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The NHS in 2008: Is the contribution of health economics a "fair, but could do better"?

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ABSTRACT

Since Oliver's (Oliver 2005) summary of the English NHS between 1979 and 2005, there has been considerable development of the policy agenda. This is most notable in the approach to competition and choice being pursued by the Department of Health. This paper provides an update on the major policy initiatives that have taken place since 2005, from an economics perspective.

Against this background the key activities (in terms of employment and publications) of health economists in the UK are described. Less than 5% of UK HESG members work for government or NHS bodies and publication of economic evaluations outnumber those relating to policy by a factor of 2:1.

The results of the review indicate that health economics continues to be preoccupied with microeconomic evaluation and remains relatively muted on the key economics questions lying at the heart of NHS policy today.

A research and engagement agenda is proposed that would facilitate a much greater connection between NHS policy formulation and evaluation in England and the health economics community. Without a reappraisal of its contribution to the NHS, health economics risks marginalisation, decreasing relevance and a sense that it could indeed "do better".

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1 Introduction

NHS policy has developed rapidly since 2005. Here, the key components are described. An exploration of the activities of health economics and health economists is undertaken and an assessment of the relevance to the NHS provided. A series of fruitful areas for further research and engagement with the service is proposed for discussion and debate within the health economics community.

2 NHS Policy Development Since 2005

In 2005, Oliver[1] provided a comprehensive description of the NHS in England between 1979 and 2005 and the key policy initiatives and developments under the successive administrations of Thatcher, Major and Blair. As well as a comprehensive description of how targets, funding, administrative structure, resource allocation methods, payment systems and outcomes had evolved over that time, he also flagged the likely importance of choice and competition as key tenets of government policy for the future:

> "*emphasis on competition and choice will probably lie at the centre of Government policy for the foreseeable future*."

Choice and competition have indeed formed important parts of government policy with respect to the NHS in the intervening 3 years, but this has been alongside other policy initiatives. Described below are some of the key developments that have taken place that are of interest from an economics perspective. Choice and competition are described within this context.

2.1 Choice

At the beginning of 2006 patients were given the right to choose between at least 4 hospitals for non-emergency treatment (with some limitations for example where care centres in England are restricted through national designation processes and in maternity care where the choice guarantees will be effective at the end of 2009 and relate separately to four key stages of care[2]). In April 2008 this was extended to allow patients to go to any hospital in England, including many private and independent hospitals now providing NHS services. This was not to be choice for its own sake but to encourage competition between providers for patient activity and thereby improvement in services to ensure a competitive edge. It was described thus by the Department of Health (DH):

> "[Patients] *will choose services that have the best clincial services; services that put their needs first; listen to what they have to say; explain what their care will entail; and make every effort to ensure it runs smoothly without irritating duplications and delays*."[3]

Providers are now also expected to accept all clinically appropriate referrals through online and direct patient booking.[4]

In addition both providers and commissioners are now expected under the new Rules[5] to "foster patient choice and ensure that patients have accurate and reliable information to exercise more choice and control over their healthcare".

Whilst this is undoubtedly the continued development of previous government policy the extent to which money will follow the patient and the freedom patients have to access any clinically appropriate services in England (rights are also available to access services in Europe under certain circumstances) is now almost complete. Providing and encouraging choice is the key lever to ensure that providers become more competitive and efficient, thereby ensuring that their activity and income not only persists, but potentially grows. If they do not compete successfully, their income will suffer.[6,†]

2.2 Competition (and co-operation!)

The DH's Operating Framework published in December of 2007 included an Annex that set out a new series of principles and rules to guide the practice of competition and co-operation within the NHS and its place in a wider health care market.[7] Competition (in conjunction with choice) was described as capable of improving quality, efficiency and reducing inequalities, but only in the context of a clear set of rules and guidance. The principles are reproduced in full at Table 2.1 (the rules are the more specific requirements that sit underneath the 10 principles). The most far-reaching of these is the first, where commissioners' activity will not be presumed – PCTs will need to demonstrate that the providers they have contracted with do fulfil patient needs regardless of their organisational form (be it NHS, private, social enterprise, third sector etc.) and that these decisions withstand external scrutiny.

These principles and rules came in to effect in April 2008. A host of complementary guidance has also been issued under the banner of "system management" and together they represent a very significant shift from an internal to a fully open health care market in England. For example, Primary Care Trusts (PCTs) are now required to actively consider open procurement for any new or significantly changed service and report any decisions not to pursue an open procurement route to their Strategic Health Authority (SHA). The spectre of EU Competition Law is also now much more evident in NHS business in England with state aid and subsidy risks coming under the auspices of principles seven and eight.

Alongside this guidance a new National Panel for Co-operation and Competition has been established and will be effective from January 2009. This Panel will adjudicate in some reserved matters (such as testing taxpayers' interest in any proposed mergers or acquisitions) as well as resolve any disputes that cannot be resolved at a PCT or SHA level. Aggrieved parties will be able to pursue formal dispute processes at PCT, SHA and National Panel (and indeed judicial review) level if they can demonstrate that any of the principles or rules may have been breached.

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† Although the extent to which NHS providers will be allowed to fail is currently a matter for debate – trading off the competitive incentive created by potential failure against a history of substantial public sector investment in organisations. The consultation on the failure regime for unsustainable providers closed in early December 2008.

In parallel, a suite of standard national contracts (which are legally enforceable with Foundation Trusts) are now available[8] and PCTs are required to use these when entering into any agreements for the provision of health care to their resident population.

Table 2.1 Principles for Co-operation and Competition

1.	Commissioners should commission services from the providers who are best placed to deliver the needs of their patients and population.
2.	Providers and commissioners must cooperate to ensure that the patient experience is of a seamless health service, regardless of organisational boundaries, and to ensure service continuity and sustainability.
3.	Commissioning and procurement should be transparent and non-discriminatory.
4.	Commissioners and providers should foster patient choice and ensure that patients have accurate and reliable information to exercise more choice and control over their healthcare.
5.	Appropriate promotional activity is encouraged as long as it remains consistent with patients' best interests and the brand and reputation of the NHS.
6.	Providers must not discriminate against patients and must promote equality.
7.	Payment regimes must be transparent and fair.
8.	Financial intervention in the system must be transparent and fair.
9.	Mergers, acquisitions, de-mergers and joint ventures are acceptable and permissible when demonstrated to be in patient and taxpayers' best interests and there remains sufficient choice and competition to ensure high quality standards of care and value for money.
10.	Vertical integration is permissible when demonstrated to be in patient and taxpayers' best interests and protects the primacy of the GP gatekeeper function; and there remains sufficient choice and competition to ensure high quality standards of care and value for money.

Adoption and compliance with the new principles and rules in the health care market in England will result in greater plurality of providers delivering NHS services to patients and a much more "business-like" and open approach to the commissioning of health services.

2.3 World Class Commissioning

As well as a new set of rules, the DH has also embarked on considerable skill and talent management on the commissioning side of the table. This programme is known as world class commissioning[9] and developed from "Commissioning a Patient-Led NHS"[10]. It aims to make PCTs more strategic in their approach and focused on the delivery of improved health outcomes and reduced inequalities. As well as support and development, the programme also specifies a range of competencies[11] (with varying levels) that PCTs require to achieve "world-classness" in their commissioning efforts. 2008 marks the first year for PCTs to be formally assessed against these competencies.

At the time of writing, these "panel assessment days" are still underway across much of England. The first assessment year is to some extent testing the system and providing 12 months grace for PCTs to respond to the results. In 2009 the assessment will be conducted again and the results for every PCT will be available publicly.

Many of the competencies have economic concepts at their core and some of the sub-competencies have very specific reference to economic ideas and thinking. These include specific references to understanding the marginal cost curves faced by providers and the use of programme budgeting marginal analysis to underpin allocative and technical efficiency assessments and decision-making. The headline competencies are reproduced in Table 2.2.

Table 2.2 World Class Commissioning Headline Competencies

1.	Recognised as the local leader of the NHS
2.	Work collaboratively with community partners to commission services that optimise health gains and reductions in health inequalities
3.	Proactively seek and build continuous and meaningful engagement with the public and patients, to shape services and improve health
4.	Lead continuous and meaningful engagement with clinicians to inform strategy, and drive quality, service design and resource utilisation
5.	Manage knowledge and undertake robust and regular needs assessments that establish a full understanding of current and future local health needs and requirements
6.	Prioritise investment according to local needs, service requirements and the values of the NHS
7.	Effectively stimulate the market to meet demand and secure required clinical, and health and well-being outcomes
8.	Promote and specify continuous improvements in quality and outcomes through clinical and provider innovation and configuration
9.	Secure procurement skills that ensure robust and viable contracts
10.	Effectively manage systems and work in partnership with providers to ensure contract compliance and continuous improvements in quality and outcomes
11.	Make sound financial investments to ensure sustainable development and value for money

This emphasis on the commissioning agenda for PCTs is also being reflected in imminent requirements for the separation of the provision and commissioning elements of PCTs. As of April 2009, PCT provider arms will need to reach a state of "business readiness" to enter contractual arrangements with their commissioners. This will start a process of formal separation and the creation of new legal entities, some of which may utilise a social enterprise rather than NHS model.[12]

2.4 Next Stage Review

The Next Stage Review (NSR), led by Lord Darzi, resulted in an array of national[13] and regional strategy statements. It contains many specific requirements for all elements of the NHS. Of particular note is the fact that this national policy

document contained no new national targets for the system and instead placed a significant emphasis on quality. The approach throughout the documents is that much has been achieved in terms of reducing waiting times and the significant increases in investment and that the focus for the service now needs to be on systematic delivery of quality health care.

In addition, this national policy signalled the aspiration to move to personalised budgets for individuals with long term conditions, allowing them to exercise choice and control over their care packages.

Finally, the NSR placed emphasis on the need to stimulate and nurture innovation in the NHS to deliver not only improved quality but greater efficiency in the system. Various policy initiatives are being brought forward to foster this approach in the system. These include a legal requirement for SHAs to promote innovation in their regions as of 31 December 2008.

2.5 Quality as the "organising principle"

As noted above, the NSR placed a strong emphasis on quality of health services. This has also been reflected in the Operating Framework for the NHS in 2009/10 where quality is described as the "organising principle" for the NHS.[14]

Of particular note from an economics perspective is the following statement in the Operating Framework:

> "*Measurement is the backbone of the quality system because without measurement we cannot demonstrate improvement…This is a key element of the quality framework and should be an important priority for all NHS organisations*."

A new payment framework for providers has also been announced, known as Commissioning for Quality and Innovation (CQUIN). In the first year, commissioners can choose to link 0.5% of contract values to the measurement of quality and acute contracts have to include a link to the achievement of specific quality goals. The proportion of the contract linked to performance will be increased in coming years.

In parallel a series of Patient Reported Outcome Measures (PROMs) will also be utilised. Initially, these will be restricted to four high volume elective procedures. Measurement will commence in April 2009 and the intention is to expand the coverage to more interventions. As well as a disease / condition specific measure, PROMs will be utilising the EQ5D to assess the change in generic health status.

2.6 Resource allocation

December 2008 has also marked the introduction of a new resource allocation formula for PCTs in England.[15] This represents a further development in the approach to measuring population, age, needs and the market forces factor. In addition, a separate, normative health inequalities adjustment was also

recommended as an interim measure by the Advisory Committee on Resource Allocation.

The influence of economic concepts and health economists has been apparent through every iteration and development of the methodology since it first emerged in 1972.[16] Indeed the monopoly of health economists in this policy area is so complete that it has drawn criticism from other disciplines![17]

Allied to the issue of resource allocation and distribution has been the significant procurement of additional GP practices and health centres across England. This represents approximately 100 new GP practices in the 25% of PCTs who are most "under-doctored" as well as at least one new GP-led health centre in every PCT in the country.[18] At the time of writing many PCTs are reaching financial close with providers and the first services will be operational by the beginning of 2009. It is worthy of note that these procurements of new services have been undertaken in the context of the new Principles and Rules for Co-operation and Competition described above.

2.7 NHS constitution

July 2008 marked the 60th anniversary of the establishment of the NHS and part of the government response to this milestone has been the proposition that a constitution should be developed to underpin the rights that patients, staff and the public hold with respect to the NHS. This is currently under development and is anticipated early in 2009. A full consultation document was published in 2008 and closed in October.[19] This document distinguished between proposed rights, for example to choice of location for clinically appropriate treatment, and pledges where the NHS will strive to deliver particular standards of treatment and care. The constitution is likely to embody the most explicit set of statements and objectives for the NHS since its inception in 1948 and will represent a clear blueprint for evaluation and assessment.

2.8 Review of co-payments / "top-ups"

A major development throughout 2008 has related to the appraisal and rationing of new drugs, and in particular high cost, low volume pharmaceuticals for patients with cancer. In part, this was a direct attack on the National Institute for Health and Clinical Excellence (NICE) by a London oncologist in response to NICE's guidance on a new drug for kidney cancer. This culminated in an article in the Daily Mail[20] with the headline of:

> "*Arrogant, illogical and totally out of touch. NICE must be scrapped…it's killing too many people*".

A modest media frenzy then arose in Britain over the summer where NICE itself was attacked as was its cost per QALY threshold of ~£30,000. This included the need for NICE to explain publicly not only the concept of QALYs but its willingness-to-pay threshold. This does to some extent illustrate the very significant influence that health economics has had upon NICE. This influence is further substantiated by the

methodology guides produced by NICE[21] and the clear evidence of complex economic appraisal within the guidance it issues to the NHS.

The speed of NICE appraisals was addressed directly in the NSR[22], which described a requirement for NICE guidance on new drugs "within a few months" of launch and was a direct response to criticism of the lengthy appraisal timescales for some medicines.

Also announced in the NSR was a review of the arrangements for patients who want to fund non-NICE approved drugs privately as part of their course of treatment. Presently, (although the policy and guidance is not particularly transparent or uniformly implemented) if a patient elects to receive part of his / her care privately then he / she is required to receive all of their care privately – co-payments or top-ups are not permitted.

This review, led by Professor Mike Richards, was published in November after a period of consultation. Patients will in future be permitted to make top-up payments to receive non-NICE or PCT approved medicines without compromising the NHS status of the rest of their care package.[23] The implementation framework for this policy is currently being consulted upon.[24]

2.9 Changing macro-economic environment and public sector financial position

As well as citing the likely importance of choice and competition, Oliver[25] also foretold the most important development around the public sector in the UK in 2008:

> "*At some point in the future, there will once again be a greater constraint on NHS spending that there is today*."

The credit crunch and recessions across western economies has completely changed the landscape in which the public sector is operating. We now know from the recent pre-Budget statement that efficiency savings to pay back government borrowing will come in to place in 2011/12 with the possibility of the NHS contributing up to £2 billion of the £5 billion of public sector efficiency savings. The Operating Framework for 09/10, included the following statement:

> "…*in the current economic climate, it is appropriate that the NHS with other public services goes further and deeper in making efficiencies to contribute to returning the economy to balance*.."

The programme of world class commissioning is also being described as the vehicle "*to unlock a range of productivity opportunities such as by reducing pre-operative bed days and reducing outpatients DNAs*".[26]

For 09/10 and 10/11 the headline growth in average PCT allocations is 5.5% (with a minimum of 5.2% in 09/10 and 5.1% in 10/11).[27]

The NHS is also being asked to contribute to the Keynesian pump-priming of the economy by, for example, bringing forward major capital development schemes wherever possible.

These drivers will be impacting on the NHS at the same time as demand on health services is likely to change as a direct consequence of the recession through the health impacts of increased unemployment and economic vulnerability amongst the population.

2.10 Ongoing development of the tariff

Under the policy known as "Payment by Results", the NHS in England operates a system of fixed prices or tariffs for the vast majority of acute care. For 09/10 substantial revisions have been put in place. These are driven by two factors – the use of the latest available healthcare resource groupings (HRGs) and the incorporation of the new market forces factor calculated for the latest round of resource allocation methodology.

The greater granularity of HRG4 (which has been heavily informed by clinicians) should reflect more closely the actual costs faced by providers in delivering care, although these changes in income for providers are likely to create some organisational turbulence for specific providers. There is also a clear signal that the tariff will be developed to reach beyond acute services and will also move to a "best practice, best value" rather than a cost reimbursement basis.[28]

2.11 An economics perspective on NHS policy

It is unsurprising that the governmental approach to health and health care in England between 2005 and 2008 constitutes a busy policy landscape - it was ever thus! However, what is of particular note is the extent to which economics, and specifically health economics, have a direct relevance to the policy agenda being pursued. These cover areas as diverse as: the informational asymmetry faced by patients exercising "choice" and between commissioners and providers of services; the operation of incentives for innovation and efficiency in the system; the equity consequences of "top-up" payments; and the operation of an open market in a system of (largely) fixed prices.

Current policy and approaches to health and health care in England (probably) represent the clearest opportunity for the contribution of health economics and economists to policy thinking, development and evaluation that there has ever been in the 60 year history of the NHS.

3 Whither Health Economics?

Given the substantial presence of economics issues in current policy approaches, it is valuable to ascertain the extent to which economists and economics research are contributing to this agenda. This was addressed in two ways. The first was to examine where health economists work as an assessment of their direct contribution to policy. The second was to explore the literature in terms of research and commentary by economists, or by those using economics concepts, on policy relevant topics.

Turning first to where health economists are employed. The HESG membership database was accessed in early December 2008. Within this database, members have the opportunity to describe their organisational affiliation. Many members do not take this opportunity and in these cases email addresses were used wherever possible to assign members an employer. Using these data, members were assigned to the following categories:

University sector
Private consultancy
Pharmaceutical and devices companies
Government
NHS
Other (this included, for example, charitable institutions)
Non-UK
Not Known

A total of 16 members (4.13%) were deemed as "not known" due to the employing institution not being recorded nor readily discernible from the email address provided. A further 34 (8.79%) were categorised as non-UK based, again based on employing institution or email address provided.

Table 3.1 provides a breakdown of where HESG members are employed as a percentage of those for whom the employing body is known and UK based. As is apparent, the least frequent of the five categories of employment are government and NHS bodies. HESG membership is overwhelming dominated by the university sector. This is perhaps not surprising given that the group is described as having "*an academic function – the creation and transmission of knowledge and ideas*". However, given that the membership is depicted as working "*in commercial, academic and government settings*" and the interests of the group are expressed as "*applied and policy orientated as well as theoretical*", these data could be viewed as somewhat unexpected.[29] Given the complex economics agenda described above within health and care, these data could be interpreted as an indication of a lack of engagement by the sub-discipline with these policy questions.

Table 3.1 Employers of HESG Members

Employer	**Percentage of UK HESG Members where employer is known (n=337)**
University sector	70.6
Private consultancy	6.2
Pharmaceutical and devices companies	15.4
Government	2.7
NHS	1.5
Other	3.6
Total	**100**

However, these results may be misleading in two ways. First, it is possible that not all health economists join HESG and that this is biased such that health economists who work in government or the NHS are less likely to join the group (although this does perhaps pose questions about the nature of HESG itself that are probably best

left to another paper or the business meeting!). Second, it may be that health economists working in fields other than government and the NHS are making active contributions in terms of applied research, evaluation and commentary.

Tackling selection bias in HESG membership and the career destinations of all health economists is beyond the scope of this paper, as is the unobservable activities of non-HESG members providing direct input to policy without any publications.

In an effort to explore the extent of non government / NHS economists engaging in policy, a review[‡] of the literature was undertaken. The purpose of the search was to determine how much of the health economics literature related to NHS policy as compared to the rest of the literature discussing health economics.

The search was conducted on Medline, HMIC and EconLit to capture as diverse a range as possible of the literature. The search was limited to 2005 – 2008, and to the United Kingdom, or England where possible. The majority of the initial broader search was carried out on Medline but the final subset of results relating to health economics and NHS policy was drawn from all 3 databases.

Initial scoping searches with broad search terms such as "economics", "health economics", "econometrics", "applied economics" and "cost effectiveness" revealed an extremely broad body of literature concerning health economics. The search was refined using appropriate subject headings and the geographical and date limits above, to focus on the literature specifically discussing the concept of health economics in the United Kingdom and give a manageable number of references for the purposes of this review.

Abstracts for these papers were then reviewed and categorised. The final set of relevant papers numbered 220. Of these, 124 dealt with technology appraisals and economic evaluations, whilst 68 dealt directly with policy issues in the NHS. Twenty-eight articles dealt with other topic areas within health economics. As Maynard and Kanavos[30] described in their review of topic areas covered in the Journal of Health Economics and Health Economics:

> "*Microeconomic evaluation at the treatment level is an activity that preoccupies many health economists*"

The literature review and analysis of HESG conducted here would concur with this observation. This is not to underestimate the very significant contribution of economic evaluation, especially through the systematic examination of analysis and evidence conducted by NICE and the direct influence this has on key decisions within the NHS. However, as a discipline there is a need to consider the opportunity cost of applying all of this scarce skill and expertise to only one of the eight boxes in Alan Williams' all encompassing "plumbing diagram"[31].

[‡] This review was more sophisticated than "cursory", but not as all embracing as "systematic" and is an element of this paper that very much represents "work in progress".

Given the review presented here of NHS policy and the significant economics questions it poses, there is a broader, more policy relevant, programme that health economics and economists in England could be pursuing. The danger is that the pre-occupation with microeconomic evaluation effectively crowds-out much more significant policy and decision-making issues being faced by the NHS. The importance of these policy decisions relates not only to the quantum of resources involved but also the longer term consequences for future policy options. Health economics as a sub-discipline and health economists as individuals need to consider their ongoing relevance to the world's largest publicly-funded health care system. As part of this discussion and debate the final section of this paper below proposes a potential agenda for research and engagement for health economics in England.

4 Proposals for Health Economics Research, Evaluation and Engagement

This section of the paper has deliberately not been restricted to the description of a "research agenda". Whilst research and evaluation are undoubtedly critical and fundamental aspects of health economics' interface with policy there is also a pressing need for direct engagement with policy formulation and interpretation. Decision-makers frequently describe the value of the different perspective and approaches that economists bring to problems and challenges. As a result this agenda should not be interpreted as exclusively about research and evaluation but also about the need to connect more fundamentally with the NHS and government policy.

The following key topics are not intended to be exhaustive or represent anything other than a personal perspective in light of the policy agenda. They are intended to act as a framework for further discussion and debate.

1. Macro-economic circumstances

The unfolding economic circumstances of the UK are likely to have a direct impact on the demand for NHS services. Can we predict this change in the volume and type of demand and what might its implications be for the service?

How will the NHS manage the tightening financial position? Are there lessons to be learned from previous experiences of constrained financial settlements? Where are the key areas for productivity and technical efficiency gains?

2. Quality

What is the best way to incentivise quality improvements amongst providers of services? What is the optimal way of making these payments? How should quality be measured? What role should PROMs have?

3. Mergers and acquisitions

How should the impact of mergers and acquisitions (M&A) be tested and evaluated in a system where prices are largely fixed? How can the broader evidence base from economics on M&A be interpreted in the NHS context?

4. Competition

What would economics predict as the likely outcome of an open market in health care? What are the inherent risks and potential unintended consequences? How should these risks be measured and evaluated?

Whilst the equivalent of an "Ofhealth" has not been created, regulation of this new market will be undertaken by a host of organisations[§]. What lessons can be learned from other regulatory systems and indeed insights from the economics of regulation?

5. Informational asymmetry

Given the extent to which patient choice is a key policy lever in a rules based and more competitive provider system, what can be done to reduce informational asymmetry and thereby increase the extent to which patients make informed choices about their care provision? How will patients be likely to exert this choice and purchasing power in relation to personalised budgets? What impact will this have on the range and type of care utilised? Will outcomes improve? Might some patients default from this decision-making arena, and if so, why?

6. Quality of commissioning

What insights could economics offer on the commissioner: provider relationship? Could such thinking be utilised to assist in the development of PCTs to become "world-class" at what they do? What economics analysis and thinking could underpin commissioning decisions for populations to improve health and health care?

7. Innovation

Does the NHS under-innovate? What might the explanations for this be? What could be put in place to reduce these barriers to innovation? How might SHAs approach their duty to promote innovation?

8. Tariff setting

How should the tariff be derived? What incentives would different approaches create? What would be the implications of using different models? How would these fit with broader NHS objectives and likely future financial circumstances?

9. Increasing GP practices

What is the impact of increasing the number of GP practices in particular areas? Does it increase the number of GPs? Does it improve equity – in access and / or outcomes? Is the plurality of providers increased? Does the competition for primary care activity improve quality across all providers? How mature is the market for primary care services and was it able to respond adequately to the step change in volume of provision?

[§] These include the National Panel for Co-operation and Competition, Strategic Health Authorities, Monitor, Primary Care Trusts, the Care Quality Commission, Advertising Standards Authority, Secretary of State for Health, Department of Health, Office of Fair Trading and the Competition Commission.

10. Provider economics
In the context of fixed prices (and considerable anecdotal evidence regarding variable profitability), how should system managers seek to shape the provider landscape to maximise outputs and what role might specialisation play in this context?

5 Conclusions

NHS policy is developing rapidly in England. This can be observed particularly in relation to choice and competition. With respect to choice for acute elective care, this is now almost entirely open for English patients to travel to any provider they choose. This is being facilitated by interactive booking systems to allow patients to select convenient slots and locations as they see fit. At the same time as choice is being expanded beyond acute elective care, the market for health care is now subject to a set of rules that confers no preferential treatment on existing providers and requires commissioners to actively source services that meet their population's needs and not those of their traditional, local provider.

Alongside choice and competition, as well as a suite of other policy initiatives, there is a significant set of economics questions at the heart of NHS strategy in England today. This large and complex programme is not matched by either the location or research interests of UK health economists.

To ensure continued relevance to the NHS in its 60th year, health economics needs to consider the extent to which it engages with policy formulation and implementation (as well as its evaluation and research) and whether the time and energy allocated to microeconomic evaluation represents the best use of the scarce resource that is health economics. Returning to the original question posed by the title of this paper, the contribution of health economics to the NHS in 2008 could certainly "do better", especially when considering contributions beyond those made to NICE and the derivation of national resource allocation formulae.

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