Convegno Nazionale Ospedale, Citta' e Territorio

Esperienze internazionali

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Principles of the NHS welfare system

To ensure that everybody in the country irrespective of means, age, sex or occupation shall have equal opportunity to benefit from the best and most up-to-date medical and allied services available - free at point of service

- Funded by direct taxation
- Government as:
  - Strategist
  - Policymaker
  - Funder
  - Implementer
  - Operator
  - Evaluator

- Recent acceleration of mixed economy delivery
- Some discretionary private healthcare

Some further characteristics

- Control by rationing
  - Availability – NICE (national institute of clinical excellence)
  - Accessibility – e.g. waiting time as a regulator
- Management by performance targets
- Centrally set pay structures and workforce conditions - but some new freedoms available
- Evaluation and influence exercised by the public - through the ballot box

Some key issues

- Control over demand
- Control over cost
- Prioritisation of spending
- From linear growth to exponential growth

Financing and Organisation

Top down organisation and funding arrangements
1948 - 1986

Contemporary pressures for change

The global ‘mega trends’

- Public expectation
  - Scale of services
  - Scope of services - wonder drugs and technologies
  - Environmental quality
- Transitions
  - Demographic
  - Epidemiological
- Workforce costs
  - Competition
  - Pensions

The macro change factor

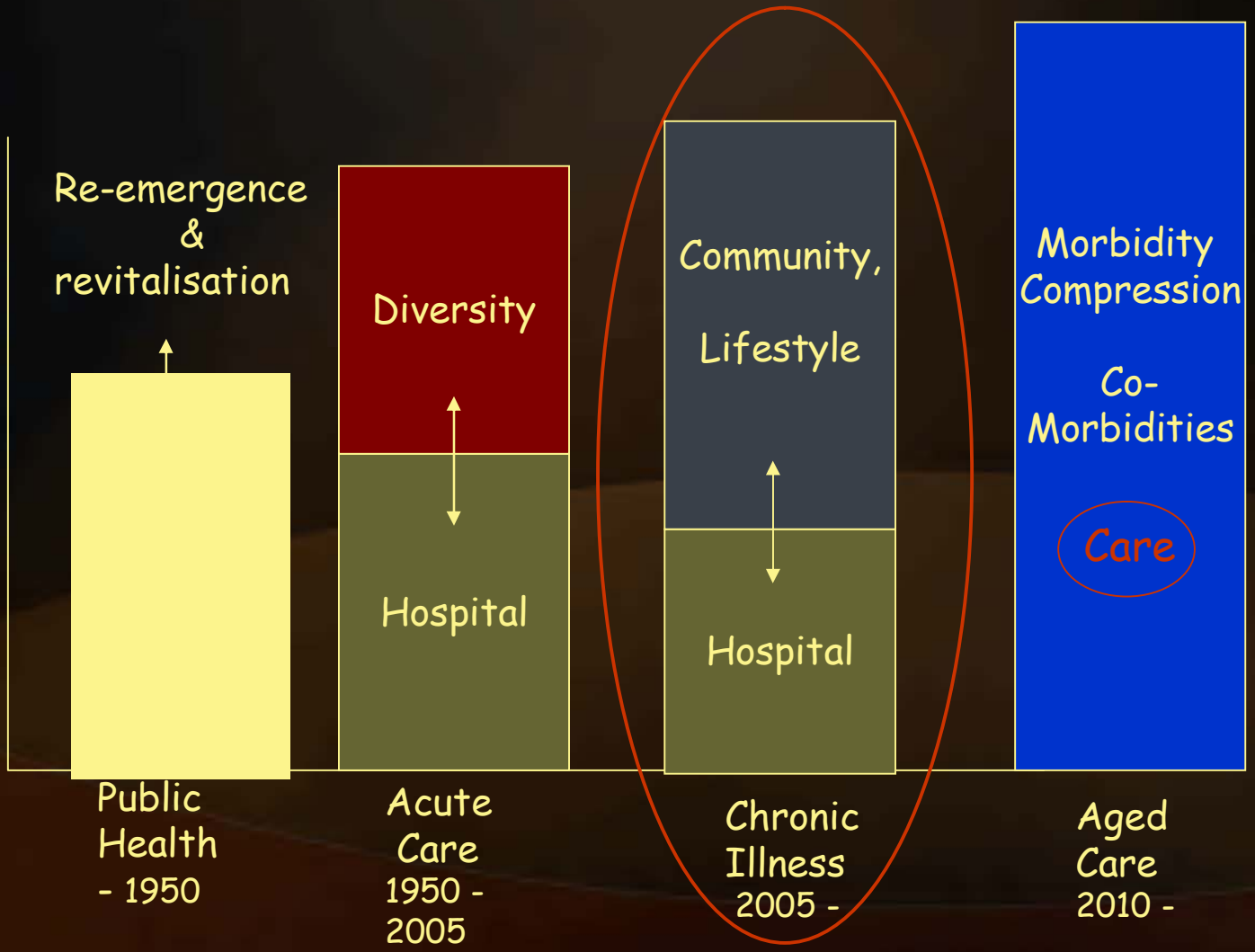
Economics

- Sustainability – a healthy workforce
    - Chronic illness
- Affordability
    - The ageing population

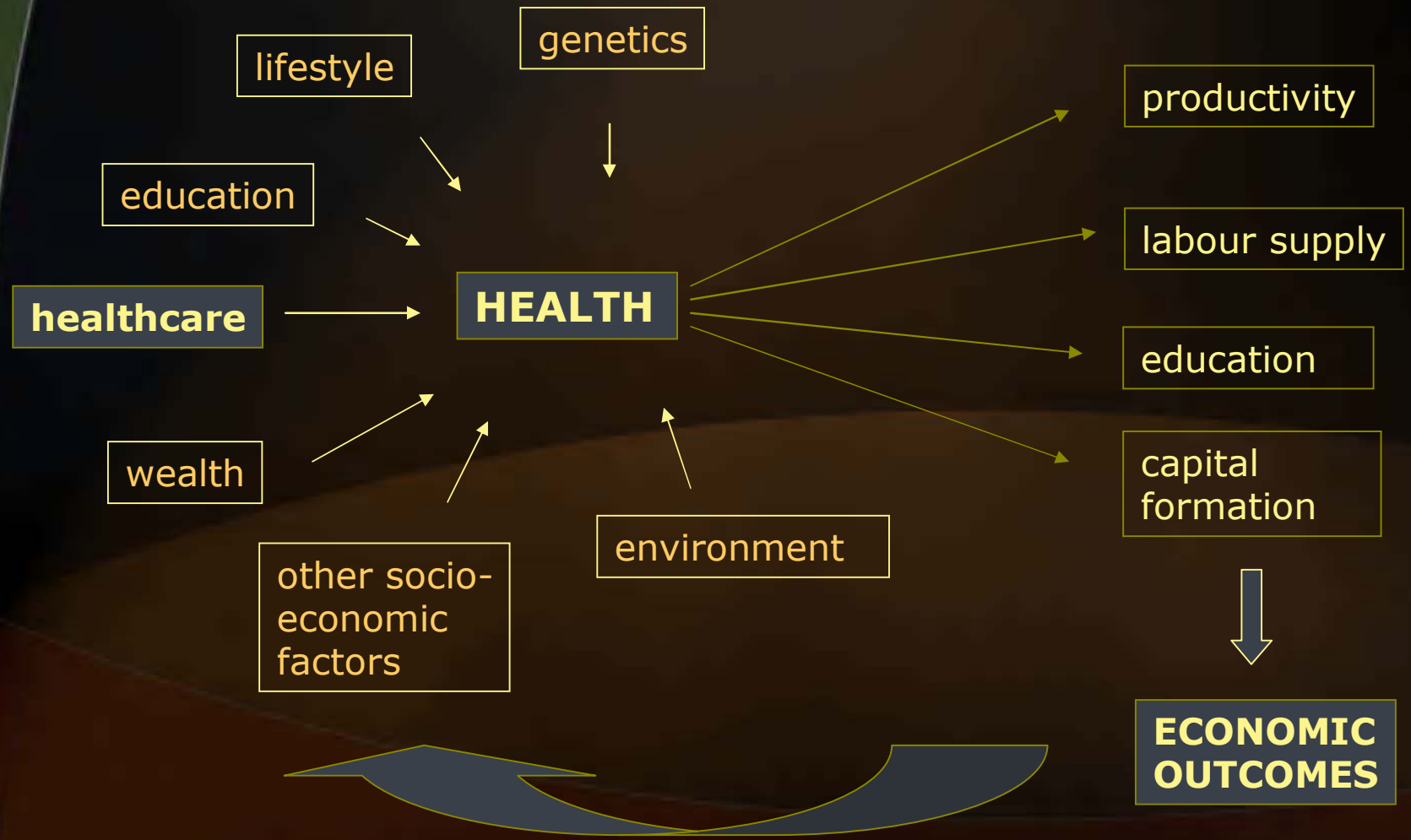
The changing role of healthcare in the economy

- From cost to investment
- From cost efficiency to cost effectiveness
- The citizen as a co-producer of good health

The third age (transition) in healthcare



Health, the State and the economy



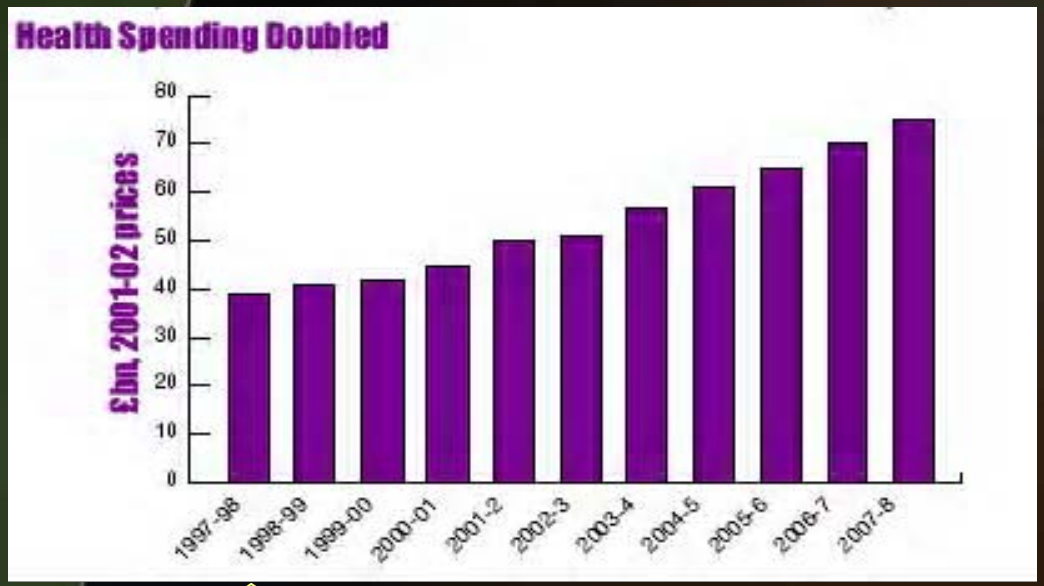
The ‘millennium’ age of NHS change

The NHS Plan 2000 – ‘must do’ targets

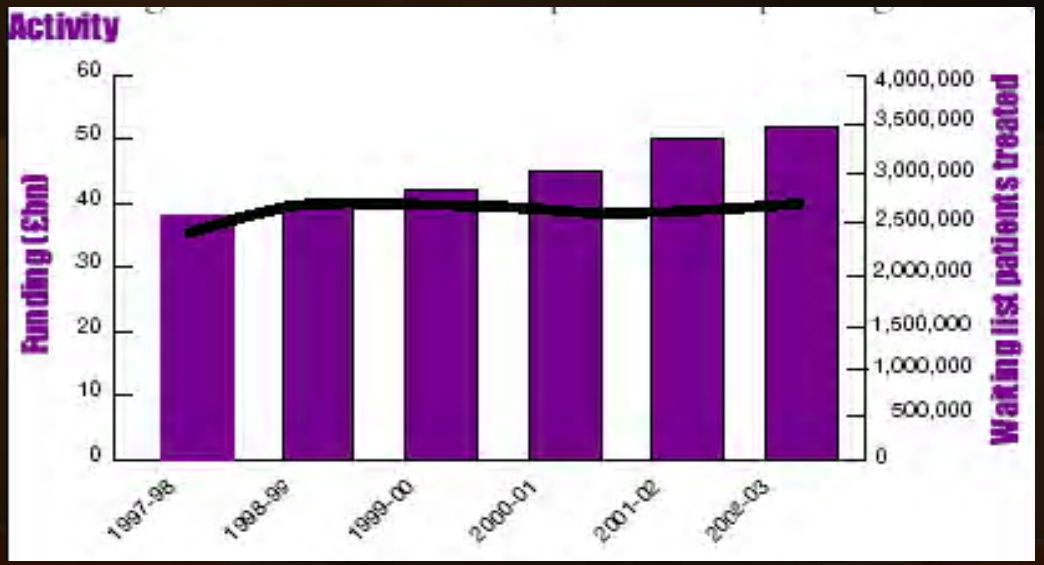
- Maximum outpatient wait 3 months - in-patient 6months - by 2005
- Guaranteed access to GP within 48 hrs
- Disease framework targets - e.g. cancer care
- Reduce the health inequality gap for children

- Hospital (earned) autonomy - Foundation Trusts
- Patient choice by 2005
- Payment by results by 2006

Funding increase – doubling of growth



But little increase in productivity



"It is not possible to continue to provide 24-hour clinical cover"
BBC Headline 9th March
Now !!! - despite growth

After 2008 ?
50% reduction in growth

The age of reform

2006 – the major policy initiative

"Our health, our care, our say"

People contributed their views on what they expected

People wanted their local services to:

- understand how they live and support them to lead healthier lives
- help them to live independently if they have ongoing health or social care needs
- be easy to get to and convenient to use
- **be nearer to where they live, or easily available in the areas they work**

Reform - "Our health, our care, our say"

A new direction for community services

- Make services more responsive
- Make services more personal
- give patients and users more control

Changing the services

- family doctors,
- primary care trusts and
- local authorities

will have more say in how to plan deliver services

- All organisations will work in closer partnership

Guiding Principle

- **Good health and social care services is an essential part of local communities.**

The NHS reforms – key messages

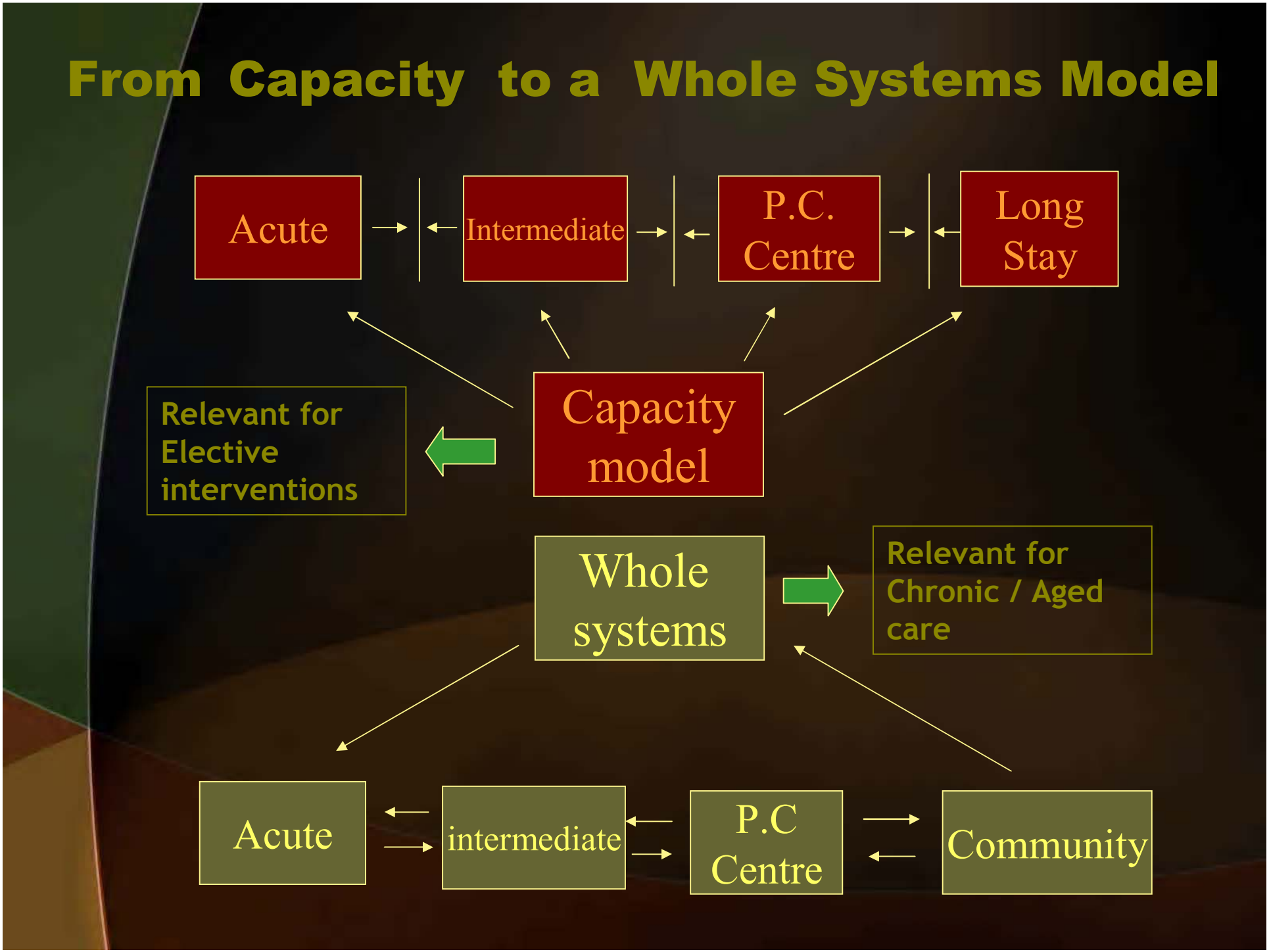
- Expose hospitals to market forces to stimulate
  - better care
  - more choice
  - better value
- Deliver more care outside hospitals
- Give people greater say
- Better integration of health and social services
- A ‘local’ focus - to meet local need
- Changing role of central government - towards regulation instead of direction

Note – Scotland, Wales and N. Ireland are not adopting an aggressive market approach

New structure

Some dimensions of NHS reform

From Capacity to a Whole Systems Model



The 'shrink to size' acute hospital economy

A combination of Care Pathway design, work process control and shifts in the locus of care e.g. chronic illness - will have significant future impact

		SHA 1	SHA 2				
		Trust B	Trust 1	Trust 2	Trust 3	Trust 4	Trust 5
Technical Efficiency Issues	ALOS and DCR are 10% better than national average	10%	9%	9%	6%	8%	9%
Allocative Efficiency Issues	Reduced repeat admissions	12%	11%	10%	11%	10%	14%
Total bed days saved		**22%**	**20%**	**19%**	**17%**	**18%**	**23%**

Ref Degeling, CCMD, Durham 2005

New providers - greater diversity

New competitors/challenges for public hospitals

- Independent Sector Treatment Centres - ISTC's
- Foundation (NHS) Hospital Trusts
- NHS Franchise operations - specialist outsourcing
- NHS Worker co-operatives - across the clinical spectrum
- Hospital role delineation, alliances and mergers
- PPP operators – e.g. treatment centres
- Private Hospital Contractors
- Overseas care

Stimulated by

- Payment by results
- Patient choice

Market principles

Markets - some thoughts

- Good healthcare depends on Confidence

- Personal Care: Doctor – Patient
- Standards: Professionals – Policymakers
- Reliability: Citizens – Government

- Introducing profit culture / competition needs better understanding

- Evidence shows shared communitarian values are critical to success

Independent Sector Treatment Centres

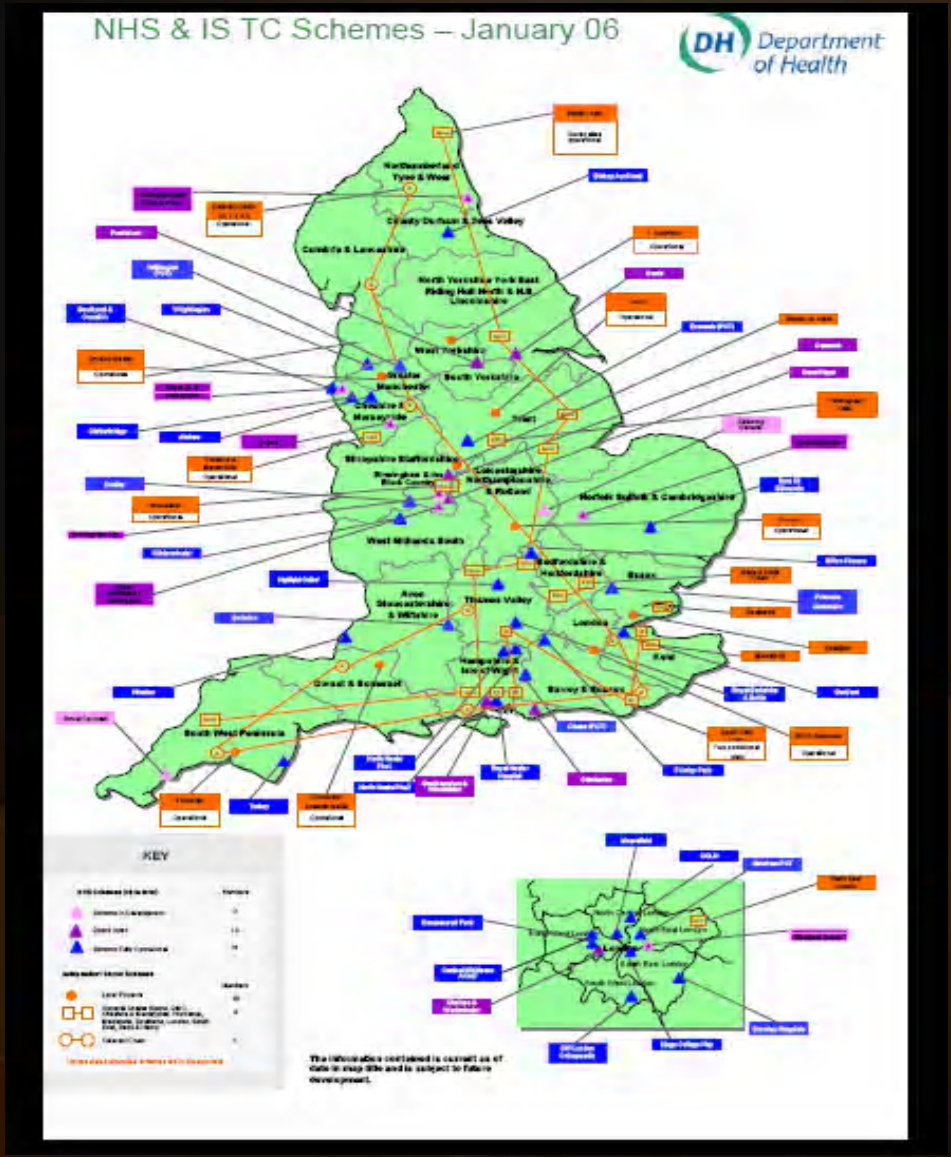
- Aim
  - More capacity more quickly
  - Patient choice
  - Innovation - challenge conventional processes
  - Phase 1 - 21 projects - 120,000 patients treated
  - Phase 2 - 11 projects - over 250,000treatments pa
- Specialise in common elective procedures,e.g. hip replacement, cataracts
- Diverse models
  - Private ownership
  - NHS public hospital ownership
  - Joint public private ownership - similar to co-locations Australia, the first to adopt this model.
- Must not poach NHS staff
- 5 to 7 year year contracts - fixed price, guaranteed numbers of procedures
- 10% of all NHS elective work to be ‘contracted’

Hope - a “self improving NHS”

Independent Sector Treatment Centres – phase 1

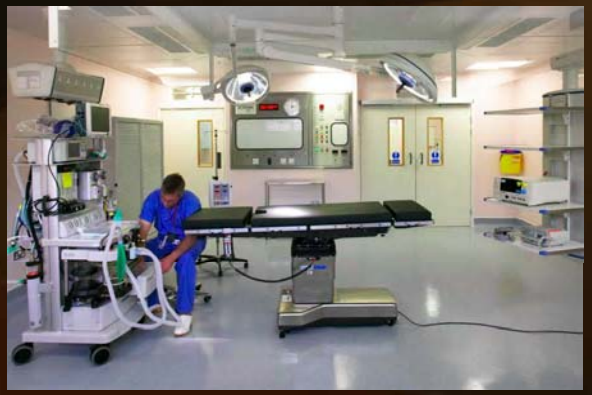
ISTC Location Map and Activity levels

Treatment Centres - 2nd Phase



Typical Treatment Centres

notable for quick-build, low cost, simple design



Treatment Centre Examples

BUPA/Redwood, Surrey - early pilot site, opened 2003

- Partnership between BUPA and Surrey NHS Hospital
- Co-location on NHS site
- 5 year contract
- 36 beds, 2 theatres, endoscopy and basic diagnostics
- 12,000 procedures per year - large number are diagnostic
- Services:
  - Diagnostics
  - Day surgery including Orthopaedics

Barlborough Treatment Centre, Trent, opened 2005

- Private ownership
- 36 beds (4 critical care) and physiotherapy
- Contract - 5 years - for a total 22,000 procedures
- Specialty - Orthopaedics
- Capital cost Euro - 12, million

Treatment Centre Concerns

- Preferential contracts - for private operators
  - Length of time e.g. 5 yrs, guaranteed capital repayment
  - Cost - on average 10% to 20% more than NHS hospitals
- Capacity planning - many may not be needed, NHS Hospitals already have the capacity, but need to improve practice
- Concern over quality of clinical standards and back up support for stand alone units
- Staff recruited from countries that cannot afford it - new EU member states, Africa
- Unfair ‘competition’ - places NHS hospitals under financial pressure

NHS Trusts - Hospital status in the UK

- All NHS Hospitals and Primary Care Centres are now ***Trusts***
  - Semi independent Boards of Directors
  - Ownership of assets
  - Direct accountability to Department of Health

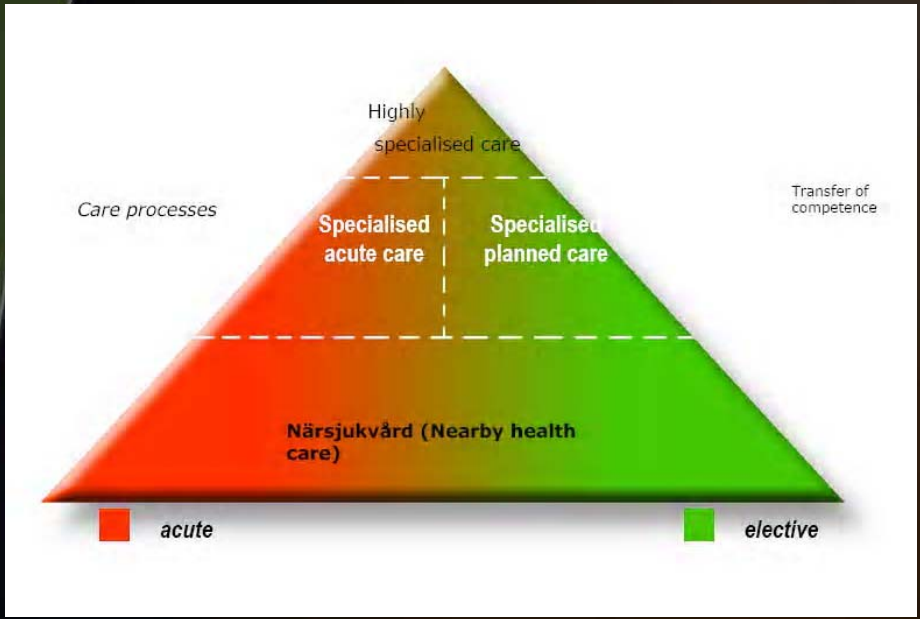
- NHS ***Foundation Trusts*** - independently approved
  - Greater freedoms
    - Financial
    - Innovation
    - Capital - but subject to Treasury guidelines (Control)
  - 'Not directly accountable' to government - BUT !!!
  - Subject to 'independent' regulation

- Aim - all NHS Hospitals will become Foundation Trusts
  - Part of Government policy to give people more control over local services and incentives for change
  - Part of government policy to withdraw from operational accountability

Welfare systems in other countries – some common themes

- Norway
  - the 'Free Hospital Choice' programme - patient control
  - St Olav's Hospital Trondheim - adaptability
- Sweden
  - Structural framework planning - Skane Vision
    - More care in community settings - the "nearby - care' concept
    - Karolinska Institute - downsizing / restructuring
- Finland
  - Integrated primary and secondary care
  - Regional structure planning - the VALSAI project
  - The Finnwell project - technology and community care
  - The Coxa and Hyvinka Hospitals - new clinical models

The Skane “nearby-care” principle



- Population based hospital restructuring
- From 14 hospitals to 9
- Changing the roles of remaining hospitals
- Most new investment - for community facilities
- Public involvement through the “nearby-care” concept

AIM - more care, more accessible to where people live and work, but specialise where beneficial e.g. networked Regional Centres of Excellence


same day surgery and endoscopy
community mental health
community health services
infusion service
BMT
ambulatory rehabilitation
maintenance dialysis
imaging services
pathology service
pain management and palliative care
interpreter and ethnic liaison services
other government agencies
NGOs
Integrated Ambulatory Care (Polyclinic) Centre Western Sydney, Australia
same day low risk ante and post natal services
specialist chronic disease clinics
Religious Health Care providers
community information service
child care facilities
24 hour GP service
paediatric services linked to a specialist paediatric hospital
coffee shop, newsagency, pharmacy, florist
complementary medicine
surgical franchises
in-reach support
outreach services from hospitals
specialist consulting services provided by the private sector

Regional Structure Planning

The need for balance

Economic Rationalism vs Society Value

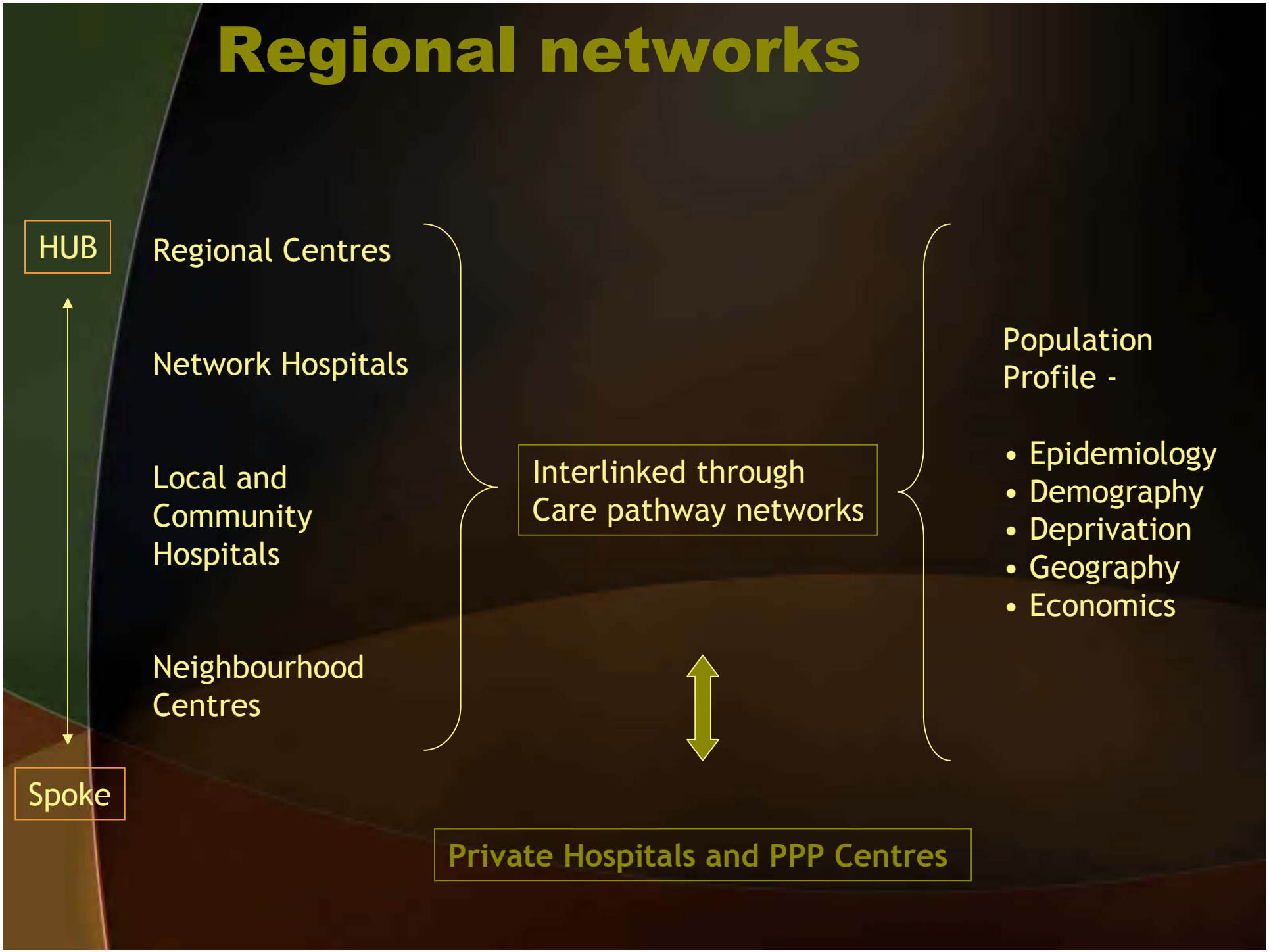
- Hospitals define societies - towns and cities
- They are important symbols of value
- They sustain urban communities

- In the UK the ‘rush’ to relocate to out of town sites on purely economic grounds has raised concerns

- New networking ideas for linking and rebalancing services between hospitals is now emerging - e.g. the Karolinska Institute, Stockholm

- As the hospital sector contracts in size, there will be greater opportunities for smaller diverse ‘hospitals’

Regional networks



Maintaining a balance

Conclusions – 'Welfare' model trends

- Regional devolution and local structure planning - as the main reforming principle
- Giving the public more say – local democracy
- Acute care – market driven reforms ??
  - Better Performance
  - Incentivised Funding, including capital
  - More Independent providers / competitors
  - Smaller Scale – more diverse, mergers, role change, co-locations with private sector
  - More Adaptable - but problems with capital

Conclusions – 'Welfare' model trends

- More care outside hospitals – new opportunities and new systems
- Redefining welfare – integrated social and public health – aged care, chronic illness and mental health (the uninsurable sector)
- The changing role of central government – as regulator
- Pressure to move towards an insurance system – in whole or in part

“ è questo che significa cura locale ?”

Grazie per la vostra attenzione