|The NHS Experience

By

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NHS Funding

1. Tax based system with an element of “national insurance” and user charges
2. Resources allocated by needs based formulae
3. Increased funding during the last decade, but much of this has funded pay and price inflation rather than service delivery

NHS performance

- The NHS is inefficient like all health care systems e.g.

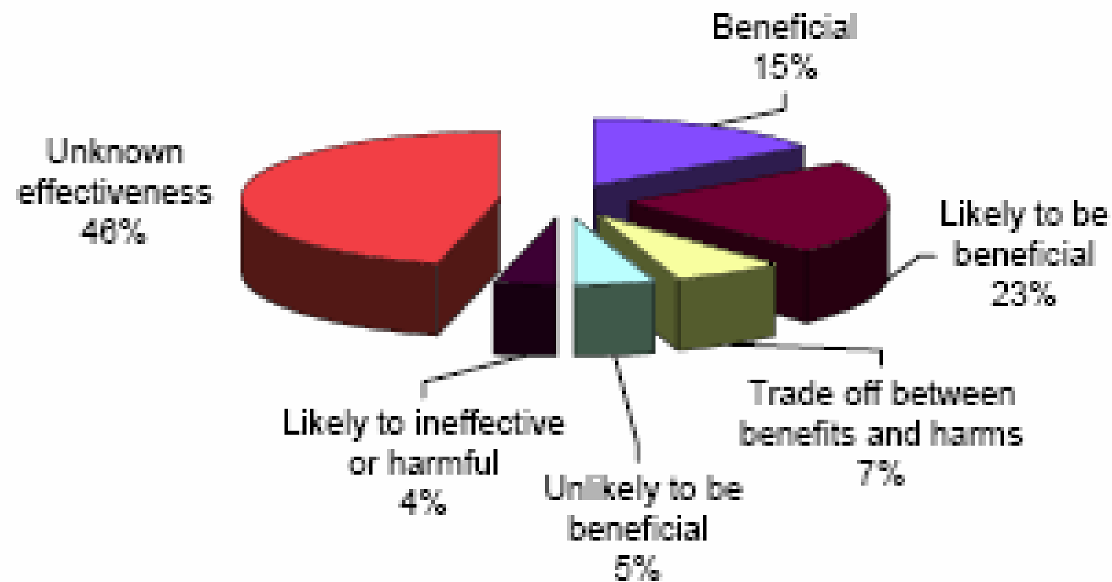
1. Much of health care has no evidence base
2. There are large variations in clinical practice
3. Medical errors affect ten per cent of patients

4 There is little evidence of “success”: does health care make patients better? E.g. no equivalent of the 1845 Lunacy Act which required assessment of outcomes (dead, recovered, relieved or unrelieved) and fined physicians who failed to record data

The NHS is like a crematorium

- " I once asked a worker at a crematorium, who had a curiously contented look on his face, what he found so satisfying about his work. He replied that what fascinated him was the way in which so much went in and so little came out. I thought of advising him to get a job in the NHS, it might increase his job satisfaction, but decided against it. He probably gets his kicks from the visual demonstration of the gap between input and output. A more statistical demonstration might not have worked so well"
- Archie Cochrane, "Effectiveness and Efficiency" (1972)

Figure 1: Uncertainty about clinical effectiveness



Source: BMJ Publishing Group 2005[13]

Reimbursement rate for non-capitated Medicare per enrollee, 2006

Hospital referral region	Medicare spending 2006 ($)	Spending growth 1992-2006 ($)	Annual growth rate 1992-2006 (%)
Manhattan NY	12114	4979	3.9
Los Angeles	10810	3707	3.0
Philadelphia	9665	3495	3.2
Boston	9526	3204	3.0
Nashville	8355	3048	3.3
Phoenix AZ	7890	2748	3.1
Atlanta	7363	2004	2.3
Seattle	7218	2379	2.9
Minneapolis	6705	2967	4.3

Source: Fisher et al, NEJM, February 26th, 2009, page 851

Hogarth

Outcome regulation

- A measure of failure: mortality data: problems of risk adjustment at the hospital and individual physician level due to small numbers but still useful e.g. cardio-thoracic surgery
- A measure of success: do you improve functional status of patients in terms of before and after measurement of physical and psychological quality of life e.g. patient reported outcome measurement (PROMs)………

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

Reforming the NHS

- An undue focus on **organisational structure** and a faith based belief that changes in structure will improve **processes** and **patient outcomes.**
- Investments in information systems (e.g. comparative data on consultant activity , costs and outcomes), with audit
- Growing attention to incentives i.e. rewarding and penalising inefficiency

Incentives in the English NHS

1. Hospital tariff system: “payment by results” (PbR)=payment for activity
2. Quality outcomes framework for GP practices: altered behaviour; very expensive and inefficient way of improving health?
3. Commissioning for Quality and Innovation (CQUIN): setting of largely process standards, measurement of performance and penalties for failure to perform well (cf US Premier programme in USA)

Lessons and questions

- Evaluation poor in UK and USA (e.g. Ryan in Health Economics, October 2009)
- Does incentivising processes of care improve outcomes?
- Does incentivising processes of care reduce costs?
- Which is more efficient: incentivising institutions or incentivising individual practitioners?
- Do penalties alter behaviour more efficiently than bonuses?
- What are the opportunity costs of such systems?