THE ENGLISH HEALTH REFORMS

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NHS SPEND

- System funded through national taxation and "free" at point of delivery to the patient irrespective of ability to pay
- Annual budget – Around 130 Billion euros
- Health care 8% of GDP

THE POLITICS OF REFORM

- "From the cradle to the grave" Bevin 1948
- Many previous attempts to achieve reform
- The Lansley route.. "destroying the bridges"
- Resistance
  - The NHS
  - The Professions

PRESENT STRUCTURE

- Operates via an internal marketplace and uses activity as the currency. Activity determined by the patient but mainly via Primary Care

- SHAs (ten)
- PCTs (One hundred and fifty two)

- Foundation Trusts (acute and mental health)

- Primary care – the GP services

PATIENT PATHWAYS

- All population needs to be registered with a GP (and cannot be registered with more than one)
- Primary care acts as the gatekeeper to secondary care and manages demand for the system
- GP Practices have delineated budgets for secondary care activity and pharmaceutical spend

REFORM TIME LINES

- SHAs abolished by 31st March 2012
- PCTs clustering now and abolished by 31st March 2013
- Likely to be remnant geographic structures of national commissioning Board

NATURE OF REFORMS

- Clinical behaviour and financial consequence clearly linked
- Practices join up into Consortia and assume population responsibility
- The Health and well Being Boards – the local authorities –new role for Public Health
- The National Commissioning Board

PATHFINDERS

- Already much more than 50% of population under care of "pathfinders"
- Implementation of NICE now only as far as is affordable for a community, given the differing priorities for different populations
- Further development of "clinical commissioning" HRG4 and new contracting (Euro DRG)

POTENTIAL CHANGES TO CONTRACTING PROCESS

- ACPPV to manage "up-treatment" and growth in secondary care activity using NICE
- Programme budgeting approach to drug spend in acute Trusts
- Use of outcome measures in contracting – Drug and Alcohol
  - Gradated payments determined by severity
  - PROMS and PREMS
  - Activity
  - Stretch outcomes – housing and employment

CHANGES IN BEHAVIOURS

- Population responsibility for primary AND secondary care
- Fixed budgets for healthcare for consortia who have to remain financially solvent – the "quality payments"
- The challenge of managing prioritisation
- Making primary care more consistent and predictable in its outputs

HOW CLINICAL COMMISSIONING IS DEVELOPING..

- Program budgeting – determined by consortia, mediated via Health and Well being boards and managed by public health

- Transfer of financial risk to Providers to stop micromanagement of secondary care clinicians

IS THE SIZE OF RESOURCE COMMENSURATE WITH NEED?

- Healthcare for the UK 8% (not that different to Spain) vs. 12% for Germany and 17.5% for the US
- Challenge of pathway redesign to liberate ££

OPPORTUNITIES AND IMPEDIMENTS

- Opportunities for risk sharing around pathways and gainshare around clinical pathways
- Integrated care ?
- The politicians and the NHS ….