


Bending the cost curve: some English lessons

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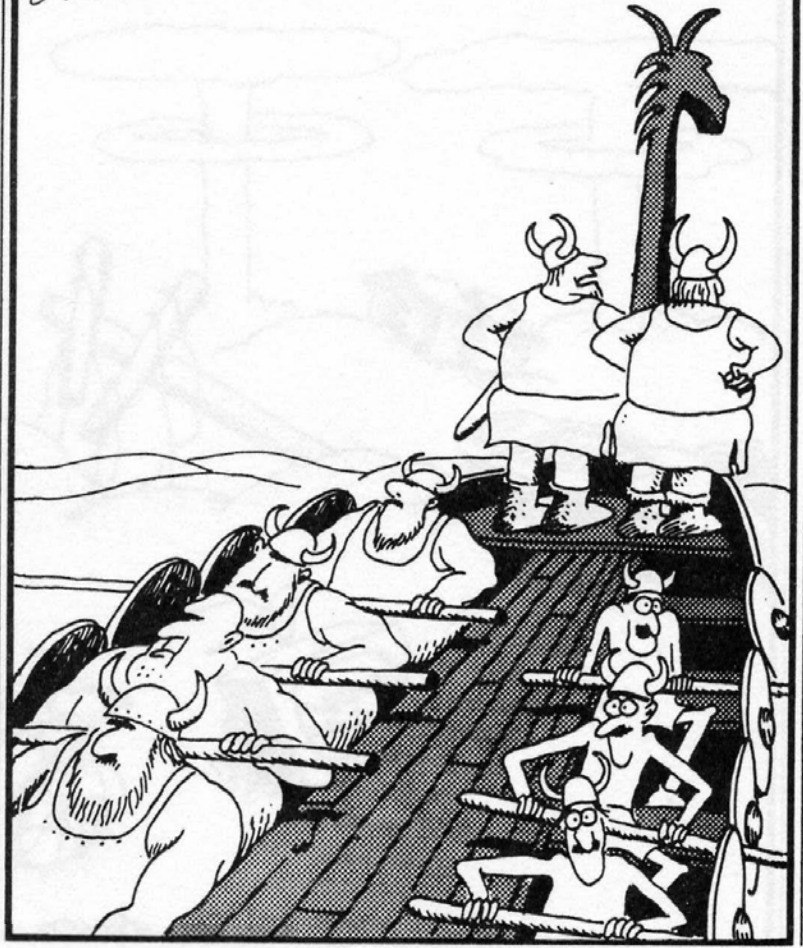
Outline

- ▶ What are the problems?
 - ▶ How did the English respond?
 - ▶ What are the implications?
 - ▶ Where to now?
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Common problems in health care systems


- ▶ The failure to evaluate scientifically the continuous processes of health care reform worldwide i.e. a refusal to learn from change
 - ▶ Universally public and private payers are price and quality takers, and public and private providers are price and quality makers. This inequality of market power preserves inefficiency and inequity. Summarised here..
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Lanson




"I've got it, too, Omar . . . a strange feeling like we've just been going in circles."


Problems in the English NHS

- ▶ Money: after the “Blair Bonanza” of rapid expenditure growth, “Cameron cut-backs” and flat real funding for 5 years
 - ▶ Belief that saving through enhanced productivity and re-cycling these funds over 5 years will enable the NHS to meet increased demand (i.e. save & recycle £20 billion of annual budget of £105bn).
 - ▶ A central policy to achieve this change is cutting clinical practice variations(Glover (1938) to Wennberg (2010))
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English policy responses : structural “re-disorganisation”

- ▶ English health care: when in doubt have a structural reform!
 - ▶ Current reform: purchaser–provider “market” split retained with purchasers being transmogrified from Primary Care Trusts to Clinical Commissioning Groups (CCGs) dominated by GPs
 - ▶ NHS Commissioning Board (a new central quango) manages system with annual contract with the Department of Health. It controls 20–30% of budget for centralised services etc
 - ▶ As ever reform based on rhetoric and prayer with no pledge to evaluate and add to knowledge
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English policy responses: attempts to increase productivity

- ▶ Vigorous implementation of reformed contracts for GPs and hospital consultants (specialists) emerging? GP Quality Outcomes Framework (QOF) costs annually £1.1bn; consultant contract gave 27% pay increase over 3 years but promised productivity gains have not been delivered
 - ▶ “Commissioning for Quality & Improvement” (CQUIN) sets “quality” targets and puts 1.5% of hospital income at risk
 - ▶ “Quality Innovation Productivity & Prevention” (QIPP) mostly locally negotiated improvements.
 - ▶ Pay freeze for 2/3 years
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What are the implications?

- ▶ Debate about what is a productivity increase (more or the same from less?) and what is mere cost cutting, with unobserved effects on process & outcome quality
 - ▶ Evidence base for “pay for performance” (P4P) schemes is voluminous but poor i.e. we do not know how to reduce unwarranted clinical practice variations in a cost effective way
 - ▶ P4P schemes lack control groups, provide little evidence of cost effectiveness, minimise “gaming” and offer poor focus of effects on non-incentivised services.
 - ▶ Policies are “faith based” rather evidence based in England and internationally
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Where to now?

- ▶ What changes behaviour cost effectively?
 1. Financial or reputational incentives?
 2. Penalties or bonuses?
 - ▶ “Pain is in almost all cases a more pungent sensation than the opposite and corresponding pleasure. The one almost always depresses us much more below the ordinary, or what might be called the natural state of happiness, than the other raises us above it” Adam Smith, Theory of Moral Sentiments, 1759
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Conclusions

- ▶ Complex re-disorganisation of structures with large staff losses and a loss of corporate memory diverting attention from enhancing productivity
 - ▶ Productivity programme will require considerable reconfiguration of services with local political opposition
 - ▶ Continuing reluctance to learn from experience and evidence
 - ▶ Failure to infect decision makers with septicæmia.....
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Scepticaemia

- ▶ An uncommon generalised disorder of low infectivity. Medical school education is likely to confer life-long immunity”
 - ▶ (Skrabanek and McCormick, (1989, 1992))
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