# The “Blurred” Reforms of the English NHS

By

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# Outline

- Objectives
- Performance
- Continuing problems
- The way ahead

# Objectives of reform

- Spend more: raise UK-NHS expenditure to “the European Union average”. What and why?
- Spend more to reduce waiting time for elective care and improve service delivery access in cancer, CHD, renal, diabetes, for children and the elderly

# Spending

- Increase in expenditure was sharp and large, with real growth rates at the local level of seven per cent for period 2002/3-2007/8 i.e. 50% real increase in funding, some £43.2 billion
- Tight regulatory regime with performance targets, performance ranking (initially “stars” and now excellent/good/fair/poor)
- Intense pressure to hit activity and process targets, and improvements resulted

# Achievements

- More activity in most areas e.g.

1. elective admissions increased by 7 per cent 2002-3 to 2005-6
2. Outpatient admissions increased by 3 per cent in the same period
3. Emergency admissions rose by 21 per cent
4. A&E attendances rose by 33 per cent
5. Prescription items rose by 20 per cent, and statins was the major item here.
6. 18 week waiting time target to be achieved by end 2008. Rapid referral for cancer patients from primary care: does it work?

# But.....

- Deficits created because of....
- Workforce inflation....
- Pay and price inflation

# NHS deficits, 2001-2006

| Financial Year | Surplus/(deficit) reported in audited accounts (£m) | % of NHS organisations with an overall deficit |
|---|---|---|
| 2001/02 | 71 | 8 |
| 2002/03 | 96 | 12 |
| 2003/04 | 73 | 18 |
| 2004/05 | (251) | 28 |
| 2005/06 | (547) | 31 |

*Source: Department of Health/NAO*

# NHS workforce growth by staff group, 1999 -2005 (headcount)

| Staff Group | Total (1999) | Total (2005) | % Increase (1999-2005) |
|---|---|---|---|
| All | 1,098,348 | 1,366,030 | 24.4% |
| Doctors (all) | 94,953 | 122,987 | 29.5% |
| Consultants | 23,321 | 31,993 | 37.2% |
| GPs | 29,987 | 35,302 | 17.7% |
| Nurses | 329,637 | 404,161 | 22.6% |
| Allied health professionals | 47,920 | 61,082 | 27.5% |
| Scientific and technical | 54,471 | 73,452 | 34.8% |
| Clinical support staff | 296,619 | 376,219 | 26.8% |
| Central functions | 73,996 | 105,565 | 42.7% |
| Senior management | 24,287 | 39,391 | 62.2% |

*Source: Department of Health*

# Comparison of 2000 *NHS Plan* growth targets with actual workforce growth (1999-2004, headcount)

| Staff Group | Projected new staff: 1999-2004 | Actual new staff: 1999-2004 | Variance |
|---|---|---|---|
| Consultants | 7,500 | 7,329 | 3% under target |
| GPs | 2,000 | 4,098 | 105 % over target |
| Nurses | 20,000 | 67,878 | 340% over target |
| Allied health professionals | 6,500 | 11,039 | 69% over target |

*Source: Department of Health*

# Pay inflation: hospital specialists

- The new consultant contract: evidence of large practice variations . Discussion of using incentives to compress the distribution and shift the mean. Rejected! Gave them large pay increase with no productivity changes in exchange.
- Best paid specialists in Europe, and activity rates continue to decline due to the new contract and European Union legislation.
- But what of “quality”? Little evidence of improvements in outcomes due to inadequate measurement!

# Pay inflation: general practitioners

- 24/7 contract replaced with option to stop “out of hours work” if gave up £6000 per year
- Stampede !
- Had to bought back at £100 per hour!
- Quality outcomes framework=QOF paid GP practices to do what they should have been doing already i.e. monitor and treat patients with chronic diseases on their lists.
- Paid a billion and pursuit of fee for service points=cash very energetic! Evidence base of QOF subject of debate.

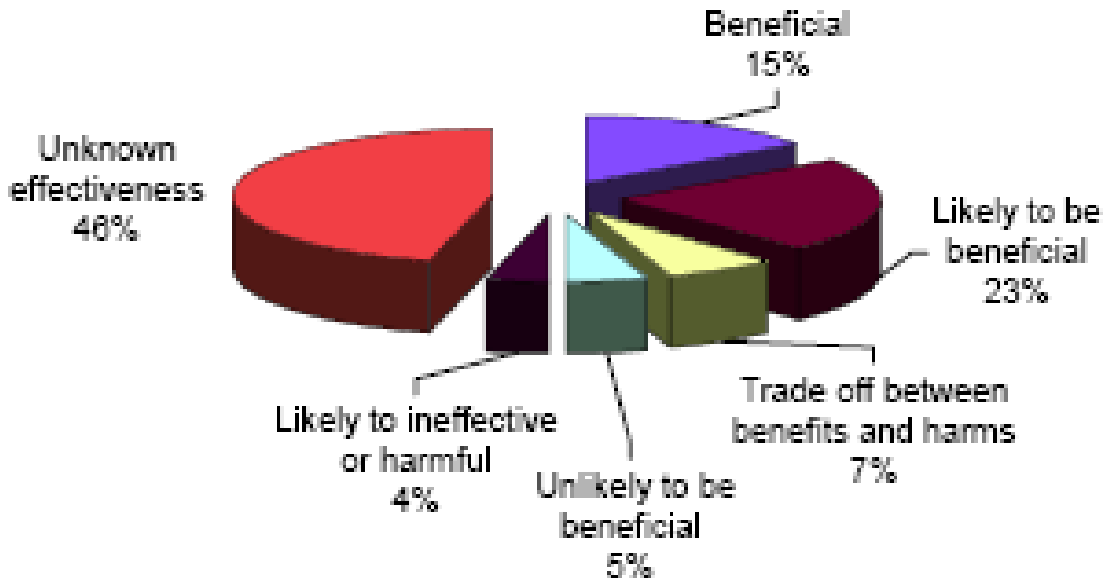
# Funding: service delivery versus “ pay and price inflation

- The reforms delivered some activity increases and some improvements in service delivery inputs and processes
- Of the additional £43billion allocated to the NHS in the five years after 2002, £18.9 billion or 43 per cent went on pay and price inflation (Kings Fund 2007)
- This outcome was unsurprising (see e.g. Maynard and Sheldon, Lancet 2002)

# Continuing problems

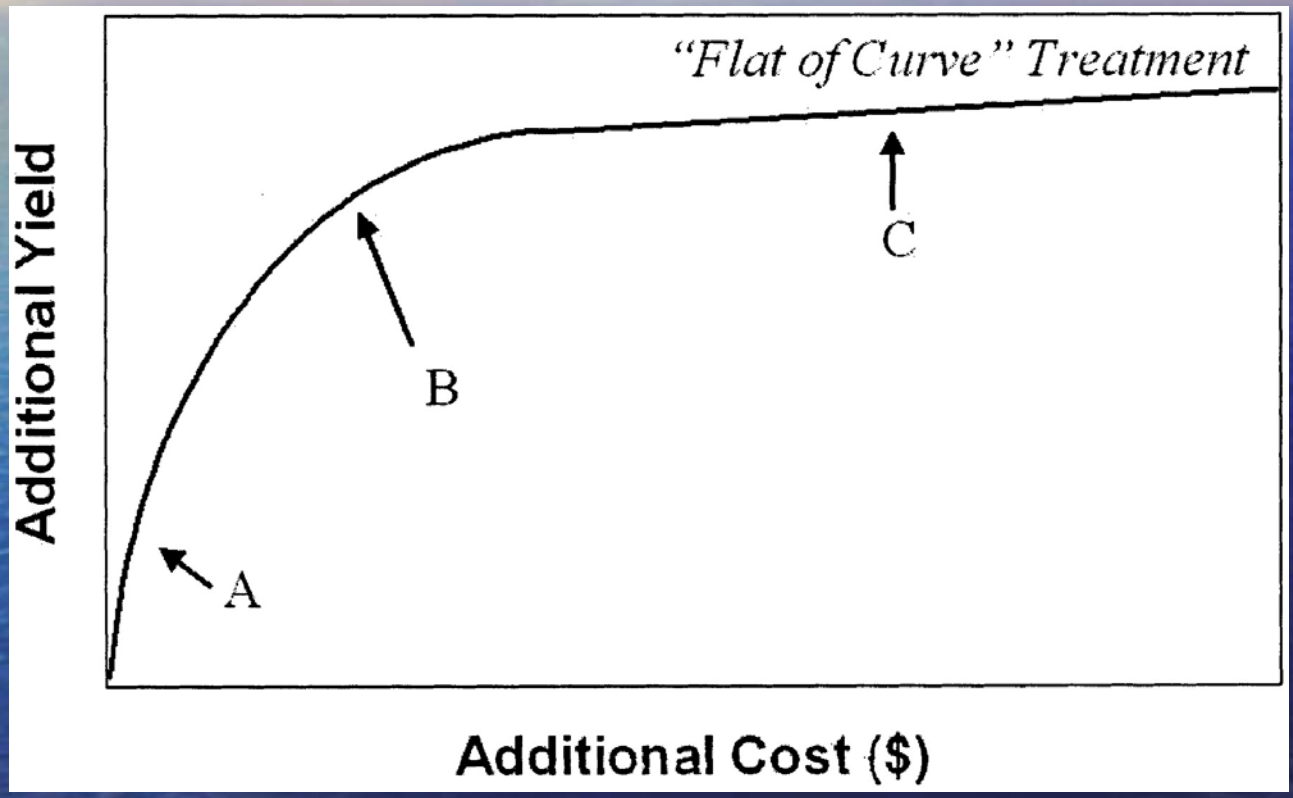
1. Most medical care lacks an evidence base
2. Health care delivery is characterised by large variations in clinical practice i.e. patients with similar characteristics and health needs are given very different packages of care
3. What is proven is not delivered to patient in need e.g. chronic disease management
4. Medical errors are poorly measured and managed
5. There is an absence of interest in and measurement and management of “success” in terms of making patients better

*Figure 1: Uncertainty about clinical effectiveness*




Source: BMJ Publishing Group 2005[13]

# ‘Flat of the Curve’ Medicine?




Mark & Hlatky 2002, Fuchs 2004

# Variations in clinical practice

- Given the absence of an evidence base for most medical care, physicians exercise discretion and offer different patterns of care to similar patients i.e. “practice style” shows great variations
- The work of Wennberg, Fisher and Dartmouth College (USA)
- Barbara Castle’s Government paper in 1976 “Priorities in Health and Personal Social Services” highlighted the scope for efficiency savings from reduced practice variations thirty years` ago.

# Hogarth

# Medical errors

- American data from the Institute of Medicine
- UK data from St Mary's Hospital in London (Vincent et al, 2002) and York (Sari et al.BMJ 2006): 10 per cent error rate
- New Zealand data 2008: 15 per cent error rate

# Do patients get better?

- 1844 Lunacy Act required psychiatric hospitals in the UK to measure success in terms of whether patients were

1. Dead
2. Relieved
3. Unrelieved

- Popularised by Florence Nightingale in her book “Some Notes on Hospitals” 1863

# Nightingale on performance management.....

- “I am fain to sum up with an urgent appeal for adopting this or some uniform system of publishing the statistical records of hospitals. There is a growing conviction that in all hospitals, even those which are best conducted, there is a great and unnecessary waste of life.....

# And again..

- In attempting to arrive at the truth, I have applied everywhere for information, but in scarcely an instance have I been able to obtain hospital records fit for any purpose of comparison. If they could be obtained, they would enable us to decide many other questions besides the ones alluded to. They would show subscribers how their money was being spent, what amount of good was really being done with it, or whether the money was doing mischief rather than good”

# The Way Forward

- A key concept is productivity
- But is this about process and activity, and/or outcomes for patients in terms of whether they “get better”?
- Measuring outcomes in terms of improvement in functional capacity using e.g. EQ5D and specific quality of life measures
- E.g. does cataract removal improve visual acuity? The use of VF 14 before and after surgery
- Experimenting with patient reported outcome measures (PROMs) in the English NHS

# Measuring Patient Outcomes in the English NHS

| Procedure | Condition-specific | Generic |
|---|---|---|
| Primary Unilateral Hip Replacement | Oxford Hip Score | EQ5D |
| Primary Unilateral Knee Replacement | Oxford Hip Score | EQ5D |
| Groin Hernia Repair | None | EQ5D |
| Varicose Vein Procedures | Aberdeen Varicose Vein Questionnaire | EQ5D |
| Plus a standard set of patient-specific questions in all cases | | |

*Source: DH Operating Framework, Guidance on the routine collection of patient-reported outcome measures, Department of Health 2007*

# Overview

- The Blurred reforms are a tale of putting the cart (money) before the horse (productivity)
- The new Government is becoming more focused on issues of outcome productivity and the role of incentives in changing the behaviour of hospitals and physicians e.g. normative tariffs for hospitals

# Conclusions

- The “Blurred” reforms were a nice example of haste in failing to address fundamental long term problems, and focusing on money rather than productivity
- Repeated the mistakes of the Thatcher regime, whose policies were described as follows:
- “ Instead of ready take aim and fire, the Government chose to make ready, fire and then take aim!”