get innovative, individualized,

prevention-oriented health care to all of the people around the globe, some increasing similarities in the kinds of challenge that we're each facing, and hopefully some opportunities to learn more from each other in how to address them.

To take on these challenges in the United Kingdom, Secretary Lansley has been working for quite some time on major reform proposals. Back when he was a Shadow Minister several years ago, he came to meet with us here at Brookings, as well as other experts in the United States, to discuss some of those ideas, and you're going to hear how those have developed over time since then with the new government in the U.K. and with the further steps towards actual legislation implementing these reform ideas.

These ideas are building on some steps that the United Kingdom has taken in recent years already, steps towards making hospitals and other health care institutions more autonomous and also more responsible for the quality of care that they're delivering, steps towards having general practitioners lead through clinical commissioning groups or, really, holders of the funds, the resources that are spent on behalf of patients in particular areas in their area of service in the United Kingdom, steps towards making better information on performance available—what health care really is intended to deliver.

It's not just supposed to be about spending the money on some kind of fixed budget or here in the United States, spending the money on fee-for-service payments but actually getting better results, better health for patients at the most efficient cost possible, so more measures for doing that.

And as you'll hear, even steps to broaden the focus of activities of health care professionals beyond just providing medical care towards really addressing some of the broader determinants of health and health disparities in a population.

So this is part of a comprehensive reform approach that potentially includes health and social care in the United Kingdom, with the goal—much more explicitly than in the past—of driving improvements in health outcomes.

Now, these goals are actually quite similar to challenges that those of you who have been following the health care reform debates in the United States have seen as well, where, there too, we have some big differences in philosophies about how health care might be financed and the role of government, the role of the private sector, the role of individual choice, but a lot of commonality in believing that there are better ways to support health care providers in doing what they want to accomplish, and that's to get better results for their patients while saving money and recognizing that the ways to do that going forward, which involve a lot of care outside of traditional institutions, a lot of emphasis on longitudinal and coordinated care for patients, and a lot of emphasis on individualizing care. Those are new directions that require new policy supports.

Here at the Brookings Institution, at the Engelberg Center, we've been working on a whole set of payment reforms towards more accountability in care, reforms like accountable care organizations, and bundled payments that are now taking hold in a range of programs around the country, in the private sector, in state Medicaid programs and hopefully soon in the Medicare program as well, as a result of new regulations about the Medicare shared savings program and potential further steps that CMS may be able to take to build on these initial accomplishments.

And so, again, I think there are some opportunities for learning from these increasingly similar challenges that we all are facing, despite some fundamental differences in how our health care systems are organized.

And I can't think of anybody better to talk about that than the Secretary of State for Health, Andrew Lansley. He will be talking about the U.K.'s current and

proposed efforts to pursue this core aim of moving towards more value-focused health care.

After he makes his remarks, I'll lead off a follow-up discussion with him, and we're looking for some participation from you all as well in that discussion about the experiences of the United Kingdom so far, what's ahead for them, and also what it means for us here.

The Health Minister has had a varied and successful career in public service. He comes from a family dedicated to public service. His father was working in England's National Health Service from its commencement in 1948. I understand he went on to run a pathology lab for several decades after that.

Minister Lansley began his own career as a civil servant at the U.K. Department of Trade and Industry, and he was first elected as a member of the British Parliament for South Cambridgeshire in May 1997.

As I mentioned before, he served as Shadow Secretary of State for Health. He did that for seven years while the Conservative Party was in the opposition, and then following the very important U.K. general election last year, he was appointed as the Secretary of State for Health by Conservative Party leader and Prime Minister David Cameron.

And the ideas that are now being implemented, now being debated in legislation, now part of the legislative process, now being implemented on a pilot basis in the U.K are, in large result, from the thinking, the work, the effort that the Minister has undertaken during that long commitment to health care reform in the U.K.

So Minister Lansley, thank you so much for taking the time to be here with us today. We're looking forward to your remarks and to some discussion to follow up, and thank you very much.

SECRETARY LANSLEY: Thank you, Mark. Thank you very much indeed, and it's a great pleasure to be here back at the Brookings Institution. Delighted to be here. Thank you for that very kind introduction and for inviting me to come to the Brookings Institution, which is truly one of the world's most respected centers of critical and creative thinking. It makes me worried about what's going to happen when we get to the questions sessions.

But we do need that sort of thinking. We need constructive, creative, critical thinking more now than ever before because on both sides of the Atlantic, we face significant challenges.

Most pressing of all, of course, is the need to deal with the immediate fallout of a dreadful financial crisis and the long-term problems of sovereign debt. Getting our respective houses in order will dominate politics in North America and across Europe for the rest of this decade.

But while that has to be a compelling priority, it cannot be our only priority. I believe—my government believes that another priority must be to secure the protection and improvement of the health of our citizens.

Core central to that task in Britain is the role of the National Health Service. For over 60 years, the NHS has been a central fact of life in providing health care in my country—as the saying goes, from cradle to grave.

Now of course some may question, why does a Conservative Health Secretary so support the National Health Service?

Well, let me take you back for a moment to its origins. June 1944, Royal College of Physicians, Winston Churchill, as Conservative Prime Minister of a coalition government, defined the future of the British Health Service in these terms—and I quote him, "Our policy is to create a National Health Service in order to ensure that everybody

in the country, irrespective of means, age, sex, or occupation, shall have equal opportunities to benefit from the best and most up-to-date medical and allied services available."

So you'll see there is nothing novel about a conservative explaining our commitment to universal, high quality health care.

Today, decades later from that, I can tell you our commitment to the NHS, providing high quality care for all, free at the point of use, based on need and not ability to pay is unchanged. The social solidarity it represents remains instrumental to cohesion in our society and to our sense of individual and family security. It is, in my view, part of the One Nation tradition of conservatism. If you'll recall, as Disraeli put it back in the 19th century when he defined it, effectively, the responsibility that those who have have towards those who have not.

And in no respect is that obligation more real and necessary than in health care—because I have been, as Mark kindly recalled, on the frontline of health reform in England for eight years, first in opposition, now in government. I am proud that my party's commitment to the NHS and the public's trust in our commitment has been continuously and strongly reinforced over that time.

And in the face of the immense challenges the NHS and all health care systems face—demographic change, technological advance, rising public expectations and fiscal consolidation—our coalition government's commitment to support the NHS through rising real terms resources and comprehensive modernization has also been unequivocal.

Now, over that time, as I learnt more about comparative health systems, I've spoken with health ministers from all over the world, as indeed I'm having the opportunity to do here in Washington with ministers at the Commonwealth Fund

Symposium.

One thing that becomes instantly clear is that we all start from a different place in terms of organization and finance. Sometimes we have very different structures and presumptions about how health care is best financed and provided. Here in America, I hear both praise for the NHS and criticisms of it.

On the positive side, the concept of universal access to health care is often admired. I think if you had been with us listening to the presentation of the results of a survey in 11 countries at the Commonwealth Fund Symposium this morning, you would indeed have heard a great deal of praise for the National Health Service, that people are not constrained from access to health care by its affordability, that there is a high level of access to care, that the service is comparatively safe, accessible, good coordination of care and gives patients access to a real medical home that coordinates their care for them.

But on the other hand, I also hear in this country a critique of the nature of state control of health care. Some commentators chastise what they call socialized medicine because they say patients cannot choose their doctor or are denied a drug treatment on the supposed lack of choice and control over health care as experienced by patients.

Now many of us in Britain, while committed advocates of NHS values and principles, are now equally committed to reforming a system long characterized by command and control, by bureaucratic processes, by a lack of choice and innovation, limited choice and poor relative outcomes.

The white paper that we published last June, *Equity and Excellence: Liberating the NHS,* was focused on achieving the pursuit of quality and improved outcomes through innovation, patient-centered services, and clinical leadership.

Combining what the title is about—equity and excellence—combining a quality of access with excellence in delivering through responsive outcomes-focused care.

I know enough not to believe that any health system can be transplanted from one country to another. It is, however, perverse not to seek to understand shared values and experience, and to learn from it. I do not see a desire in the NHS to adopt an NHS structure. We in Britain do not intend to adopt U.S. health care funding organizational structures, but I think we can recognize shared values.

For example, a social responsibility to provide universal access to health care, the imperative to reduce health inequalities, public responsibility for health protection, for health promotion, and for the improvement of population's health and a need, therefore, to impact on the wider and social determinants of health.

Now in England, we already have universal access. That one's in the bank. But it is not universally excellent, nor universally responsive to patients. So our focus is on quality and on providing a personalized service built around the needs and wishes of the individual.

So I'd like to share some lessons from our experience, just as I've taken such a lot from yours—not least from thought leaders such as Michael Porter and the late Barbara Starfield—and indeed, from experience of places like the Cleveland Clinic and Keiser Permanente.

The reason we can learn so much from each other is that so many of the issues we face are common to all countries. But to these, I believe there are also some common solutions: a comprehensive shift to measuring, publishing and improving health outcomes, the creative use of incentives and quality-based competition, a focus on prevention and on public health, and better information and far better use of information technology in health care.

Now of course in United Kingdom, responsibility for health care has devolved to the individual nations of England, Scotland, Wales, and Northern Ireland. I am Secretary of State for the United Kingdom, but I am responsible for the NHS in England.

And in England, we have embarked on a comprehensive program of modernization that incorporates all of those things that I just mentioned. It is a program of modernization based around three principles.

First, shared decision making between patients and clinicians—for patients, the principle of no decision about me without me.

Second, giving power and budgets directly to clinically led commissioning groups.

And thirdly, a focus system-wide and at every level on the measurement and improvement of health outcomes. Health outcomes are the things that really matter most to patients. Things like survival rates, recovery rates, whether people can live independently and with dignity, a patient's overall experience of their health care.

Everything we do flows from this principle. We are putting patients more in control of their own care, of where, by whom and even, where appropriate, how they are treated because it will lead to better outcomes.

And we're giving power to design and buy in local health services to doctors and other health care professionals because they are best placed to improve health outcomes by doing so.

Critically, this enables us to ensure that as clinicians make the decisions which determine the use of services and resources across health care—because they are the ones who are doing that in referrals—they do so in the context of taking a collective responsibility for using budgetary resources to optimize service design to meet

the needs of their patients and the needs collectively of their population.

Through clinical commissioning groups—and indeed, I think in the United States, through accountable care organizations—we are in both United States and in England focusing on the benefits of bringing clinical decision making and control of resources together in order to secure the efficient and effective improvement of services for patients.

As I say, I'm here primarily to attend the annual meeting of the Commonwealth Fund. If you read their report, our National Health Service comes out very well. More people in England can get a same or next day appointment than in other countries. More people feel they spend enough time with their doctor when they see them. And almost nobody has serious problems paying their medical bills.

But if you dig a little deeper, the picture is not always so rosy. We perform poorly compared to almost all other European countries on mortality amenable to health care—where we could save lives but we don't. The premature mortality rate from all respiratory diseases in the United Kingdom is above the European average and more than twice as high as it is in France or Sweden. And five-year survival rates are below the OECD average for cervical, breast, and colorectal cancers.

And even within England, there is an unacceptably high variation in the quality of outcomes that patients receive. We know this because for the first time, we have started to measure health outcomes.

Last December, we published the first *NHS Atlas of Variation in Health Care*. It compared 24 sets of clinical outcomes data across all 152 NHS districts. Immediately, huge variations unexplained by local differences in the population became apparent—a fivefold variation in the proportion of diabetes patients receiving the recommended level of care, a fourfold variation in emergency admissions for under 18s

due to asthma, a fourfold variation in the number of emergency bed days for patients with the respiratory disease COPD.

And in a separate survey, death rates following bowel cancer surgery were demonstrated to be variously as low as 1.7 percent, and in another hospital, above 15 percent, depending upon which hospital you are treated in.

While there is truly excellent care and world-leading medicine to be found in the National Health Service, there is also too much that is not yet good enough in terms of outcomes and in terms of the personal care given to patients. In that respect, of course, England is, of course, far from unique. The same is true in every country in the world. The quality of care varies.

So what do we do about it? How do we narrow the gap between the best and the worst while raising the bar for everyone?

For us, it all starts with the NHS outcomes framework. It isn't a list of targets set in Westminster by politicians, nor is it a strict set of rules that bind the hands of doctors, undermining their professional and clinical judgment. Rather, the outcomes framework is about being clear about what we want every health care organization, every purchaser, every provider, every person who works within the growing NHS family to work towards in their day-to-day working lives.

Reducing avoidable mortality—for example, measuring one- and five-year survival rates after cancer diagnosis.

Enhancing recovery after treatment—for example, measuring patient-reported outcomes such as recovering mobility or reduction of pain following knee replacement—or indeed, measuring the six-month status after a stroke of stroke patients.

Improving the quality of life for people with chronic conditions—measured by, for example, by a survey tool called EQ5D, which asks about things like

whether one is in pain, whether one is mobile, whether you can do usual activities, whether one is anxious, whether one is able to achieve self-care.

And maximizing safety—for example, minimizing medication errors and reducing levels of health care-acquired infections.

And not least, measuring and continually improving patients' experience of their own health care—for example, through patient surveys.

Those are the five domains of the NHS outcomes framework—reducing avoidable mortality, recovery after treatment, enhancing quality of life for people with long-term conditions, maximizing patient safety and enhancing patients' experience of their own care.

Now, the outcomes framework will help clinicians and managers to come together, pulling their services in the same direction. They are deliberately broad, so as to enable us to cover, in effect, all areas of health care—a broadly representative structure across a health care system. I might say, from my point of view, not the English health care system.

I think this is something which we are hoping to see increasingly something we can work internationally, to have what one might regard as an understanding broadly across health care systems of what good looks like and how we measure it, and our capacity to compare so that when we're, for example, comparing, as we do at the Commonwealth Fund, issues of affordability and access, we also are able to go on collectively to benchmark and compare ourselves internationally in terms of the outcomes that we achieve. And I think that was one of the most positive issues this morning, is a commitment to move from access to outcomes.

To flesh out the detail, NIHCE—National Institute for Health and Clinical Excellence—is developing a library of condition-specific quality standards so we know

what good looks like. We already have quality standards for diabetes, for breast cancer, 10 other conditions, another 16 currently in development, a further 120 to come.

So clinicians will be able to see what excellent care, based on the latest evidence and best global practice, really means, and be in a position to judge whether or not they're delivering to that standard.

These quality standards only say what needs to be achieved, not how to achieve it. That responsibility must rest with local clinicians, with local knowledge and an understanding of the needs of their communities.

In time, everything will flow from these outcome objectives. The reputation of clinicians, the success or failure of providers and a properly regulatory regime for individual hospitals and other providers will then be an important part of the new system. Everything will depend on how well they can deliver against those outcomes. There are three main reasons for this.

First, a line of accountability must run from providers through local and national purchases to the Secretary of State, based along that chain on the NHS outcomes framework and its complementary measures of progress. As David Cameron and I said back in January 2006, we want to be very clear about what it is we want the NHS to achieve. We will also let the NHS themselves be clear about how they best achieve it.

Second reason for that accountability is because we are changing the way we pay for care. At the moment, hospitals or other health care providers are paid for every episode of care. So if a hospital messes up and a patient is readmitted for further treatment, they get paid twice—not that a hospital thinks that way necessarily, but they should not have a perverse incentive not to provide the best care.

So we are progressively introducing a payment system that will pay for

results, which will encourage and reward the best care through quality increments and best practice. That will incentivize integrated services designed around the pathway of care, irrespective of primary and secondary care divisions.

So for example, we have a structure of payment now in place for cystic fibrosis, which is effectively a single payment system for a whole year of care based on a structure of understanding what best practice for the management of cystic fibrosis looked like, or for example, where the best practice tariff for is concerned, by putting best practice into the payment system, it incentivizes the achievement of quality.

We've seen in the course of a year the best practice tariff has reduced the length of stay for patients following fragility hip fracture by one and a half days. We've seen a reduction in mortality of 1.4 percent from 9.4 to eight in the course of a year, as a consequence of the payment system leading directly to the adoption of the standards which reflect evidence-based best practice.

So if you deliver excellent care for your patients and improve outcomes, health care providers stand to be paid more than if they don't. The emphasis moves from the quantity of care to its quality.

Next year, this new payment system will include, for the first time, adult mental health—the first payment system in the world to do so—improving access to psychological therapies, ambulance services, radio therapy and chemo therapy, and community services such as podiatry.

The third reason for that accountability, that outcomes will matter most, is patient choice. We'll be doing more than just measuring health outcomes; we will publish them. This new wealth of data will help providers compare their performance with their peers and drive change where necessary, will help purchasers to use the best providers, and to keep track of their performance.

But perhaps most importantly, it will empower patients themselves to take more control of their care. If they need surgery, they will be able to choose not only the best hospital but the best consultant team for that type of operation. If they have a long-term condition like diabetes, they will be able to choose which provider or set of providers are able to offer them the care that fits around their needs and wishes.

This choice will place a huge incentive on health care providers to up their game. Basic principle here, of course, is the money follows the patient. If providers want to attract patients, then they need to offer them the best care.

In some cases, this might mean a patient traveling further to a better hospital. If it's important, then it will be worth it. It will be the choice of the patient to do so, and I'd also say insofar as patients often say, "But what I want is to have a good hospital local to me," if that local hospital isn't good enough, the publication of data and the capacity for choice is precisely the mechanism that is best calculated to arrive at a local hospital. That is good and is the choice of local patients.

Of course, to make this happen, we need good information technology. All the information in the world is no good if people can't read it, understand it, or make decisions based on it. So we're opening up the market for innovative IT companies and health care providers to develop products people can use.

My Department of Health is currently holding a competition to find the best health care apps and encourage the development of new ones. I want people to be able easily to see and compare the record of different institutions, different consultants' teams, different providers of health care. We have the technology. We'll soon have the data published.

I'm very excited to see what happens when the two come together to empower patients and energize clinical services—so what Michael Porter refers to as

value-based competition. Providers of care competing on the quality of what they can offer patients, not the price at which they can provide it.

I think the work we are doing on the outcomes framework on quality standards on a payment system for whole pathways of care—these are areas where we and other health systems, including here in America, can share experience.

But as well as refocusing the treatment side of health care, we need to do far more on prevention, on public health. In Britain, 1.6 million people are dependent on alcohol. Smoking still claims 7,000 lives a month. Almost a quarter of adults are now obese.

And it's the poor who disproportionately bear the brunt of ill health. We can't just wait for people to get sick and crowd our hospitals. It's far better for them, far better for the health service, far better for society to keep people healthy—at the very least, actively to manage them to keep them from getting any worse. So we're also reforming public health.

Of course, this is easier said than done. It's not wholly within the power of any government or health care institution. I can't force people to stop drinking or take up exercise. The Elimination of Obesity Act 2011 hasn't been written. I don't think it can be written.

But we can do much more to make healthy behavior easy and more effective. When someone weighs up the list of pros and cons, we can add a few more pros to the list, and we can do more to manage those most at risk.

I read an article recently in the *New Yorker* about how Dr. Jeffrey Brenner, a physician in Camden, New Jersey, used a statistical analysis of emergency room admissions. He found that one percent of the 100,000 people who made use of Camden's medical facilities accounted for 30 percent of its costs. A bit more digging and

a lot of hard work, and he started focusing on how to help that one percent. The focus was not on cutting costs, although that was a welcome side effect. His goal was to improve the quality of people's lives, and it's something we are doing too.

Yorkshire and Humber in the north of England—the ambulance service there gives local NHS commissioners a monthly breakdown of their top 10 most frequent callers. These people are then given intensive personalized help—not only to manage any chronic conditions, but to look at their lifestyle, their diet, their home—to look at the whole person rather than just treating the immediate symptoms.

The result for that group—a 60 percent fall in unplanned admissions, a 20 percent reduction in bed days, a halving of ambulance journeys.

Better care for patients, better value for taxpayers. By analyzing the data and intervening early, we can prevent what are often catastrophic outcomes before they happen.

Improving health, of course, will only ever be the result of a locally led partnership between the clinical commissioners of health care services and local government, the latter under our reforms providing not only social care services, but crucially, leadership in public health.

Integrating health, social care and public health together, to prioritize preventative care, to make health and social care more joined up and to impact on the wider and social determinants of health, local government occupying a central role in health improvement because they are the organizations who can themselves impact on education, on employment, on poverty, on housing, on environment and transport. Those wider social determinants of health, which we know will have the biggest long-term impact on the health of the population.

That local partnership that I describe will be mirrored by national

leadership, in setting evidence-based standards and outcomes for the NHS through the National Health Service commissioning board, through the Department of Health and through our responsibility for public health and public health England.

We will lead in the Department of Health on national health protection such as pandemic flu preparedness, on tobacco control and on health screening. And we will lead nationally on promoting health improvement, such as in the responsibility deal and change for life—as indeed, the national government, the federal government here is leading on health improvement in campaigns such as Let's Move.

So let me sum up. Aspects of our health care systems may be different, but we all face common challenges. Working out the best way forward will mean finding some common solutions. We have a lot to learn from each other, but we can work together, I believe, by focusing on outcomes. We can share experience of how we can align every incentive behind improving those outcomes. I think we all have a way to go in being more open and transparent, and we can all achieve much more by putting at least as much emphasis on prevention as we do on treatment.

I believe we can achieve great things—far better quality of care for patients and a far better deal for those who pay for care, whether it be through their taxes or, in your case, through their insurance premiums.

As we face up to the challenges of rising demand and cost pressures in both the United States and in the United Kingdom, I believe we can both draw on increasing evidence that we can achieve higher quality and reduce cost through clinically-led, accountable services incentivized to innovate around the needs and expectations of patients, delivering quality and value in improving health outcomes for all.

Thank you very much.

DR. MCCLELLAN: Well, thank you very much, Mr. Secretary.

While we're getting these microphones on, I wanted to just remind the people in the audience that we're going to start a discussion up front here, but definitely would like your participation in a few minutes. There will be some microphones going around so if you have some questions or comments, now's a good time to get ready.

To start off that discussion right now, though, I wanted to ask you, Mr. Secretary, about how you see this vision that you've laid out today, going forward with implementation.

A lot of the policies that you described sounds like are already very much part of the government's priorities, very much on an implementation course now. At the same time, there's been a lot of discussion around some major legislation related to health care reform in the United Kingdom. What is the role of the legislative reforms in achieving what you've just described, how important is it, how do you see that unfolding?

SECRETARY LANSLEY: Well, thank you, Mark.

I mean, the legislation is instrumental to the long-term stability of the reform process because if there were no legislation, then it wouldn't be possible, for example, to transfer the statutory responsibility for commissioning services into the hands of the clinical commissioning groups. It would stay in the management-led organizations that currently exist.

So although we already have throughout England clinical commissioning groups formed of general practices who, of course, in our system—virtually the whole population is registered with a local general practice—series of general practitioners and their colleagues. But they're working with a broader clinical community.

They created clinical commissioning groups. We've got about 250 of them across the country who are pretty much already in place, but it's not possible for them to go beyond, as it were, delegated responsibility for budgets from the existing

organization until we actually effect the legal change.

As I was describing, for example, the transfer of a local health improvement responsibility for public health into the hands of local government to impact on wider social determinants of health. That can't happen until the legislation has gone through, then we can put the budgets in their hands to make that happen and they have the statutory basis to do it, as local government tends to be a statutory body.

They've established their local boards. We've got about 130 of them across the country so we know they're ready to go. So to that extent, we are piloting and shadowing the whole system with relationships that are being established already. But the legislation, to that extent, is instrumental to achieving the long-term stability of that—because I think one of the things that—in the National Health Service in Britain—is that people have got very fed up with the idea that every year there's a new health bill and every year there's a new idea of how it should work.

And I know these are comprehensive reforms and I know that entails a lot of structural change. But it's there for a very simple reason—is that what it creates then is autonomy and accountability in the service with a stable structure for the long-term—and that, I think, is something which people in the service really will, in years to come, look back and say, "That was terrifically important," because previously, things just kept on changing.

A topdown system that every year had a new idea about how we should organize ourselves and what we should be doing and how we should be doing it. We didn't feel we had ownership of the system. We didn't feel we had ownership of the service we provide.

And one of the essential changes, from my point of view, I want us to make is that not only patients should feel more in charge of the care that is provided to

them and the decisions made, but that the clinicians themselves should take greater ownership of the service they provide. That can't happen in a topdown system.

I can't achieve that kind of fundamental transfer of responsibility and culture unless and until the legislation has taken that degree of day-to-day control out of the hands of Secretary of State. I must be responsible for their being a comprehensive health service. I must be responsible for the quality of what it does. I must be responsible for the outcomes we achieve, but I don't think I can achieve the best outcomes for the future unless and until I have understood that happens in a service that has greater autonomy day to day, and is transparent and accountable for the service and quality it provides.

DR. MCCLELLAN: And you feel like enough of the Parliament has come around to this view as well, that the legislation should be able to go through. Any particular concerns from providers, physicians, hospitals, from consumer groups that there are too many risks here?

SECRETARY LANSLEY: Well, the way it works—and you may have—I think actually in your own system, you'll be very well aware of how the legislative process works—is it feels a bit like a Christmas tree on a production line. As it goes along, everybody puts their own particular bauble on.

So yes, there's been quite a lot of action around that. And it's quite interesting because we did, earlier this year, engage intensively in a process of literally saying, "We've been very clear about the principles. Here is the legislation." Actually, people are saying they want to be reassured. They want to ask questions. They have concerns, and we did that intensively.

What is interesting is that many of the issues that then came forward were issues that were actually unresolved from the past and the simple fact of wanting to

have comprehensive health care reform meant everybody was walking in and saying, "Well, what's the answer to this?"

So, for example, the legislation when we published it said we weren't going to change the structure of education and training of health professionals in the United Kingdom. But we've had a lot of people who've come in and said, "Well, actually, one of the things you've got to do in this legislation is set out very clearly how you're going to reform the structure of education and training because you can't leave that out." So there's a lot of kind of solving problems from the past.

Another problem from the past was that there was no mechanism in place to deal with a service that was clearly failing. We need that to be there, not least because the only solution in the past has been, well, just give it more public money—and of course, every pound you give to a failing organization to meet its debts each year is a pound not available for providing health care for somebody somewhere else.

So we have to arrive at a place where we have not only a better regulatory system for delivering sustainable, viable services in the first place, but one that is equipped to intervene to ensure continuity of services. It didn't happen in the past but we're having to tackle those issues now.

Well, in terms of the Parliamentary process, our upper house, the House of Lords, are considering the bill. They supported in principle at second reading with a majority of 134. It's already been through the Commons. To that extent, I expect revision in the Lords. That's their job. And they are going about it in a constructive but critical and challenging way. I have no difficulty about that.

One of the reasons why the legislation is in order to provide a stable structure for the future—and a long-term structure for the future—to that extent, the more we build a consensus in the service about what the legislation achieves, the more we

deal with the concerns people have now, the less, I hope, in the future people will feel they need to revisit the legislation in order to tackle problems that haven't been dealt with now.

DR. MCCLELLAN: One of the points that you emphasize in your remarks were some things about the NHS that weren't changing as part of these reforms, and part of that was this commitment to access to care.

And I know, as you mentioned, there have been challenges there, but another point was the availability of care at a low or really at no cost to patients, to consumers, and that is a big difference from the United States, obviously, where not just the more conservative members of our legislatures but others as well believe that patients should have some accountability, some responsibility for some of the costs—and conversely, if they make decisions to stay healthier, if they make decisions to use care more effectively, that they should get some of the savings.

You put a big emphasis on how these reforms are going to lead to more patient choice in terms of GPs, in terms of hospital care, in terms of specialist teams and so on—as you said, money following the patient.

Is that going to be enough? There are a lot of people here who believe that you really need even more consumer involvement, consumer stake in care to drive real reforms in care.

SECRETARY LANSLEY: Well, I understand the view that says if people pay directly for something, they value it more. I actually think in the British context, where health care is concerned, people understand the value of the health care that is provided to them, and they don't need to have it itemized in a bill sent to them and pay for it out of their own pockets to realize that the National Health Service provides them something that they should attach enormous value to.

I think, generally speaking, it isn't the case that people in Britain consume large amounts of health care that they don't need to because it is free. And in particular, I think through the intermediation process with general practitioners, the relationship that is built up between the British public and their general practitioners is instrumental to the process of managing demand in a way that is responsible and effective.

Now it's not perfect, and I think that's one of the central reasons why I think we need to give patients a greater say in decision making. I don't think in a free system as a consequence of that, we are going to see irresponsible or excessive demand. I think patients themselves, given good information and opportunities to make choices, on balance will make decisions that are probably less costly, less invasive, less interventionist because they want to have care that supports them at home—and very often they don't want to be in hospital.

So issues like avoiding admissions to hospital—I think patients are with us on this. They're not conflicting with this.

The one thing I would say is important in terms of access that we don't necessarily achieve, where we do need to act, is to ensure that patients do have access to the latest and most effective treatments and medicines. And there particularly, we acted since the election and creation of the Cancer Drugs Fund because we knew that in Britain, for example, there was a very low takeup of cancer medicines within five years of their being introduced.

And I think that is absolutely an area where the public have an expectation and a right to expect that they should have access to whatever clinicians regard as the most effective treatment available, as long as it's cost-effective, but on that basis with clinical judgment, they should be able to get access to it.

I have to say when you look at the costs of—literally the transaction costs alone—of moving away from a taxpayer-funded service as the NHS is and the way in which we're organized, at the moment we have something like five percent of NHS costs consumed in administration. I'm planning to bring that down to about three to three and a half percent over the course of the next four years. That alone will save us about 1.5 billion pounds a year.

But that is very modest administration costs relative to the costs of the administration of insurance systems in the United States. So on that basis alone, I think there is—in a constrained financial environment, there's no intrinsic merit in moving away from the structure of the system we have.

DR. MCCLELLAN: I'd like to open this discussion up to some of the people who are here. So if—yeah, hands up. Let me start—Dr. Lewin, I'll do you here.

DR. LEWIN: Hi, I'm Jack Lewin with the American College of Cardiology. Thank you for that very enlightening presentation.

I wanted to ask you if, in terms of specifics—we're thinking here our health care costs are going up—GDP plus three percent or more. If we got down to GDP plus one percent, we'd probably eliminate our national deficit over a couple decades. Do you have a specific, targeted goal for how costs should rise? Is there a cap?

And then in terms of the hospitals and the physicians—in addition to the incentives, are there disincentives that are going to be employed as well?

SECRETARY LANSLEY: Yeah, thank you very much.

Of course, I'm responsible for a budget. It's about 105 billion pounds a year so in American context, it's not that large. But I don't live in—the health services, we do live in a budget. And I don't have a demand-led system.

So to that extent, yes, I do have an expectation about what we have to

achieve in terms of costs and improvement of services within that. Over these four years, where our planned spending through to 2015 is clear, the increase in that budget is very modest in real terms each year. Measured against the GDP measure of inflation, it's of the order of about one percent increase over that period—just over that.

What that meant, for example, this year compared to last year is that we've got just over three percent—about 3.4 percent more cash this year than last year. And we're expecting to live within that budget. We're expecting there to be a small prudential surplus. We're expecting to improve the quality of what we do against that.

That is contrary to the experience of a decade in which each year productivity was declining and where resources were rising at about seven or eight percent a year.

In order to achieve that, therefore—to put it in sum—it's something like a 30 percent potential impact on the NHS in terms of increasing demand and cost when you take demographics and other changes into account. So we've got about a 30 percent increase in potential cost. We've only got about 12 percent increase in cash. So we are going to have to deliver efficiency savings.

At the moment, we're in a position where we delivered 4.3 billion efficiency savings in pounds last year. We're planning 5.9 billion this year.

We're planning a total of about 18.9 billion potential savings, and we can see where they're going to come from. They come from constraining administration costs, from limiting pay inflation—which was a considerable component in the past—it comes from reducing the tariff and driving efficiency through tariff reductions. It comes through clinical service redesign, and a transfer of activity closer to home and into community and to less costly settings, and avoiding admissions and cost, and it comes from better prescribing management and better procurement. And we can see the shape of that

across the service as a whole.

About—yes, of course. I mean, in a sense, through the tariff—best practice tariffs—quality increments are all around a proposition of incentivization for quality. So at the margin, yes, there is an incentive for quality, there is a disincentive not to meet quality standards.

DR. MCCLELLAN: Next in the back.

MR. HEIN: Matthew Hein with the Department of Commerce.

My question relates to—you mentioned information technology very briefly in your discussion. How does the U.K. plan to institute that, especially as you're decentralizing a lot of these activities? Is there still going to be a central procurement arm that's handling a lot of those activities, or is that going to be disseminated outwards to the local commissions and stuff?

SECRETARY LANSLEY: Yeah, it's a good question.

My predecessors believed in central procurement. I'm afraid they tested to destruction the proposition, that the central procurement of health infrastructure and IT was the best way to achieve it.

There are some things you have to do. We've created a spine, a network so that all NHS organizations are able directly to transfer information to each other. We've got a central system of structure for the ability to transfer digital images across the service.

The prescription system has still not met its objectives but is a central system because we have a central billing and payment system back to pharmacists for the NHS prescriptions.

But we've resolved now, given the lack of progress and escalating cost potentially of doing it through central procurement—we had central procurements that

were something like 7.4 billion pounds, and they just weren't delivering. It was just too big.

And therefore, to arrive at a place which I think probably is closer to the way in which your own administration is tackling these things is to be very clear about now what the standards are for communication, being very clear ourselves what the care record needs to look like in order for people to be confident that they are getting comparable information about patients, wherever patients are presenting to clinicians.

But after that, allowing the hardware and software essentially to be offered to hospitals, surgeries, clinics on the basis that they are the customers—because our problem—one of the fundamental problems in our IT structure as my predecessors implemented it was the people who generally are the customers weren't the customers. The hospitals, the clinicians, the GPs—they were taken out of the loop of being the customers.

This was absurd. By 2002, even before they interfered, half the GP—the general practitioners—in Britain already had their own IT systems in place. They could so easily in 2002 have said, "Let's go with that. Let's back it up. Let's make sure they can all talk to each other," and I think some years ago, we'd arrived at a place where 100 percent of general practices would actually have had good IT systems in place.

DR. MCCLELLAN: I think we have time for one more—maybe over here. Wait, wait—a microphone.

SPEAKER: (Off mic)—need a system like the U.K. I am a user now of the GPRD database and it's magnificent.

The thing that I would like Mark and you to talk about is how we can learn from what you are doing, and share in some kind of formal network and not keep reinventing the wheel. We have 30 silos of data in this country that can't talk to each

other. You have one principal database, which I understand you're going to be enlarging, to account for more and more of the patients in your country.

We need to share experience, but when you go to Capitol Hill and you talk to some of the idiots in my Republican Party, if you mention that the U.K. has something good, they sneer at you, okay?

I brought a copy of the *Electronic Medicines Compendium* here to the United States and had to re-bill it. We call it the *Electronic Medicines Compendium* in the U.K. We call it *Daily Med* here in the United States. You are four years ahead of us.

But when I was touting it as something from the U.K., I was fought. This is impossible. We need to learn from each other, and we need a formal mechanism to share not only with you but the rest of Europe, and we're not doing it.

Thank you.

SECRETARY LANSLEY: Thank you for that.

Let me just—first thing I'd like to say—Mark will recall, I was here literally with Mark, talking to Mark about two and a half years ago—and I think this is a two way traffic.

I mean, I remember when I was here, for example, conversations with your National Quality Forum, which pointed me towards what more we should be doing in relation to the identification of never events in hospitals, which actually, we've since the election—just in the course of last year—consulted and implemented an enhanced structure of never events.

But I was here, I think, talking to some of your colleagues. It was clear under Medicare that the payment system was going to be adapted so as to incorporate readmissions so as to avoid that perverse incentive for readmissions, which is precisely the path down which we're going. So there is two way traffic.

And indeed, if the National Institute for Health and Clinical Excellence—NIHCE—in my country—I think after Britain, the largest number of hits on its website are in America because it is providing high quality appraisal of clinical and cost-effectiveness of treatments.

The problem is a political one, is that the way in which it happens in Britain is in the context of making a decision about whether a particular medicine is sufficiently cost-effective to be available through the NHS. Well, as it happens, I want to arrive at a place through the value-based pricing of medicines where NIHCE no longer has to make that kind of decision, that the economic evaluation and appraisal of medicines is one part of a process, as it were, of establishing the reimbursement price for medicines.

So the job of NIHCE, hopefully from your point of view in America, becomes something which doesn't have that rationing issue attached to it. It is simply we need to do high quality appraisal.

I'm very pleased to hear what you say about the general practice research database. It is very important. I can tell you that we are indeed—one of the most important facets of having a National Health Service is that we have in England 50 million patients who, by the virtue of the characteristics of Britain, actually are themselves ethnically diverse as well.

So we actually have populations which, from the point of view of, for example, clinical trials or even more so the examination of the relative effectiveness of treatments in practices, gives you a unique capacity to understand the effectiveness of health care treatments and systems.

We are going to do more to link datasets in Britain. I think the Medicines Health Care Regulatory Agency and ourselves just published some information about

how we're going to go about that task. We'll have more to say soon about that, but I hope it will present something which is pretty unique across the world for health researchers.

DR. MCCLELLAN: And so you see NIHCE as becoming less about making --

SECRETARY LANSLEY: Not about rations.

DR. MCCLELLAN: —decisions and more about driving better outcome information and --

SECRETARY LANSLEY: About identifying quality, about how you commission for best clinical effectiveness and about --- for assessing, rigorously assessing the relative clinical and cost-effectiveness of treatments and treatment processes, but where medicines are concerned, instead of the application of an arbitrary threshold, broadly speaking, what I want to move to—and we intend to move to by 2014—is a system where for new medicines that become available, we will establish what is a value-based price for that, which will incorporate not only its therapeutic benefit—obviously things like the incremental cost-effectiveness ratio—but also its innovative value, the extent to which it responds to unmet needs and its wider societal benefits.

So, for example, if you have a medicine which—and this fell foul of NIHCE. If you recall, there was a number of treatments for Alzheimer's disease at early stages, which—the principal impacts of which were to delay the further progression of the disease but didn't actually have much impact long-term on the point at which patients went into residential or nursing homes.

So they didn't actually have that much impact on the overall medical cost, but they had quite a big impact on the extent to which those individuals were able to work and quite a big impact on the extent and the time at which their terrors --

DR. MCCLELLAN: In the past, those drugs have not been used much in the U.K.

SECRETARY LANSLEY: Those drugs weren't used. They are now being used. The NIHCE evaluation has shifted, but from our point of view, that's an absolutely classic illustration of where you've got to address, as it were, the wider societal benefits of medicines, as well as seeing them purely by therapeutic reference.

DR. MCCLELLAN: Well, clearly this discussion could go on for quite awhile longer. Lots of interesting topics. As we've seen, some big differences across our health care systems, but a lot of similar commitments to try to address challenges about improving outcomes, about addressing rising costs and hopefully more opportunities to learn from each other in the future.

I hope we can have you back again as these reforms progress.

Thank you all for joining us today.

SECRETARY LANSLEY: Thank you very --

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