Inform

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New Zealand Institute of Health Management Auckland Branch Newsletter

Inside this Issue

The NHS - Changes, Challenges and Current Issues 1

Exciting times ahead for General Practice 6

2004 Conference 7

The NHS – Changes, Challenges and Current Issues

Hugh Ross is a member of the NHS Modernization Board and has recently been appointed as Chief Executive of the Cardiff and Vale NHS Trust, the third largest NHS Trust in the UK. Hugh's understanding of health systems in the United Kingdom and New Zealand enabled him to place his entertaining review of changes, challenges and current issues in the NHS is a context relevant for our June seminar audience.

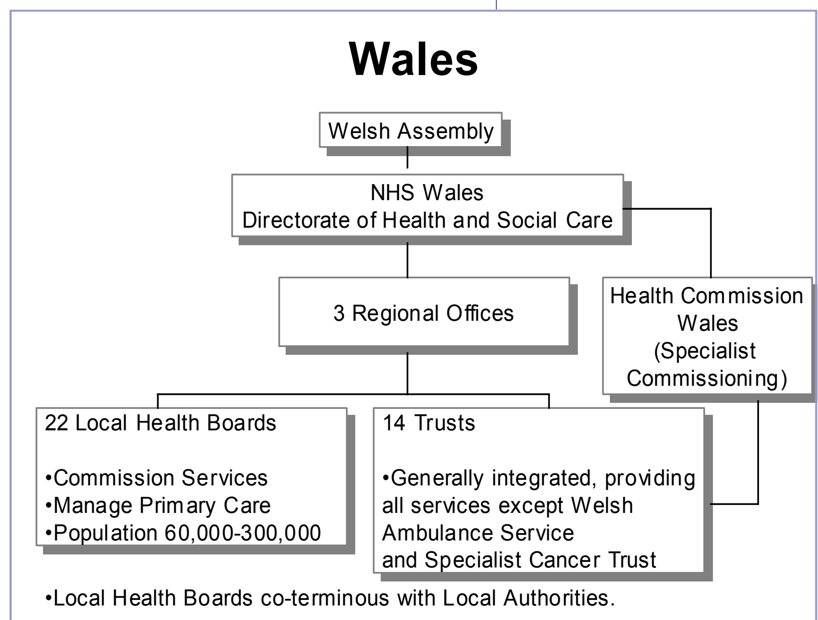
Hugh Ross with Branch Chair Trisha Dunn

What is going on in the NHS at the moment? Britain is into year 6 of the most fundamental rethinking about the National Health Service and the service is enjoying the biggest real growth in resources that it has ever seen. There are changing values and expectations from both the government and from the public and for the first time there is a move towards a mixed economy of providers.

The result of the devolution of services and power to Scotland and Wales and the parliament and assemblies there, has been an ending of the NHS monolith. Four different organisational systems are emerging in the U.K. However, while there are four different systems revenue is still raised and controlled centrally. In an attempt to reduce perceived inequality public services in Scotland and Wales are currently funded at a higher rate per capita than England . So far the health results suggest that Scotland and Wales are not doing as well as they should with the extra money they are getting

Scotland has very wisely abolished the NHS Trusts and gone back to a system very similar to that operating in New Zealand. The local Health Boards are both commissioning (funding) and providing health services as our DHBs do. Similarly, there is significant variation in the size of the Health Boards

In Wales they have set up lots of Health Boards with responsibility for funding secondary services and providing primary services. (Sound like a PHO model?) Some of the Welsh Health Boards are very small and their long-term sustainability is very problematical. These Health Boards are in small isolated and very parochial communities and amalgamation with a Health Board in a neighbouring valley would be an anathema to them.

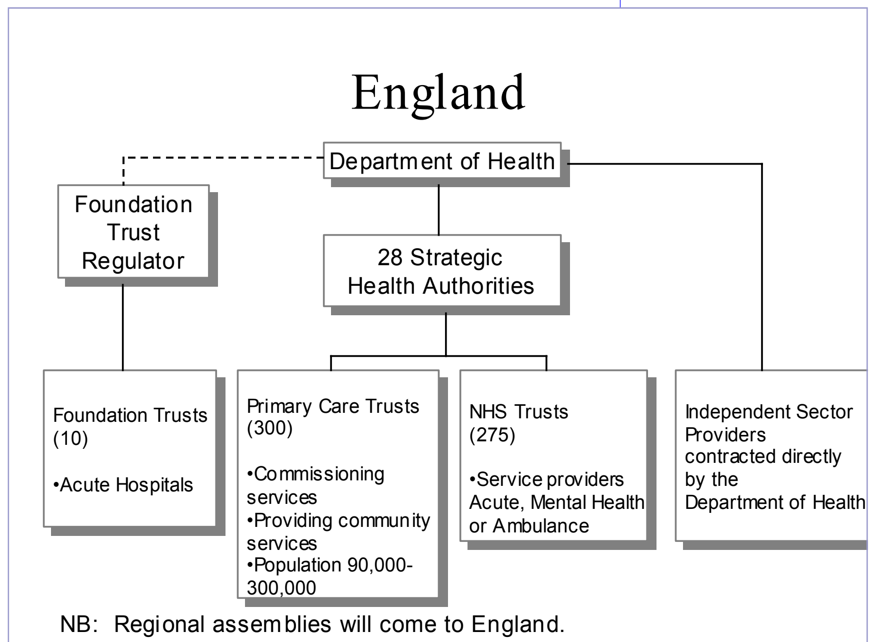


The model for combined health and welfare services in Northern Ireland has been in place for a very long time. Again, some of the services are quite big, others in more remote areas are small and their sustainability is questionable.

The English system, introduced two years ago, has seen the abolition of the regions and

(Continued on page 2)

(Continued from page 1)
the introduction of 28 Strategic Health Authorities – typically with a population of between 1.5 to 2 million. They are essentially the arms of the Department of Health in running the system. Then there are Primary Care Trusts, which took over when Health Authorities were abolished; and NHS Trusts concentrating on acute services, mental health services, or ambulance services. Already the debate in the NHS is on what are we going to do about Primary Care Trusts? When the Health Authorities were split up the management team was basically split into four of five Primary Care Trusts and with the creation of so many new organisations there was no strength or depth of management. The Primary Care Trusts are being asked to run before they can walk. They are being expected to do a job to a standard that the old Health Authorities did not reach.



While there are some shining lights, on the whole they are not doing very well. The betting is that they will not be around for long after the next election - everyone is expecting an amalgamation again.

The capacity of independent sector providers has been massively increased through expansion of those already operating in England and through inviting in established providers from abroad to provide more elective surgery capacity and diagnostic services.

As a consequence of devolution, the service in Scotland and Wales has become increasingly politicised. This has created another layer of politicians who all want to have a local input. Wales and Scotland see themselves as guardians of the old Labour ideal of the NHS and this has created new challenges for those managing health services there. There have quite different approaches to capital funding. While England is going down the private finance model for capital funding, the Scots and Welsh are funding everybody they can to avoid going down the private funding route – but such is the Treasury's stranglehold on capital, in the long term they probably will have no choice other than to also seek private funding.

A variety of funding models are used for specialist services. This is not necessarily a good thing for despite a larger population there are some specialist services for which there is probably a need for only one or two in a country. There are also different approaches to regulation, accreditation and safety. A Council for Regulation of Health Care Professionals oversees all the regulatory bodies for all the country. There is also a National Patient Safety Agency that only covers England and Wales – the Scots do their own thing. Then there is the Commission for Healthcare Audit and Inspection (CHAI), which covers England and Wales, but only for some things. So the machinery of regulation and accreditation is getting increasingly complex and the boundaries are becoming quite difficult. A challenge for the government is that they now have some internal UK comparisons of service between England and the Labour heartlands of Wales and Scotland, which are doing less well than England.

The spending on public services has increased 30% over the past 5 years and the increase in NHS spending, which for the third year in a row had a real increase of 7%, has increased even more. The government has a target of taking NHS spending by 2011 to the EEC average of 9% of GDP. In the longer term it is predicted that 11% of GDP will be required to maintain the NHS as a full service model. Interestingly, Sweden, Germany and France are trying to come the other way because they feel they have a system they are finding great difficulty in affording.

The Treasury is driving the underpinning principles of reform. The principles they are trying to work to are clear long-term goals, and standards with a real push about taking accountability out of government control and having strong independent bodies with power to accredit and regulate. Devolution of responsibility is the new mantra with maximum local flexibility and discretion to innovate; and incentives to ensure that the needs of communities are met. As part of the devolution the Department of Health is currently in the painful process of cutting its staff by 35%.

The government is promoting a lot of transparency about what is being achieved. This is a very

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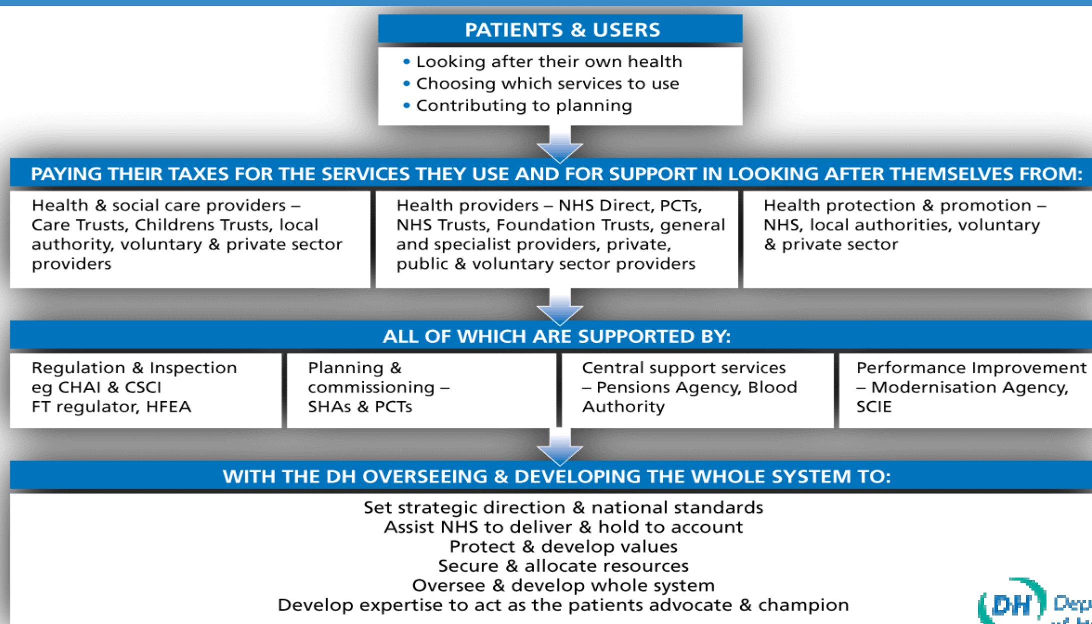
noteworthy objective when two or three of the national newspapers will criticise the government no matter what they do and minimise any achievements.

There is another significant agenda running under all of this. For most of the post-war era the government has allowed the professionals to run public services. However, the government has made it clear that the professionals have had their chance and in the last decade, in response to under-performance, power shifted from the professionals to the government. For the past six or seven years the government has been pulling power back centrally and they will only give it back when they are sure that it will be used wisely and well. When the government decides to devolve power again it needs to remember that it will continue to be held accountable and it must ensure that through devolution and citizen/ consumer involvement, pressure for improvement is enhanced and professional incentives are strengthened.

From Margaret Thatcher's day the government has been tackling the different professions.

Changing Values and Expectations from Government: *System Reform*



Health has been the last and most difficult bastion and the current government has very much adopted a carrot and stick approach, particularly with the medical profession whom they identified as the major barriers to change. So far there have been lots of sticks and not many carrots, although there is a growing realisation that there needs to be more carrots, otherwise the somewhat precarious support for the change programme will evaporate.

One strand of thinking is based on targets and the National Health Service has become very target driven. Targets, alongside investment have enabled the government to inject ambition; establish direction; link investment to outcomes more explicitly; tackle poor performance; and establish minimum standards. Significant progress is evident across all the public services. While there are many problems with the targets, it is fair to say that the targets, which the NHS has been given and which have been driven mercilessly, have been quite effective. Most of the change has been driven by a massive injection of resources. The key has been perspiration rather than inspiration – that is not sustainable in the long term and once the waiting list backlog is cleared there is a need to rethink how to avoid getting back to long waiting lists. The down side is that things like chronic disease, for which no targets have been set, are ignored.

Rising patient and public expectations will increase demands on those providing health and social care; require continuous service improvement; more responsive services; real choice; and raise important issues of equity. Note however that Rhodri Morgan, the Chief Minister in Wales and a

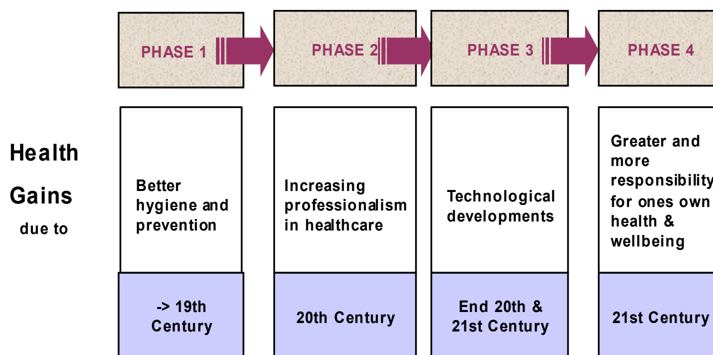
(Continued on page 4)

(Continued from page 3)
traditional Labour man has said, “voice not choice,” so choice might not be the same all across the U.K.

New opportunities exist for patients to take an active part in their own care and to become expert patients (“self management”). That is, there will be a greater focus on the responsibilities of patients as well as their rights. The government seems to be trying to develop quite different relationships between patients, the public and health services than has traditionally seen. They are putting in place all sorts of things to stop the public from automatically accessing the health system – for example, pharmacists are going to be given powers to diagnose as well as prescribe, nurses powers to prescribe will be greatly extended and the range of direct by telephone and digital TV advice/support services have been hugely extended.

Prevention Strategies

The potential of prevention strategies to generate health gain has yet to be realised

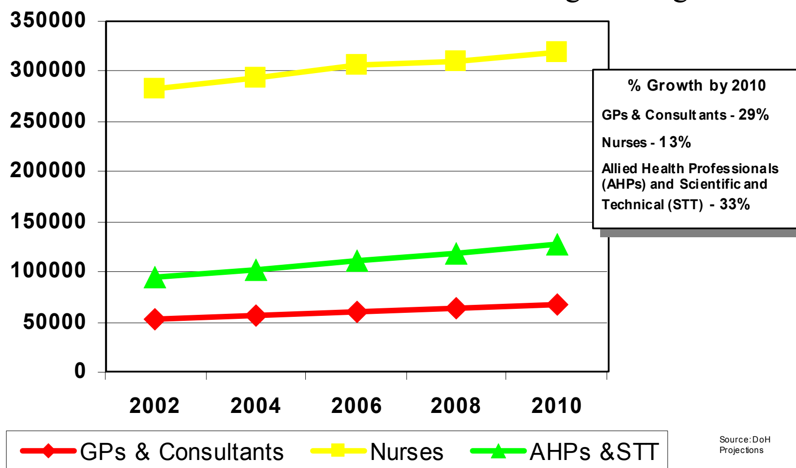


Adapted from: The hospital of the future envisioning health care in 2010 and beyond, Dutch Hospital Association (www.public-space.com)

In the workforce context there are ambitious targets for growth and this has created enormous tensions. For example, in Bristol on January the 1st this year 50 nurses arrived from India to start work. That is the scale of staff imports required to keep up with the expansion programme. For the first time they are even recruiting nurses from the United States. In 2003 the Nursing and Midwifery Council registered more new registrants from outside the U.K. than inside. Through the expansion of the Economic Union with free access between countries there will be access to staff from ten more countries. The problem is that the U.K. does not recognise a lot of the professional qualifications of people from those countries. The people in the regulatory authorities are aghast at the prospect and it something the government did not think about before they opened up the access.

Workforce Issues

Workforce Context - ambitious targets for growth



Increased numbers will come through poaching from other countries, including New Zealand

Also working against resource building is the European working hours directive which will reduce the hours staff can work – they will go from 100 down to 48 hours maximum in about eight years and this means that a whole range of services that rely on the massive hours being worked by junior medical staff will not be able to be delivered. A whole range of 250 – 350 bed hospitals will just not be able to sustain the services they offer. In political terms this will be very difficult and just blaming it on Europe will not be good enough.

The change to the mixed economy of providers has been restricted almost entirely to England. The government has started setting up NHS-run Diagnostic and Treatment Centres (DTCs) but as this did not move fast enough they advertised for the independent sector to come in with chains of DTCs to provide massive amounts of elective procedures. The government also realised that part of the problem was with scanning so they have invited independent imaging/scanning suppliers to work alongside the NHS to clear up some of the bottlenecks in the system. Mobile surgical facilities for procedures such as cataracts are going to where ever cataracts are to be found. This has significantly changed the clinical behaviour of ophthalmologists.

Some of the big American HMOs, like Kaiser Permanente, are working alongside Primary Case Trusts on how to improve community based support and minimise repeat admissions - currently 5% of the patients over 65 use 40% of the available bed days. The aim is to make an improvement to their quality of life and more importantly make a huge reduction in the planned admissions to hospital.

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The big debate in all this is about what will happen in five years time - whether or not this is just a big government plot to change the face of the NHS for all time. A mixed economy of providers is now probably here to stay.

Choice is central to the vision for public sector reform. For Coronary Heart Disease patients who have to wait 6 months, London and some other pilots are now offering choice and the waiting numbers are diminishing fast. The Prime Minister and Secretary of State have announced that by Summer 2004 choice to go elsewhere will be offered to any patients waiting 6 months for elective care. By December 2005 every General Practitioner referring a patient for an elective procedure will be obliged to offer that patient the choice of five different providers. This will upset a lot of long established relationships and referral patterns and it is hard to predict how successful it will be. At this stage it does not include chronic disease management and the people who would really value choice are those who have chronic disease problems because it is an episodic part of their lives.

Another part of the system reform in England is a move towards tariffs and 'Payment by Results'. This is very topical worldwide and the whizzes in the Department of Health claim to have trawled the world to devise a system that will work. The focus is on acute services and is already under way. There are a number of concerns. Surgical hospitals are concerned that the complexity of the work they do will not be picked up and satisfactorily rewarded by the HRG-based reimbursement system as it currently stands. There will be a fixed-price for a procedure everywhere in the NHS and the government is saying this is the price the private sector will get as well. This has a major impact for health insurers because it will push up their costs as well.

The end result is that fixed price rewards low-cost providers for no overall benefit. The problem with a fixed price is that if a hospital has been able to operate at 90% of the average price the taxpayer will reward it with another 10% for everything it does without any additional benefit to the public. There will be perverse incentives such as HRG 'creep' to squeeze out every dollar – already coding departments have been ramped up for this very purpose. The worry is that treatment thresholds will change, driven by maximisation rather than clinical judgement and more unnecessary investigations will take place. An inappropriate focus on traditional service models is likely and perhaps most importantly it ignores and does not reward good chronic disease management.

The setting up of Foundation Trusts is a new attempt to 'let go' from the centre by allowing some providers to float free. It has initially been restricted to a small group of Trusts who have to be approved by an independent regulator but it is the direction of travel for all acute Trusts. They will be able to borrow on the market; something the Treasury in the U.K has never relinquished control of before .

There are some significant differences, such as freedom from some aspects of performance management which the rest of the NHS has to comply with; and they will have a wider board of governors, with direct elections from members of the foundation trust hospital. This is another attempt by the government to close the democratic deficit, which, as they see it, exists in the running of the NHS.

But one of the biggest outcries from the traditional members of the Labour party was that these Foundation hospitals would concentrate more on private patients so their private patient numbers have been capped. The Trust Board will remain in overall control and there will be no break from National terms and conditions. After the first wave of Foundation Trusts there will be no more until 2006 – that is, after the next election.

For the future, in the next two years some form of re-integration seems probable with almost certainly some form of horizontal integration and perhaps some form of vertical integration as well. Some of the Foundation Trust Chief Executives are very entrepreneurial types and will look to control the whole chain of supply to guarantee the success of their service.

The government is likely to completely rethink patient and public involvement and the powers of local government, who are likely to be given the power to oversee and challenge the way local health services are delivered in their areas. It is somewhere the health system and the councils have not been before and it is somewhere many of the councils would rather not have to go because it will force them to take positions on very controversial issues.

Finally the report on the Shipman Inquiry is due out in a few months. We will probably never know how many people Dr Shipman killed but the pressure on medical regulatory bodies is intense. The likelihood is that professional self-regulation will be rejected or so largely rejected that it will be rendered ineffective.

Exciting Times Ahead for General Practice

General Practice has received a bad press over the past few years. Terms like: dispirited, over worked, under valued and under resourced being freely sprinkled through media commentary. Perhaps the pendulum is about to turn. Bruce Arroll, Associate Professor of General Practice and Primary Healthcare at the University of Auckland's School of Population Health, reports being told by GPs that they think it is an exciting time to be General Practice. Addressing a recent Scientific Symposium held to mark the opening of the School at their Tamaki campus, Bruce offered a glowing vision of how a primary care clinic will be functioning in 2014.

By then the clinic will be part of an organisation that has metamorphosed from a PHO (Primary Health Organisation) through a number of the ubiquitous acronyms favoured by health policy makers to a DHO (District Health Organisation). The clinic staff will include GPs, nurse practitioners, practice nurses, receptionists, community workers, and administration staff. There will also be community practitioners to deal with lifestyle and mental health issues as well as to facilitate health promotion activities. There will be also be a DHO exercise facilitator, a role which developed out of a demonstration programme in 2004-05. Job satisfaction of all GPs, nurse practitioners, practice nurses and community practitioners will be at an all time high – even better than the good old days.

In this utopian setting computers will have a pivotal role in providing: rapid clinical answers, assisting with multiple clinical tasks and providing an audit tool. Clinicians will be able to use the internet to get instant clinical information from a computerised text book called "allknowing.com". They will also use "Predict version 9" to do rapid cardiovascular assessments and give advice. This will all be integrated into "allknowing.com" and allknowing.com will provide computerised decision support for a whole host of conditions. When a blood pressure is entered into the computer a flag will come up asking if an electronic decision support system is required. Note, the year is 2014 – not 1984 and the physician's name is not O'Brien.

Patients visiting a clinic will be asked to sit at a computer terminal where they will answer a screening questionnaire on lifestyle and mental health issues - smoking, alcohol intake, drug taking, gambling, depression, anxiety, domestic violence, and eating disorders. As well, family history for heart disease, breast cancer, bowel cancer and diabetes and any other serious conditions that run in their families will also be recorded. The computer software will collate this information and transmit it to the patient's GP, nurse practitioner or practice nurse.

Next comes the human touch. The provider will make an assessment of lifestyle and mental health issues and either manage them themselves or refer the patient to the community practitioner. Computers will also be used to provide cognitive behavioural therapy for a wide range of mental health issues and for weight loss management. With all patients linked to the clinic through their cell phone like 'communication assistant', they will be reminded and encouraged to continue their programmes. Auditing will be done 6 monthly using the computers to see how well the targets have been met. For example, the proportion of diabetes patients with blood pressures below 140/90 or the proportion of 2 year olds fully immunised.

The clinic health promotion facilitator will have run a campaign with local fast food outlets to reduce the size of servings and to add fruit to the combinations. A clinic physical activity advisor will arrange walking groups from the clinic and each clinic will be linked to their local gymnasium and swimming pool.

Does all this sound a little far fetched? Try explaining to a teenager what life was like before text messaging. The technology for these proposed changes is already available. On May 25th a Rand Corporation panel released a set of 60 recommendations for electronic prescribing. The technology entails the use of handheld computer devices to check a patient's medical data, review options for which drugs to prescribe, and order drugs clearly and legibly in a way that avoids interactions and lessens side effects.

To provide more information on the patient's medical history, one recommendation is that systems be linked to electronic medical records or to practice management systems. Another is that systems provide the prescribing doctor a list of current medications the patient is taking.

Mindful that designers of e-prescribing systems could use them to influence what drug the physician prescribes, the panel urges that the display of drug options not influence which drug is picked. Some systems try to influence what drug the doctor picks by listing it first or by displaying special symbols such as asterisks. "In general, the panel believed that substantial biases could be deterred through full disclosure of any third-party sponsorship coupled with full disclosure of decision-support rules," said Douglas Bell and other authors of the Rand report.

New Zealand Institute of Health Management
A Branch of the Australian College of Health Service Executives

For all inquiries re Branch activities or membership contact admin@nzihm.org.nz or (09) 577 5477 Phone/Fax

Inform Editor Bruce Parkes

Seminar Programme

August 2nd

@ Cap Gemini ,18th Floor, 41 Shortland St

5:30p.m. for 6p.m.

Ethical Issues in the Treatment/Non-Treatment of Non-Residents

Jan Crosthwaite, Department of Philosophy, University of Auckland

Non Members Welcome

Cost

Members $20

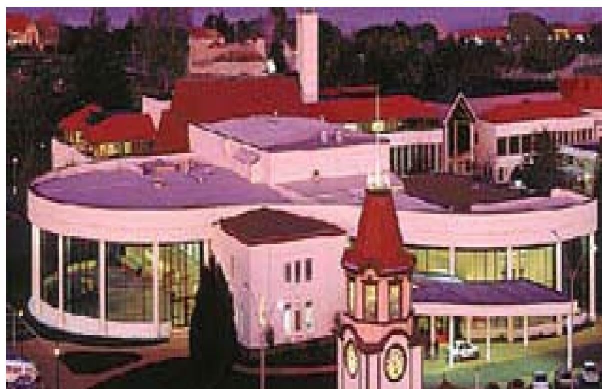
Non Members $25

Eurest support our seminar programme

Innovations from Isolation

Wednesday September 29th — Friday October 1st

Rotorua Convention Centre



Following on from the very successful 2002 ACHSE:RACMA Joint Conference in Perth, NZIHM and RACMA are delighted to host a joint conference on this side of the Tasman. Managers and clinicians work in partnership as leaders in health care organisations through the world. This conference will provide a further opportunity to cement this relationship through shared professional development and networking.

The focus of the conference is on new developments and innovations in a variety of health management contexts. Keynote speakers from Hong Kong will share their SARS experiences, management and medical staff relations will feature highly, along with workforce planning, service reconfiguration and lessons from both those who have led large hospital redevelopments and those who are successfully providing community based services. With both keynote and concurrent sessions, this programme is sure to appeal to health managers in both line management and clinical leadership roles.

Rotorua, is an easy 150 minute drive from Auckland. Use the conference as a time for both intellectual stimulation and bodily relaxation and rejuvenation before our traditional end of the year rush. Take a couple of extra days to enjoy some of the things that Rotorua has to offer - soak in hot thermal mineral pools. Indulge in a spa treatment at your hotel or the famous Polynesia Spa. Visit crystal clear lakes, and forest-clad hills. Fish in the local lakes or streams teaming with trout. Try white water rafting, mountain biking, or race down the hill by luge or zorb. Visit one of the geothermal wonderlands, a legacy of volcanic eruptions from the not so distant past.

Registration is available on line at www.meetingsfirst.com.au/fsite/site/registration.asp

or download a form from www.meetingsfirst.com.au/RegistrationForm.pdf

Earlybird registration closes on August 27th

Contributions Welcome

1. The Auckland Branch welcomes contributions to **Inform** on subjects of interest to managers in the health and disability sector. Articles may be longer researched contributions, comments on current practice, or shorter notes and/or reviews. The range of possible subjects is very wide.
2. The maximum length is generally 3000 words. Shorter contributions are very welcome. Please include an e-mail address so authors can be contacted and a brief list of key points or an abstract.
3. Copy should be provided by e-mail or on a computer disk.
4. Contributions may be passed to the Editorial Committee for consideration.
5. Make submissions or contact the Editor for more information at admin@nzihm.org.nz