Is central government responsibility an answer to the dilemma of setting priorities in healthcare? Experiences from England and Norway.

ENGLAND

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What is meant by centralisation?

- ‘Command and control’

- Holding the budget and making all the resource allocation decisions

What are the ‘dilemmas’ you are trying to address?

Access to high cost drugs

Geographic variation

- What is provided
- Access criteria
- Quality

Demographic variation

- Addressing hard to reach groups
- Health inequalities
- Inverse care phenomena

What are the other major challenges Sweden health care system needs to address?

- Information on primary and community care
- Quality assurance systems
- Co-ordination of care
- Waiting lists
- Meeting the challenge of growing elderly population

Organisational Disruption

Unintended consequences

Achieve the change needed

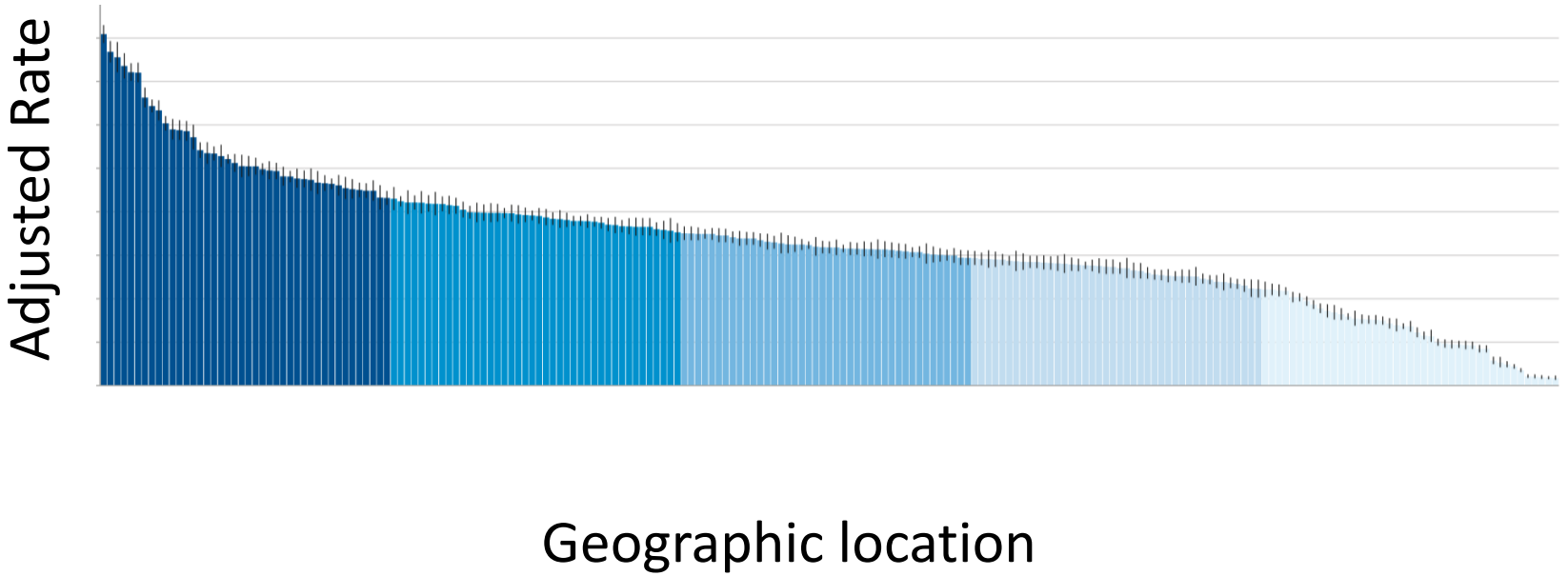
Geographic variation cannot be eradicated

Some factors which influence geographic variation:

- The absolute level of funding
- Infrastructure costs and efficiency
- Commissioner and system capability
- Clinician behaviour and interests
- The nature of the population (needs) and patient behaviour
- Historical decisions concerning services

Diagram X: Any procedure rate / Any access rate

Modified from NHS Atlas of Variation



No budget, no mandate!

The NHS in England

The UK Government

- Determines tax
- Sets the health care budget
- Influences ‘design’ through political philosophy

The Department of Health

- Shapes policy

NHS England

- **Oversees the allocation formula**
- **Sets the budgets for programmes and individual commissioners**
- **Determines priorities for the whole of the NHS**
- **Set performance targets**
- **Commissions**: (16% of the NHS budget)
  - **Highly specialist services**
  - **Specialised services**
  - **Cancer drugs fund**
  - **Armed forces**
- Contracts with primary care and dental services

The UK Government

The Department of Health

The National Institute for Health and Care Excellence

- Produces central guidance for the NHS / Social Care and Public Health
  - Clinical guidelines
  - Service design
  - Quality standards
  - Assessment of treatments
  - **Commits commissioners resources through its Technology appraisals**

The National Institute of Health Research

- Agrees R&D programme for the NHS
- **Commits commissioners resources through that programme**

NHS England

NHS England

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Clinical Commissioning Groups

- Degree of discretion to determine local priorities
- Can make decisions about what treatments to provide (except NICE TAs)
- **Commission: (67% of NHS budget)**
  - **Secondary care**
  - **Community care**
  - **Nursing care**

Local Councils

- Responsible for public health
- **Commission:**
  - **Social care**
  - **Primary prevention**

Addressing equitable funding	• The Resource Allocation Working Party Formula (1975) • Greater efforts to move towards target funding (2013 onwards)
Nationally set priorities	• Health of the Nation (1994) • Performance management of the NHS (1990s)
'Template services and care pathways' (do once)	• The national service frameworks (1994) • NICE clinical guidelines, care pathways , quality standards
Service reorganisation	• Purchaser provider split (1990s) • Introduction of primary care trusts (2002) • Major reform (2013) • Accountable care organisations (2017)
Centralised commissioning	• Regional collaborative commissioning (1980s onwards) • National commissioning of highly specialist services (1990s) • National commissioning of specialised services (2013) • The cancer drugs fund
'Eradication' of postcode lottery (for cancer drugs)	• Funding of NICE's technology appraisals mandatory (2005)
Better data	• Right care benchmarking and NHS Atlas of variation
Improving quality	• Peer review programmes

Some of the good

- Progress towards equitable funding
- Strong central planning (although regional planning has been weakened)
- Service specifications for specialist services and control over provider proliferation
- Some of the ‘do once‘ functions have been centralised
- Maintains local flexibility (but this is difficult to apply if little money and too many central directives)
- Greater accountability within the system
- Collaborative commissioning option

Some of the bad

- The NHS is now very fractured in design
- Heavy command and control as the money gets tighter
- Loss of commissioning expertise at the local level
- Weakened local planning and commissioning structures
- Providers are much stronger than commissioners (imbalance)
- Lack of courage to address the core issue of scarcity
- Priorities are skewed in some aspects ('UK plc')
- Little impact on clinical variation
- While there has been some geographic progress on inequity it has been poor on demographic inequity and inequalities

Geographic variation and NICE's Technology appraisal programme

- NICE is not a neutral party
- NICE is a third party decision maker and as such engages in singular decision making
- NICE cannot tell the NHS or an individual commissioner what the next most important investment
- Decision making should never be on the sole basis of cost effectiveness
- NICE recommendations worsen inequity in poor areas which are currently most likely to be underfunded
- NICE recommendations collectively have unacceptable opportunity cost

Recommendations

- Think about all the desired changes
- Decide which are the most important inequities/inequalities to address
- Some redesign is probably desirable but avoid organisational disruption
- Collaborative commissioning is a good solution to creating commissioning expertise but keeping the responsibility with the budget holder
- The ability to plan across the whole care pathway is important for priority setting and the patient experience
- Look to PHARMAC (NZ) and not NICE
- Look to other health care systems which have large rural communities (Scotland / Canada)

Thank you