England: Europe's healthcare reform laboratory?

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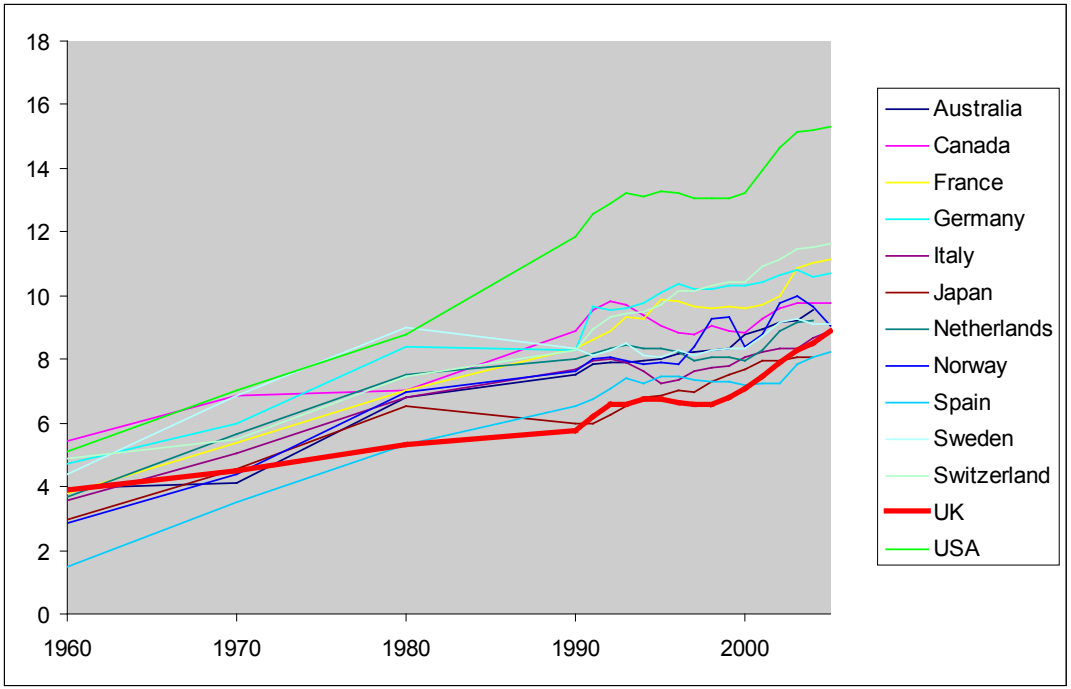
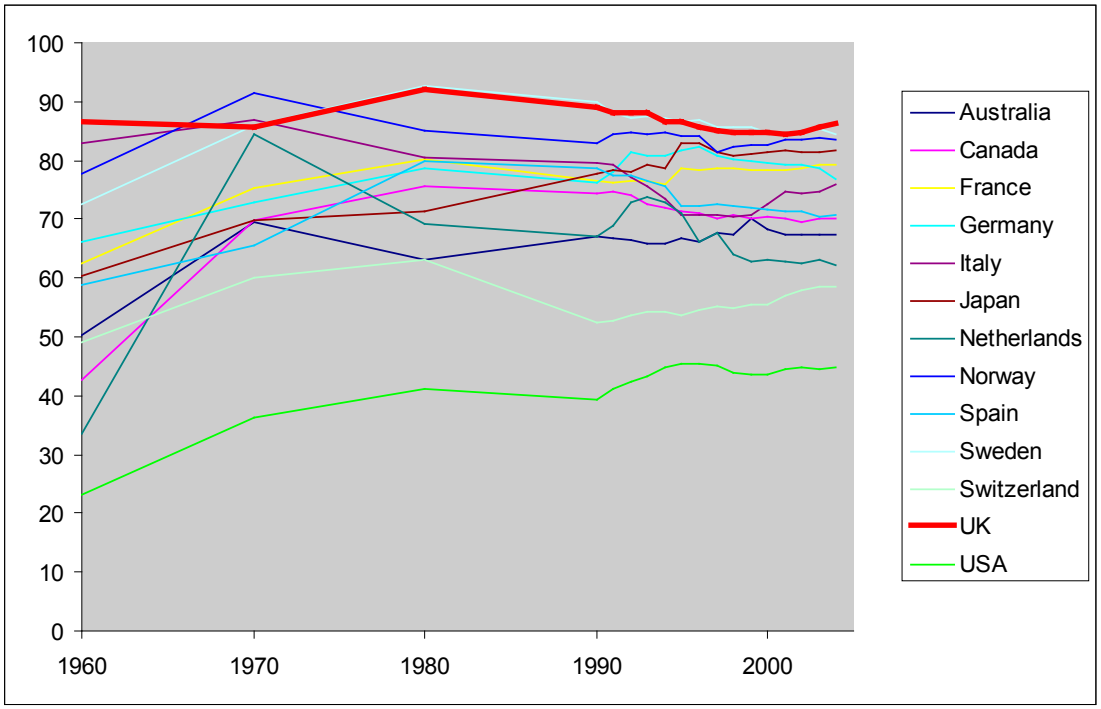
Total health care expenditure as % of GDP by country, 1960 - 2006



Source: OECD Health Data 2010

- UK total health care expenditure has until recently grown at a systematically slower rate than most developed countries. Even with recent increases, it remains below most countries' levels.

Proportion of health care expenditure in public sector, 1960-2006



Source: OECD Health Data 2010

- Amongst the same countries, UK clearly spends a greater proportion in the public sector than most (about 85%).

English National Health Service (NHS): historically ...

- Low spending
- Good expenditure control
- Good risk pooling and financial protection
- Waiting times and other quality concerns
- Slow innovation

Overall Views of Health Care System, 2010

Percent	AUS	CAN	FR	GER	NETH	NZ	NOR	SWE	SWIZ	UK	US
Only minor changes needed	24	38	42	38	51	37	40	44	46	62	29
Fundamental changes needed	55	51	47	48	41	51	46	45	44	34	41
Rebuild completely	20	10	11	14	7	11	12	8	8	3	27

Source: 2010 Commonwealth Fund International Health Policy Survey in Eleven Countries.

THE COMMONWEALTH FUND

Reforms since 1997

- Priority setting
  - National Institute of Health & Clinical Excellence (NICE)
  - New technologies
  - Treatment guidelines
- Performance information
  - Public performance reporting: report cards and targets
  - Pay for performance (general practitioner performance incentives)
  - Patient-reported outcome measures (PROMs)
- Strategic purchasing (commissioning) of health services
  - ‘World Class Commissioning’ by local health authorities
  - General practitioner commissioning
  - Personal budget experiments
- Choice and Competition
  - Enhanced choice of provider for patients
  - Increased plurality of health care providers,
  - Diagnosis–related group (DRG) financing of provider organizations

English reforms: three cases

1. National Institute for Health and Clinical Excellence (NICE)
2. Public reporting and central targets
3. Pay-for-performance in primary care

CASE 1: Health Technology Assessment - NICE

- Created 1998 as health technology assessment agency
- Initial focus on new healthcare technologies
  - Prime role for cost-effectiveness analysis
- Broadened to include:
  - Public health interventions
  - General treatment guidelines
  - Quality criteria
- Some guidance is mandatory
- Undermined by ministers:
  - Pre-empting NICE decisions
  - Increasing threshold for ‘end of life’ treatment
- ‘Value based pricing’ now under scrutiny

Cost-effectiveness analysis as a 'referee'

- Sets explicit 'rules of the game', for delegation to a regulator (NICE)
- Removes politicians or managers from involvement in case-by-case decisions
- Allows insurers and other health authorities to set the 'health basket' funded from statutory sources
- Allows pursuit of health system objectives
  - Efficiency (best use of limited funds)
  - Equity (equal access for those in equal need)
  - Politics (addresses the resource allocation debate)

But many methodological challenges remain …

- Definition of benefits (health gain or broader?)
- Setting the ‘threshold’ for accepting technologies
- How to handle interactions between treatments
- Measurement of benefits
- Measurement of costs
- Incorporation of equity into cost-effectiveness analysis
- Generalizability of results from specific studies
- Should price be negotiable?
- Speeding up the process
- Extending evaluation to all treatments (including established ones)
- Securing appropriate ‘public involvement’

… and some perverse outcomes can emerge

- Incomplete disclosure of information
- Central direction vs local discretion
  - Are decisions mandatory or advisory?
  - Postcode rationing
- Drift of prices towards the threshold, even for low cost technologies
  - Threshold becomes the ‘going rate’ for a QALY
- ‘Competition’ between health systems
  - Once a health technology is accepted somewhere it is difficult to reject
- Extension of treatment beyond the target population group
  - Lower benefits for the broader group
- Suboptimal research and development policy

CASE 2: Public reporting – NHS Star Ratings

- Prepared for every NHS organization 2001-08
- Every organization ranked on a scale of zero to three stars
- Objective is to inform the public of the performance of their local health care organizations
- Complex composite measure reflecting centrally determined objectives (pre-eminently waiting times)
- Organizations with higher scores given increased freedoms
- Jobs of chief executives at risk in organizations with poorer scores.

Star ratings – key targets 2004

1. no patients waiting more than 12 hours for emergency admission
2. no patients with suspected cancer waiting more than two weeks to be seen in hospital
3. a satisfactory financial position
4. improvement to the working lives of staff
5. hospital cleanliness
6. at least 67% of patients with booked appointments
7. no patient waiting longer than the standard for first outpatient appointment (21 weeks, reducing to 17)
8. no patient waiting longer than the standard for in patient admission (12 months, reducing to 9)
9. no waiting in emergency for more than 4 hours
10. a satisfactory clinical governance report

York Hospital Star Rating 2002

York Health Services NHS Trust **3 Stars***

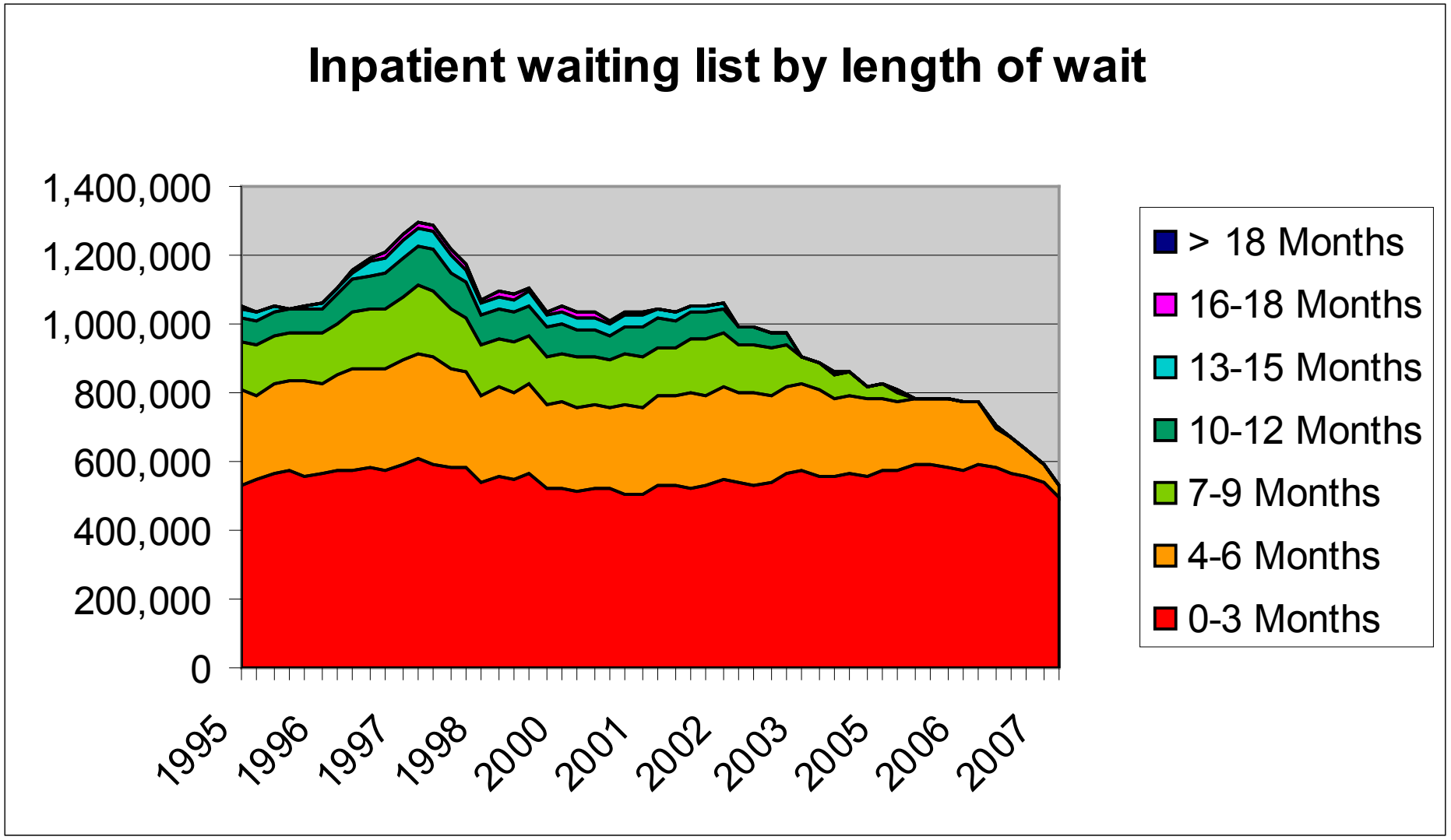
Key:	
Achieved	3
Under-Achieved	-
Significantly Under-Achieved	X
Significantly below average	1
Below average	2
Average	3
Above average	4
Significantly above average	5

Key Targets:	
Eighteen month inpatient waits	3
Fifteen month inpatient waits	3
Twenty six week outpatient waits	3
Twelve hour trolley waits	3
Cancelled operations	3
Two week cancer waits	3
Improving working lives	3
Hospital cleanliness	3
Financial management	3

Patient Focus:	
Six month inpatient waits	2
Total inpatient waits	3
Thirteen week outpatient waits	3
Total time in A&E	5
Cancelled operations not admitted within a month	3
Heart operation waits	n/a
Breast cancer treatment	5
Delayed discharges	2
Inpatient survey - Coordination of care	5
Inpatient Survey - Environment and facilities	3
Inpatient Survey - Information and education	4
Inpatient Survey - Physical and emotional needs	5
Inpatient Survey - Prompt Access	4
Inpatient survey - Respect and dignity	4

NHS Performance Ratings and Indicators 2002 Home Page

Inpatient waiting list by length of wait, England, 1995-2009

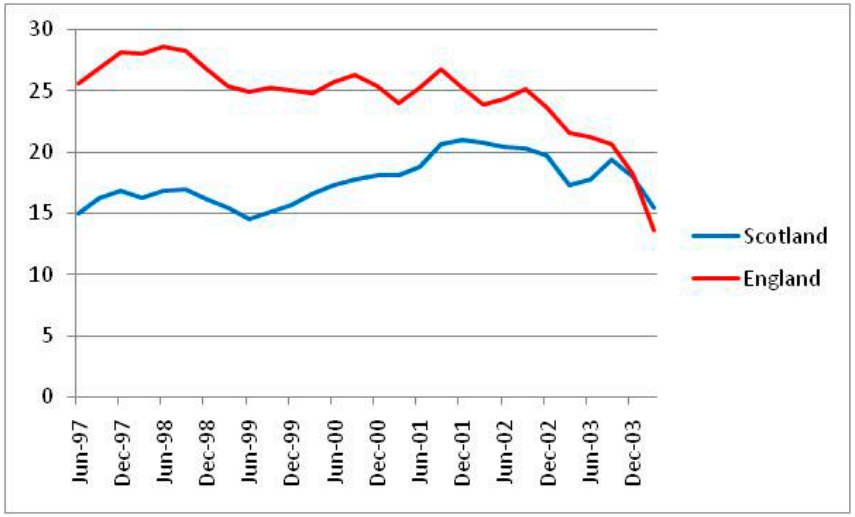


Carol Propper, Matt Sutton, Carolyn Whitnall, and Frank Windmeijer (2008) "Did 'Targets and Terror' Reduce Waiting Times in England for Hospital Care?," *The B.E. Journal of Economic Analysis & Policy*: Vol. 8: Iss. 2, Article 5. Available at: http://www.bepress.com/bejeap/vol8/iss2/art5

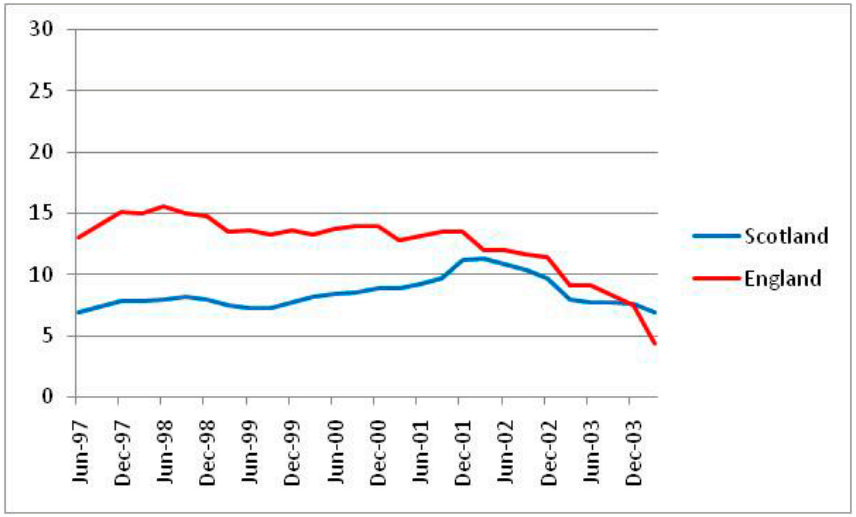
- Examines trends in waiting times in England (with targets) and Scotland (without targets) over a 7 year period
- Finds the target regime did reduce waiting times in England, relative to Scotland

Propper *et al* (2008): England vs Scotland

Waiting more than 6 months



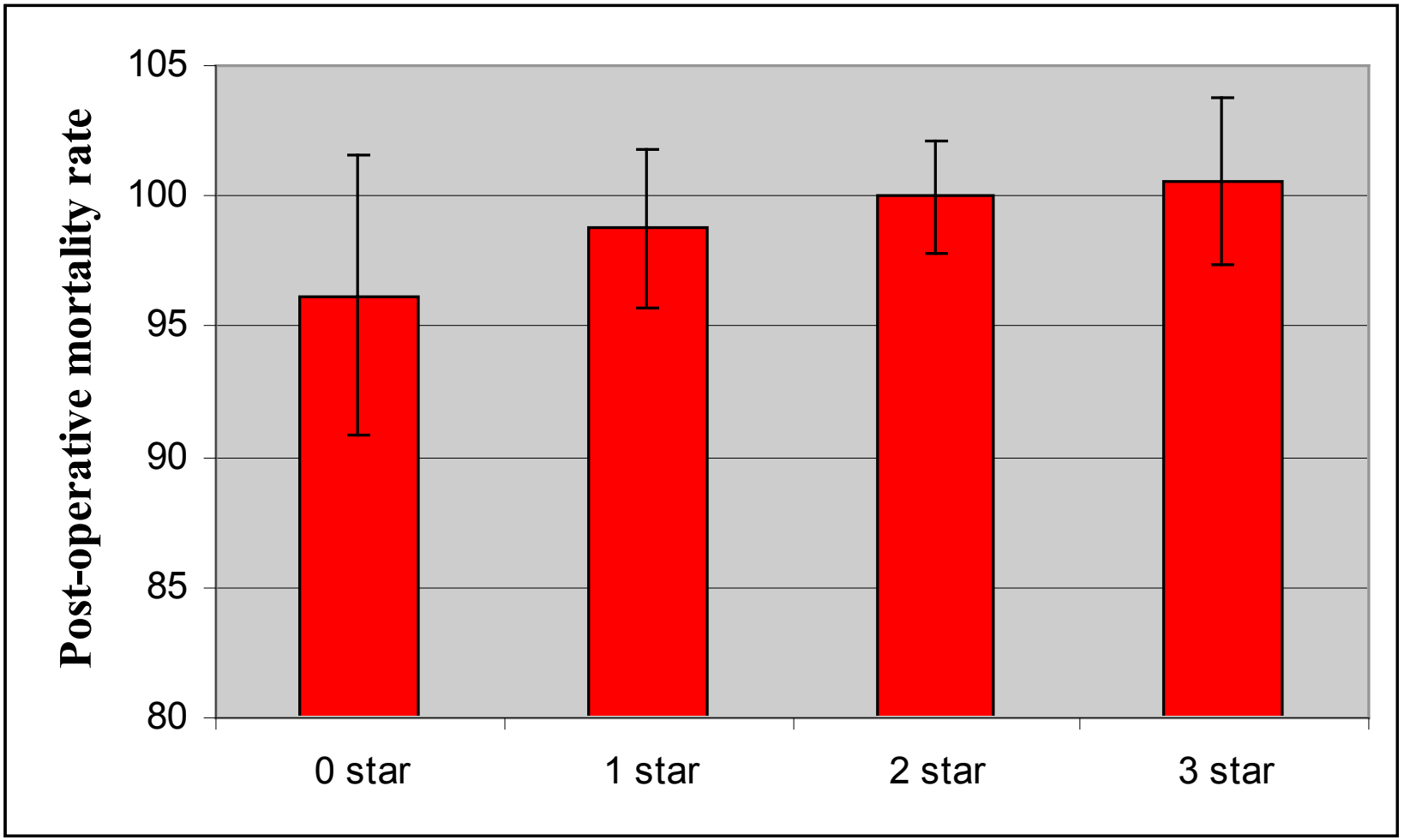
Waiting more than 9 months



But adverse outcomes can arise...

- Ignoring untargeted outcomes
- Misrepresentation and fraud
- Gaming

Post-operative mortality rate by star rating 2001/02



Key questions for target regimes

- Who should choose the targets?
- What targets should be chosen?
- When should outcomes (rather than processes) be used as a basis for targets?
- How should targets be measured and set?
- How should adverse outcomes be neutralized?
- How can targets regime be refreshed and sustained?

CASE 3: Pay for Performance - the Quality and Outcomes Framework

- All citizens must be registered with a general practitioner
- Typical practice population 8,000 (but increasing)
- 85% of GPs are independent contractors with the National Health Service
- GPs are used to working in an incentivized environment
- Traditional GP contract was developed piecemeal over decades - a mixture of capitation, salary, fee for service and grants
- New GP contract in force since 2004, including a major system of incentives for quality – the Quality and Outcomes Framework (QOF).

http://www.qof.ic.nhs.uk/
http://www.nhsemployers.org/pay-conditions/primary-890.cfm

Quality and Outcomes Framework 2004/05: Indicators and points at risk

Area of practice	Indicators	Points
Clinical	76	550
Organizational	56	184
Additional services	10	36
Patient experience	4	100
Holistic care (balanced clinical care)	-	100
Quality payments (balanced quality)	-	30
Access bonus	-	50
Maximum	146	1050

Hypertension: indicators, scale and points at risk

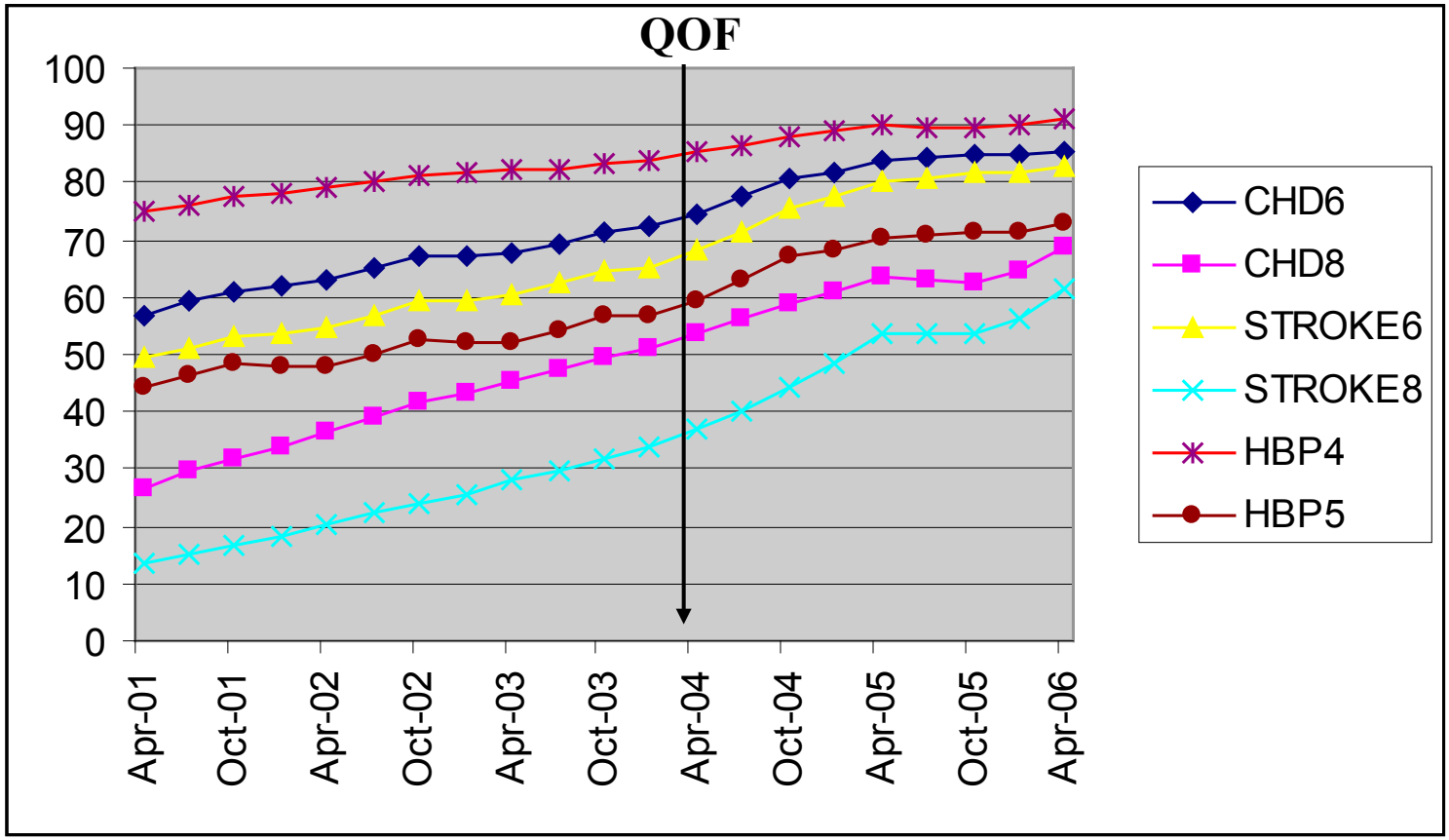
Records	Min	Max	Points
BP 1. The practice can produce a register of patients with established hypertension			9
Diagnosis and initial management			
BP 2.The percentage of patients with hypertension whose notes record smoking status at least once	25	90	10
BP 3.The % of patients with hypertension who smoke, whose notes contain a record that smoking cessation advice has been offered at least once	25	90	10
Ongoing Management			
BP 4.The % of patients with hypertension in which there is a record of the blood pressure in the past 9 months	25	90	20
BP 5. The % of patients with hypertension in whom the last blood pressure (in last 9 months) is 150/90 or less	25	70	56

Achievement in England

	2004/5	2005/6	2006/7	2007/8
Average points score (%)	91.3	96.2	95.5	96.8
Practices achieving full marks (%)	2.6	9.7	5.1	7.5

Source: NHS Information Centre http://www.qof.ic.nhs.uk/

Trends in six QOF indicators 2001-2006



CHD	Coronary heart disease
STROKE	Stroke
HBP	Hypertension

Recommendations for P4P

- Involve clinical professionals in design
- Set a quantitative ‘baseline’ against which the impact of the P4P scheme can be measured
- Seek out performance measures in ‘hard to measure’ domains
- Evaluate the scheme carefully
  - Measured domains
  - Unmeasured domains
- Start with pilots, testing much lower rewards than used in the QOF
- Undertake continuous monitoring and review of scheme.

New reforms

- Coalition government elected May 2010
  - Abolition of ‘politically motivated targets’
  - Freeze in NHS expenditure (requiring 20% real terms savings by 2015)
- Major health care reform bill introduced into parliament
  - Devolution of strategic purchasing to general practitioner ‘consortia’ and abolition of statutory health authorities
  - Creation of an ‘economic regulator’ for health services
- Considerable political controversy
  - Role of competition, markets and private sector providers
  - Accountability for public spending
  - Hostility from healthcare workforce
- Under review and reconsideration

The key reform levers

- Information
  - Personal information (electronic health records)
  - Provider and purchaser performance
- Accountability
  - Markets (Competition and choice)
  - Politics
  - Professional
- Autonomy
  - Providers
  - Purchasers
  - Patients
- Financing mechanisms
- Public health, risk factors and behavioural change

Summary of reform experience

- Lots of policy innovation and experimentation
- Immense investment
- Focus mainly on effectiveness rather than productivity
- Sometimes a lack of sustained policy commitment
- Very weak evaluation and only limited learning
- Lack of long-term strategic consensus