Managing health care in England: lessons and challenges

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What is running health services all about?

High quality care at least cost
A high quality health service would provide care that is:

- **Safe** (does no harm)
- **Effective** (does good!)
- **Humane** (treat people with respect and is timely)
- **Equitable** (available to everyone in need regardless of their sex, age, ethnicity etc)
And balanced by cost….

• Is **efficient** (care provided in a way that ensures greatest benefit at least cost)

• but…..trade-offs inevitable as not possible to maximise all dimensions

• So….societies must decide what they are prepared to forego (eg some inequity to achieve efficiency)
And sustainability

• Impact of health services on carbon footprint
  – Primary angioplasty for acute myocardial infarction v thrombolysis
    • Increased carbon emissions x 3.24
      (Zander et al 2010)
  – Mobile breast screening v central facility in an English health district
    • Less car use: 75 tons carbon dioxide a year
      (Bond et al 2009)
Three stages of managing quality

• **Defining** good quality care
  – What care should be provided?

• **Assessing** quality
  – What is the quality of care being provided?

• **Improving** health care quality
  – How can quality be improved?
Assessing quality in England

• Different domains of quality require different methods
  – Effectiveness
    • clinical audit data (quantitative, prospective)
  – Safety
    • case record review (quantitative, retrospective)
    • adverse event reporting (quantitative, prospective)
    • critical incident inquiry (qualitative)
  – Humanity
    • patient surveys (quantitative)
    • observation, interviews, focus groups (qualitative)
  – Equity
    • routine and clinical audit data (quantitative)
Improving quality in England

• Education (re-education)
• Incentives
• Re-design
• Regulation
• Legal action
(a) Education (or re-education)

- Tends to be first response but often inappropriate in that staff know what should be done
- Staff tend to take ‘short cuts’ to be more ‘efficient’
- Methods
  - Traditional: seminars, lectures etc
  - Guidelines: need to create short, concise user-friendly versions; consider issuing guidelines to patients
  - Cost-awareness: info on cost of tests, treatments etc
...education not confined to staff

- Increasingly focus on educating and supporting patients as the ‘co-producers’ of health
  - Self-management eg Expert Patient programmes
  - Particularly with long-term conditions

- Shared decision-making effective in reducing demand and improving outcomes
  - Software providing individualised risk prediction and personal utilities
Shared decision making: the evidence
Elwyn G et al BMJ 2010;341:c5146

• Implementation has proved difficult and slow
  – Need good scientific evidence on options
  – Guidance on how to weigh up pros and cons
  – Supportive clinical culture
• 55 RCTs on impact
  – Patients better informed and less passive
  – Adhere better to chosen treatment
  – Tend to defer surgery (RR 0.8, CI 0.6-0.9)
  • Surgical rates reduced by 25%
(b) Incentives

• Two main types
  – Financial (based on market/competitive ideology)
    • Quality and Outcome Framework (QOF) in primary care since 2004
    • Commissioning for Quality & Innovation Payment (CQUIN)
    • Best Practice Tariff (BPT)
  – Socio-behavioural (appealing to desire of staff to be well regarded by peers)
Impact of incentives

• Professionals
  – tend to respond more to socio-behavioural
  – financial effective for specific changes (eg immunisation)
  – people respond better to rewards than fear of penalties

• Organisations
  – respond to financial incentives eg reimbursement
  – impact on availability and utilisation
  – little evidence of impact on other aspects of quality

• Patients
  – can motivate behaviour change (eg uptake of screening)
  – co-payments can deter use (both of appropriate and inappropriate care)
(c) Re-design

- Change availability of a service
  - limited drug list to avoid misuse and contain costs

- Change access to a service
  - justify need for diagnostic test; allow or prohibit direct referral; telemedicine and telecare

- Change staff responsibilities
  - nurses take over checking BP from doctors

- Pre-authorisation and concurrent review
  - GP referral management systems
  - surgeon has to get permission from purchaser before operating

- Computer-based reminders
  - screening test; immunisations; drug interaction
• Scope for re-designing processes of health care are enormous
• Staff often already aware of problems and ‘know’ the answers
• Involving staff gains their commitment and ownership
(d) Regulation (individuals)

• Entry
  – Licencing
    • legal requirement to practice (GMC, NMC etc)
    • compulsory for individuals to enter a profession
  – Certification (and recertification)
    • assurance fit for specialist practice
    • control entry to specialty by Royal Colleges

• Retention
  – Revalidation (NHSE and PHE)
    • Ensure professional up to date and allowed to retain their licence
    • Assure employers and public still fit to practice
Regulation (institutions)

- Certification (DH/NHSE)
  - Eg permission to acquire expensive technology

- Accreditation (Royal Colleges/ind orgs)
  - Usually focuses on inputs/structures
  - Usually voluntary (and payment required)

- Approval/rating
  - Inspection (Care Quality Commission)
    - regular/routine or reactive
    - announced or unannounced
  - Surveillance/monitoring (CQC)
    - Quantitative data eg waiting times; outcomes
Impact of regulation

• Some evidence of effectiveness of
  – Targets in reducing waiting time
  – Inspection can motivate change
  – Licensing of professionals improves quality

• Potential adverse aspects of regulation
  – Expensive
  – Need to be repeated frequently as judgement becomes out of date
  – Antagonises those regulated and creates resistance
  – Easily discredited by false negatives
  – Can be taken over by those being regulated (eg surgeons decide to be regulated on basis of post-op mortality whereas patients might be more concerned about long term QoL)
(e) Legal action

- Use of legal action (litigation) varies internationally
- Debate as to benefits/costs as regards quality improvement
  - Costs
    - Defensive care, avoiding high risk cases and encouraging unnecessary interventions (e.g. Caesarean sections)
    - Diverts resources from the many to the few
    - Fear may create workforce shortages
  - Benefits
    - Fear keeps practitioners and providers alert/up to date/careful
Does quality improvement work?

• Evaluation is difficult as generally not possible to experiment (RCTs) with interventions
• Difficulty of attributing causality
• Cost-benefit of interventions uncertain given assumptions that must be made (eg length of any benefit)
Factors associated with success

- Participants recognise need for change
- Correctly diagnose the problem
- Support and involvement of respected opinion leaders
- Sense of ownership by participants
- Focus on improving quality rather than reducing costs
- Combination of approaches, changed regularly to ensure persistence of effect
Need both technical and relational interventions

• Technical
  – Scientific evidence/guidelines; quality assessment data; monitoring mechanisms

• Relational
  – Organisational culture; leadership; clinician engagement; staff motivation; transparency; good communication; ward-to-board involvement; patient-centred