



BUPA's Response to HM Treasury's consultation on 'Securing Good Health for the Whole Population'

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Executive Summary

- BUPA welcomes this consultation and the opportunity to contribute to the debate on how public health interventions can be made as cost-effective as possible.
- BUPA continues to have concerns about the risk of unmet demand on the healthcare system over the next 20 years. The government needs to mobilise all the resources available -including those of the independent sector- to boost capacity and choice.
- The independent healthcare sector could be much more fully engaged with the public health agenda.
- The main thrust of this response is that the role of employers has been underemphasised - the proposed framework for investment should therefore major on the role of employers.
- The *fully engaged* scenario implies more encouragement of voluntary involvement and payment in health.
- Public financing is still often confused with public provision: voluntary and not-for-profit companies can also make public health interventions, as well as plcs and the statutory sector.

Introduction and background information about BUPA

BUPA welcomes the opportunity to contribute to this consultation process because the company has a great interest in improving public health and in making cost-effective decisions about health interventions.

BUPA is a provident association. This means that any profit is reinvested in better schemes and services for the benefit of BUPA's customers, extending choice of high quality care and treatment to the communities we serve. The Association's Articles encourage "the prevention and relief of sickness"...and "the promotion of health".

As the leading independent organisation in health and social care in the UK, BUPA makes a major contribution to improving public health. BUPA treats around 230,000 people in its hospitals and arranges treatment for 750,000 people with health insurance each year. That is nearly one million people whose treatment would otherwise fall to the NHS.

BUPA is a broad-based health and care organisation with a growing international presence. It has operations in Ireland, Spain and Malta, Saudi Arabia, Thailand, Hong Kong, Singapore and Australia. It has more than seven million customers in 180 countries and approximately 40,000 employees.

Its main interests are health insurance, hospitals, nursing and care homes, health assessments, workplace health and childcare services, and recruitment services for healthcare professionals.

In the UK, BUPA runs 34 hospitals, and the first privately operated Diagnostic and Treatment Centre. In 2003, BUPA will treat approximately 15,000 people under the Concordat with the NHS and a further 12,000 at the NHS-funded Redwood DTC. Quality of care is crucial to achieving cost-effective public health gains. BUPA Hospitals focus on the effectiveness of treatments, and take steps to measure the health outcomes of their patients.

BUPA Wellness provides over 75,000 health assessments a year - helping people to become fully engaged with their own health, and supporting them in making lifestyle changes. BUPA provides health service support to more than 50 per cent of the companies in the FTSE 100.

BUPA Care Services is the largest provider of nursing care in the UK. It cares for over 17,000 residents in 246 care homes. As approximately 70 percent of residents receive some form of state support this is a long-standing public/private partnership.

BUPA Membership, as a commissioner of clinical services, has a strong record of driving quality initiatives in the independent sector. It accredits breast and bowel cancer units in both independent and NHS hospitals; it encourages appropriate delivery of care, and has co-funded BUPA's leading edge work on the measurement of clinical outcomes using patient survey tools.

BUPA Hospitals also supported this work by implementing the survey across their network, having already introduced evidence-based care pathways with the support of their consultants. In common with other independent hospitals, they have also joined a benchmarking scheme to measure clinical performance indicators across the sector in a consistent manner.

As an insurer, BUPA Membership assesses the cost-effectiveness of new treatments and works with employers to tackle sickness absence.

BUPA is a leader in good employment practice; for example in March 2002 BUPA Care Services won the Large Employer Award at the New Deal Awards in recognition of its demonstrated commitment to diversity and equality.

BUPA makes a big investment in the training and education of its staff; particularly in management training and in post-graduate and post-registration courses for clinical and professional staff.

BUPA gives in excess of £1.5 million a year to the BUPA Foundation, a medical research charity which supports original medical research in three areas:

- Epidemiology;
- Surgery- with particular emphasis on the evaluation of health and economic outcomes, and
- Communication between healthcare professionals and patients.

The Foundation also runs an annual thematic competition encouraging applications for up to £500,000. This has included the reduction of adverse events in hospitals and surgical innovation. Finally, the Foundation promotes excellence through its annual awards which recognise outstanding work in six different medical fields.

BUPA Community Connections organises local charitable work in areas where BUPA is a significant local employer. BUPA is a member of the Business in the Community, Opportunity Now and Race for Opportunity programmes. It is also a funder and member of the Employers Forum on Disability and the Employers Forum on Age.

Progress since the Health Trends Review 2002

BUPA responded to *Securing Our Future Health: Taking a Long-Term View* (‘the first Review’) in January 2002, and has continued to monitor the health system since that time. Our contribution at that time and subsequently, has been informed by a Health Funding Dynamics Project which BUPA is undertaking with input from independent third parties.

In that response we highlighted some concerns:

- The Interim Report acknowledged that **health outcomes** in the UK lagged behind most other developed countries. Recent evidence from the Department of Health shows that this is still the case: although mortality rates from cancer have been falling for the past ten years, the five-year survival rate for prostate cancer is still lower in the UK than in Germany or France.¹
- The **risk of unmet demand** on the UK health system over the next 20 years will be significant. Our estimates in 2002 suggested that even a 7% per annum increase in funding in real terms over 10 years would not provide the capacity to meet the estimated demand and so cut out waiting. Recent evidence shows that while waiting times for first outpatient appointments are falling, the length of time between diagnosis and treatment is not. Only 60% of cancer patients received first definitive treatment within two months of referral in 2002.²
- We had and continue to have real concerns over the scope for **productivity** gains in the NHS. The 2% assumption underlying the report is achievable only through radical redesign of clinical processes. The latest figures from OHE show finished consultant episodes rising at 1.7 per cent a year over five years, while real-terms resources have increased by 40 per cent. Pay settlements are running at well ahead of 2 per cent. There is still evidence that some of the additional cash invested in the NHS does not reach the front-line³.
- The NHS alone - as a provider system- cannot deal with the emerging demands for healthcare. The **capacity** of the independent sector in both acute and intermediate care also needs to be fully utilised in order to meet NHS Plan targets. However, at present, NHS commissioning tends to be “in odd-job lots in individual cases”⁴, rather than in more efficient and cost-effective longer term contracts.

¹ The National Cancer Plan – Three Year Report, Department of Health, October 2003

² Bosanquet, N. and Sikora, K. Cancer care in the United Kingdom: new solutions are needed
BMJ 327 pp 1044-46

³ House of Commons Science and Technology Committee Report 2001-02

⁴ Rt. Hon John Reid – Evidence to the Health Committee 31 October 2003

- The major constraint over the next 10 years will be the shortage of skills in the **workforce**, particularly doctors and nurses. The proposals in the NHS Plan for additional staff may be insufficient to address the necessary demand. While posts may exist and be funded, the skilled staff may not be available. For example, the Royal College of Pathologists estimates that over a third of histopathology posts (400) will be vacant in 2005.⁵

While agreeing that the UK has suffered from cumulative under investment in the healthcare system over the last 20 years, BUPA continues to believe that the Government needs to encourage additional voluntary funding from individuals and employers to help it cope with these substantial demands.

Voluntary funding provides an essential element of choice, which enables competition and so creates the right environment for a responsive and dynamic health system. The independent sector plays a key part in enabling that choice by providing alternative services. BUPA has recently responded in these terms to the Government's consultation on ways of improving capacity and patient choice in the NHS, and contributed research which BUPA has commissioned to that consultation process⁶.

Bringing about the *fully engaged* scenario

The first Review described the *fully engaged* scenario as one where levels of public engagement in relation to their health are high. The *fully engaged* scenario was of course the least expensive scenario and it delivered better health outcomes than the other scenarios. However, to date, there is little evidence of trends going in this direction. Indeed, the most recent research suggests that the UK's performance in tackling mortality that is amenable to health care⁷ is not as good as was earlier thought.

Published 'health outcome' data- such as this- tends to focus on mortality rates, rather than systematically measuring improvement in health status. BUPA's approach is to work towards measuring outcomes by checking health status from the patient's viewpoint before treatment, and then after treatment.

To achieve the vision of the *fully engaged* scenario, individuals and organisations need to be encouraged and incentivised much more effectively to preserve their health. In BUPA's view, this aim is best achieved by encouraging individuals' efforts to choose healthy lifestyles, and by incentivising employers to assist them to do so.

⁵ Royal College of Pathologists Submission to NICE on liquid based cytology for cervical screening RCPATH 2002

⁶ Trust me I'm a patient - MORI research August 2003

⁷ Measuring the health of nations: analysis of mortality amenable to health care Nolte,E; McKee,M BMJ 327: 1129 15 November 2003

The role of employers in improving public health

Given appropriate incentives, employers would take a much greater role in effectively managing the health of their employees. Employee assistance programmes, health screens and occupational health services all contribute towards creating a more dynamic and productive workforce, and through the early identification of health issues reduce the cost of treating them. Currently, the cost to companies of all these activities comes on top of tax and National Insurance.

Sickness absence is currently costing the economy £13 billion a year. This cost could be substantially reduced to the benefit not only of companies and employers, but also of the NHS and the economy as a whole. BUPA has calculated that companies, which provide healthcare as a benefit for their employees, will reduce sickness absence and increase productivity by one day per person covered each year.

Responses to the questions for consultation

What is best practice, in the UK and internationally, in public health policy?

Mobilising a mixed economy by fully engaging employers, providing screening and occupational health services. Encouraging more voluntary involvement: risk assessment and better commissioning.

As an organisation with interests in a wide range of countries, BUPA's view is that the most effective health systems deploy all available resources towards meeting public health needs. This means that, within a framework of public health policy, all providers and funders of health promotion/prevention and healthcare services are mobilised to promote the health of the population.

In the UK, however, the public/private divide means that NHS funds mainly flow to the NHS provider system. The NHS has consistently underinvested in health promotion, preventative medicine and chronic disease management, so as to fund acute hospital services. As a result, much of the burden of chronic disease falls on industry.

A rational economic framework for investment in public health would ensure that funds would flow to the most cost-effective providers of preventive care. Best practice therefore starts with financing mechanisms which support this flow of funds within a mixed economy of provision.

Fully engaging employers

As well as public funding, financing can involve providing incentives for employers and employees to encourage more investment in health promotion/disease prevention, and chronic disease management. It is during adult life - when most people are employees- that most preventive measures can be taken against chronic disease. The proposed framework for investment should therefore major on the role of employers - as is commonplace in other developed countries. This approach would be in line with the government's thinking on welfare to work, as outlined in the DWP paper 'Pathways to work: helping people into employment'⁸

There are 2.7 million people of working age receiving an incapacity benefit in the UK. Nearly half of those on this benefit have been receiving it for at least five years. No impact has been made on reducing this burden in the past five years. As the paper points out, one-third of these claimants have musculo-skeletal or circulatory problems, many of which could have been prevented by effective occupational health services. The report says that employers have a key role to play in actively managing health at work and that this needs to be seen as good business sense. The Government also needs to play its part in helping employers to see the merit in this argument by considering targeted tax relief.

Occupational health services

BUPA works closely with the occupational health teams in major companies such as HP to reduce sickness absence costs, which average £476 per employee each year in the UK. Simple things can make a huge difference - for example HP found that when managers had to interview employees face to face on day one after any period of sickness this led to a significant decrease in absence.

Effective tracking of absence and proactive case management of specific conditions lead to better attendance. Case managers co-ordinate health services to make best use of resources. Research also shows that remaining at work wherever possible leads to better outcomes. On-site GP and physiotherapy services reduce short-term sickness absence because people seek help earlier so leading to speedier recovery. Typically, the savings from occupational health schemes offset the cost of the extra investment which the company makes in healthcare provision. For example, in one factory, a saving of £500,000 has been achieved.

⁸ <http://www.dwp.gov.uk/consultations/consult/2002/pathways/pathways.pdf>

Disability and incapacity benefits for people of working age currently not in the workforce amount to £19 billion a year⁹. Better occupational health and rehabilitation services provided in partnership with employers could make a big reduction in this burden.

Case study- Back Pain

Back pain is a major burden on business, estimated to result in the loss of at least 10 million working days per year. It is the biggest cause of sickness absence, and a leading cause of long-term disability and early ill-health retirement. With over £50 million spent annually on the diagnosis and treatment of back pain, dealing with it in the workforce - by promoting effective clinical management, earlier recovery, and a reduction in long-term disability - has to be a priority for public health. BUPA also identifies areas of back-pain risk within companies and targets prevention programmes

BUPA reviewed its approach to back pain in 2002 by considering the value of non-surgical treatments. It found that treatments did not always take into account the available research evidence. Following consultation with professional bodies, BUPA developed a new policy which makes funding decisions based on scientific evidence. It now funds diagnostic and treatment services that are of demonstrable effectiveness. This led to more emphasis on multidisciplinary functional restoration programmes. A variety of practitioners are involved and so BUPA Wellness is developing teams which will provide an on-site service to companies, supported by access to centres of excellence.

The next phase of this work will review surgical treatments for back pain.

Encouraging more voluntary involvement

Comparison of other OECD and European countries' healthcare systems also suggests that health outcomes tend to be better in countries where there is greater use of the private/voluntary sector, in combination with the mandatory element¹⁰. Getting people 'fully engaged' therefore includes encouraging personal responsibility - and funding - of preventive measures. Experience in Australia suggests that people do respond to such incentives. The rise in tax funding of the health service has been capped as the level of personal insurance has increased, following tax changes.¹¹ People are taking more responsibility and being directly incentivised to maintain their health.

⁹ The Medical Assessment of Incapacity and Disability Benefits
HC 280, Parliamentary Session 2000-01

¹⁰ OHE Compendium of Health Statistics

¹¹ Harper Associates <http://www.australianunity.com.au/au/hins/pdfs/PreservingChoice.pdf>
2002

Facilitating people to take more responsibility for their own health is key. Research underway in the World Bank is looking at how boosting people's 'voluntary health financing' can underpin 'mandated' (i.e. tax or insurance) funding. There is a strong connection between taking personal responsibility for one's own health, and being prepared to make out-of-pocket contributions towards health. Education and health promotion are key to this and so the incentives and barriers for people taking responsibility need to be addressed as a priority. There is scope for more public/private partnership in this area.

Screening

Other examples of international good practice include the easy availability of healthchecks or screening. This forms part of the basic package of most European social insurance schemes but is lacking from the NHS. The health system in the UK still relies too much on waiting for disease to manifest itself and health to break down before action is taken. Getting your health status checked regularly is a good way to reinforce engagement and so help bring about the *fully engaged* scenario.

Risk assessment

In most other countries, where healthcare is predominantly funded through forms of insurance, risk assessment of the insured population is routine. Insured people and their dependants are considered as 'members' - an inclusive term that underlines their role. Insurers are incentivised to encourage their members to take appropriate action to reduce risk. For example, BUPA Australia invites its customers with heart, breathing, arthritic or diabetic conditions to have a free health assessment. If necessary, a personal health plan can then be drawn up.

The Australian Government has encouraged companies like BUPA to offer programmes for the management of health. There is no similar incentive in the UK system. The proposed economic framework could aim to encourage risk assessment within the 'insured' population of a PCT, using expertise from actuarial and insurance sources. BUPA would be prepared to work with PCTs on the NHS commissioning agenda to assess risk while addressing the access and equity issues.

Better commissioning

Best practice to implement public health policy would include incentives for healthcare providers to work towards health gain, rather than simply maximise the production and cost of healthcare. Possible models for this include forms of vertical integration, such as the Kaiser Permanente model and their work on risk assessment. BUPA has strong links with Kaiser and many other insurers across the world. As an international organisation, BUPA is well placed to advise on how best practice can be translated to the UK system.

How can we compare and prioritise between different public health interventions?

Priority setting depends on having explicit criteria. The criteria for prioritising public health interventions characteristically focus on four goals: reducing inequalities; health protection; health promotion, and preventative medicine:

- **Reducing inequalities** (trying to make health and a full lifespan equally available to all): as improving health starts with increasing economic wealth, 'interventions' include actions to boost employment. Large employers - such as BUPA which employs 40,000 people- need to take responsibility by offering employment in deprived areas. BUPA Membership is based in Salford and has contributed to the regeneration of the Salford Quays area. BUPA Care Services also runs over 200 care homes which are labour-intensive and provide jobs which help to get people into the labour market and then train and develop them. Given appropriate incentives, employers could do more to help tackle inequalities.
- **Health protection** (measures that keep people healthy): the independent healthcare sector could be more *fully engaged* in health protection measures. During the SARS virus outbreak, BUPA Hong Kong won an award for providing a special information service on its website which attracted 1.5 million visits. This experience suggests that insurers could be mobilised to help provide health information to combat similar threats to the UK in the future.
- **Health promotion** (encouraging people to look after themselves better): BUPA undertakes a range of activities to encourage people to look after themselves better. For example, by sponsoring the Great North Run and other Fun Runs each year, BUPA stimulates its own employees and many thousands of other people to get fit. Health promotion could form a larger part of other employers' corporate social responsibility work. This would focus on 'pulling' people into healthier lifestyles, rather than 'pushing' health promotion messages to them.

BUPA Wellness runs health promotion programmes in a wide variety of workplaces including seminars on mental health issues such as 'how to cope with teenagers'; as well as stopping smoking and healthy eating. BUPA also administers 20,000 flu injections a year through company schemes - which is a good example of current investment by companies in the health of their workforces.

Obesity

Obesity is a key threat to public health: the response requires:

Effective marketing: BUPA's subsidiary 'Lighten Up' offers overweight and obese people a sustainable method to lose weight and then maintain their healthy size. These types of approach need to be marketed effectively and so private sector marketing expertise should be brought to bear in public health campaigns.

Research: The BUPA Foundation has made an award to researchers who have identified a hormone which controls hunger.¹²

Action at work: Employers could also be given incentives to help tackle obesity in their workforces, as part of an overall strategy to improve public health. As the Health Development Agency's recent report made clear¹³, one of the public health interventions which works is when parents take responsibility for reducing obesity in their children. As most parents are employees, this message can be reinforced as part of a corporation-wide approach to health promotion.

Information is key to marketing the benefits of healthier lifestyles. BUPA offers evidence-based, clearly written information on diet, exercise, sleep health, stopping smoking etc on its website www.BUPA.com and would be happy to work in partnership with the Government to promote positive health messages more widely.

- **Preventative medicine** (measures to keep people healthy that involve a health professional): BUPA Wellness runs a network of centres that work with individuals and employers to identify their areas of health risk and agree action plans to keep them healthy. This type of approach is fundamental to achieving the *fully engaged* scenario. Market research shows that 30% of adults would like an annual health check and 60% would like it provided by their employer. 68% of respondents said that employers should take more responsibility for their employees' health and care needs.

¹² <http://www.bupafoundation.com/>

¹³ The management of obesity and overweight: An analysis of reviews of diet, physical activity and behavioural approaches Health Development Agency October 2003

What is the best way to develop a cost-effective way of managing diseases?

Better commissioning of chronic disease management from a plurality of providers

With particular reference to diabetes, to take one example, the first step is to boost awareness of the disease and its causes among the target population. Information sources could be better co-ordinated to ensure widespread understanding of the hazards of inappropriate diet and lack of exercise. Action with the food industry, education and parents may help to boost awareness and deter behaviour which leads to obesity.

Going with the flow of the wishes of the at-risk population, so far as possible, is key to effective interventions. This may involve providing multiple routes for testing, monitoring and treatment. Currently, testing for diabetes requires either GP referral, or people buying a self-testing kit. These kits could be much more actively advertised among those most at risk.

The role of PCTs in managing chronic disease is so far undeveloped. A more co-ordinated approach to bring together the multiple agencies is required. PCTs should research schemes to contract out the diagnosis, monitoring and control of diabetes to independent organisations. BUPA is working actively with the Foundation for Informed Decision Making (and its business arm in the United States, *Health Dialog*) to help bring their best-of-breed chronic disease management programmes to the NHS.

Is there a measure of cost-effectiveness that can be applied consistently across different interventions to improve population health?

QALYs, the SF36 questionnaire, utility measures and generic health status measures are all potential models

Prof Alan Maynard, who has advised BUPA in the past, pioneered the use of QALYs to measure cost-effectiveness. As well as the QALY methodology, BUPA uses the SF36 questionnaire routinely to assess whether patients get better after treatment. A 'balanced scorecard' could be developed using these and other methodologies.

In addition, Outcome Technologies, a BUPA Group Company, is designing, building, and implementing a variety of programmes across a range of disease areas from oncology to orthopaedics. These utilise measures that can be used to ascertain the cost-effectiveness of services and products. Among the tools used are utility measures (such as EQ-5D) which can derive QALYS and generic health status measures, both of which can be used consistently across different interventions.

What are the priorities in public health over the next 20 years that will help us to meet the fully engaged scenario?

Smoking; stress; depression and healthy ageing

The first Review received a great deal of evidence about the impact of smoking on public health and on the future costs of the NHS. Making a step-change in attitudes to smoking would be a major priority. At present, companies offering smoking cessation programmes are faced by barriers. NHS purchasers are reluctant to buy these services from non-NHS providers, and new contract arrangements for GPs and pharmacists may hinder the development of smoking cessation. There are therefore ideological and practical barriers to making progress in this important area.

Given the recent prominence of stress-related illness in the media, the whole area of occupational health, stress reduction and achieving better work/life balance needs to be addressed. Depression is a growing problem and stress management is clearly linked to reductions in the abuse of alcohol and other substances. Depression is also often linked to chronic back pain in a downward spiral with major impact on industry and the economy through working days lost.

A high priority should be supporting 'healthy ageing', as the extent of compression of morbidity is a key factor in determining future health needs and expenditure. As the population and the workforce ages, it will be increasingly important economically to maintain fitness to work in older age groups. BUPA has relevant experience based on its care for 17,000 residents in care homes and assisted living units.

..And what does this mean for the health status of the population in 2022?

Voluntary engagement and contributions towards health need to be encouraged

A vision for effective engagement in 2022 would be that those who are equipped - intellectually, practically and financially- to take most responsibility for their own health are incentivised to do so. This would involve shifting the 'bell curve' of health activists so that many more people are 'early adopters' of good practice in maintaining health. A starting-point for this would be to reinforce the willingness of people who already pay either through insurance or directly for health services to continue to do so.

In this vision, it would be the norm for people to supplement State funding of health services by a range of voluntary contributions. As part of a wider strategy of long-term investment, the result could be demonstrable through indicators such as visibly improved weight, diet and fitness.

Is implementation of public health policy to date, and particularly over the past year, consistent with the fully engaged scenario?

Independent sector capacity is not being fully used; productivity is slow to improve, and the public is not being fully engaged

As mentioned in the Introduction, there is little sign of public policy support for the *fully engaged* scenario at present. Recommendation 6.36 of the 2002 Review said that the scope for future co-operation between the NHS and the private sector in the delivery of services should be explored, building on the Concordat set out in the NHS Plan. While the Government has tendered for Independent Sector Treatment Centres, and BUPA has successfully managed the first independent DTC for NHS patients at Redwood, there has been no systematic exploration in the terms of the recommendation.

Most sub-contracting of hospital services is on an ad-hoc and short-term basis and so independent providers are not fully engaged in providing additional capacity. BUPA has pointed out to Ministers that there is slow progress in NHS purchasers adopting a plurality of provision. Additional capacity which exists in the independent sector has not been fully utilised. There has been slow progress by PCTs in adopting a wider public health view and purchasing health promotion/prevention services from independent providers. This is hindering secondary prevention in such diseases as CHD.

Productivity in the NHS hospital sector does not so far appear to be improving at the rate envisaged in the 2002 Review 'Securing our Future Health'. This may be linked to outdated measures of productivity. As John Reid has said recently: "Investment in keeping someone out of hospital is recorded as a productivity decrease."

As paragraph 3.20 of the first Review put it, 'the difference between the *solid progress* and *fully engaged* scenarios is a dramatic improvement in public engagement, driven by widespread access to information.' BUPA is contributing to better access to information, for example, by publishing an 'ABC of health' - a series of factsheets on common conditions aimed at providing up-to-date and trustworthy health information to help people make informed treatment choices. However, there is scope for more progress on getting the public much more fully engaged in health and healthcare.

What are the difficulties and barriers to implementing a cost-effectiveness approach?

Public financing is still often confused with public provision. There is no framework for public health investment, and so PCT commissioning does not take a population-based approach

The method of delivery is often confused with the method of financing, in UK healthcare. In other words, the most cost-effective healthcare is not always commissioned because the NHS is seen as a provider system. Nationalisation of funding and objective-setting should be seen as separate from delivery issues. The presumption that healthcare and health promotion should normally be delivered by NHS providers is widespread. This is inhibiting more cost-effective competition between a wider range of providers.

The lack of a coherent framework for decision-making is also a barrier to cost-effectiveness. Investment in health needs to be underpinned by a clear framework for decision-making such as that proposed by the Review's terms of reference.

PCTs have to take a population-based approach to public health, although much of the experience which they possess is based on individual patient contacts - for example with GPs. The mindset needed for meeting the needs of the population as a whole is radically different from that for meeting individuals' needs.

Conclusion and next steps

BUPA looks forward to discussing this submission with HM Treasury and hopes to contribute further to the policy debate on public health. The independent healthcare sector - and employers - have much to gain from doing so; equally, public health can only be maximised if all sectors of the economy are fully engaged in the required effort.