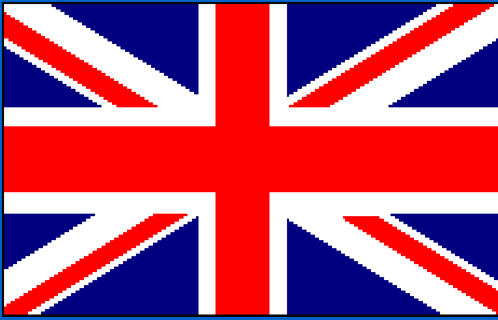
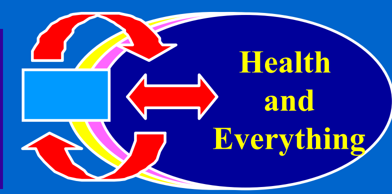


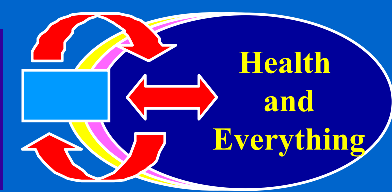
Primary Care Reforms in the UK

WHO World Health Report



	UK	USA	Canada
Per Capita Expenditure on Health	26th	2nd	10th
Overall Health System Performance	18th	37th	30th
Fairness of Health Distribution	2nd	32nd	18th
Fairness of Financial Contribution	8th	54th	17th

Some Comparative Statistics



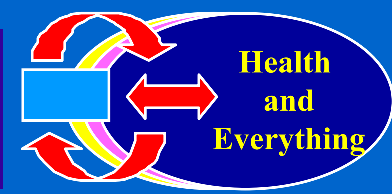
Canada

- Life Expectancy
  - Women 83
  - Men 79
- 9.8 % GDP on Health
- Over 65s: 12%
- 2.3 Physicians /1000:
- Institutional Places: High
- Public/Private mix
  - 69%/31%
- Community Budget Low

UK

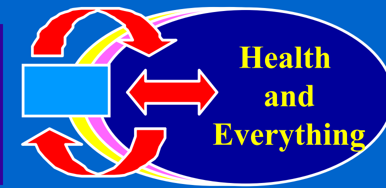
- Life Expectancy
  - Women 79
  - Men 74
- 6.5 % GDP on Health
- Over 65s: 16%
- 1.8 Physicians /1000:
- Institutional Places: Low
- Public/Private mix
  - 85%/15%
- Community Budget High

Four Snapshots of the NHS



- 1984:Single Centralized system
- 1987:Thatcher's Reforms
- 1997: The Results of Reforms
- 2003: The Blair Reforms

NHS:1984



Ministry of health

Department of health and social services

Direct financing with strong cost control

14 Regions

192 Districts

Citizens' Committee

Direct Financing

Family Health Services Authority

68% of expenditures 1983

23% of expenditures 1983

Hospital and Community Units

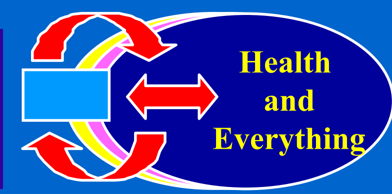
General Practitioner Dentist, Optometrist and Pharmacist Services

NHS Care

NHS Care

The PUBLIC

1984: Single Centralized System

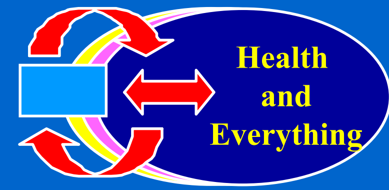


- The centre is directed by Sir Len Peach from IBM, the General Manager of the NHS
- There were **14 regions** with their own general manager who had authority over the districts
- There were **192** general managers for the **districts** of the NHS with responsibility to provide services to the local population.

The Districts

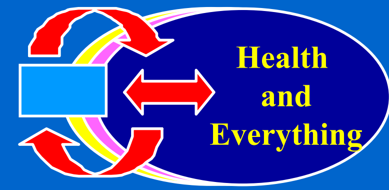
- Each district provided health services to a population of 250,000.
  - General Hospital
  - Community Services
  - Mental Health Services
- The annual budget was controlled by the District General Manager who led an executive team made up of Unit General Managers and functional managers

Doctors



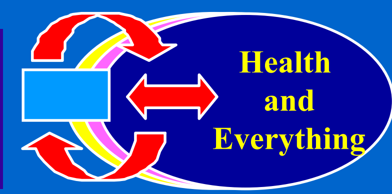
- General Practitioners are independent contractors to the NHS
- Specialists are contracted employees of the regions

Strength of the NHS (1987)



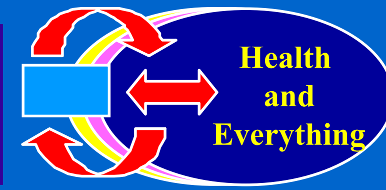
- Comparatively comprehensive
- Reasonably equitable and accessible, irrespective of the ability of pay
- Good record on cost containment
- Relatively good standards of care and treatment
- Effective personalised primary care doctor system
- Low administrative (transaction) overhead costs

Weaknesses of the NHS (1987)



- Low over all level of investment in healthcare
- Under-investment in capital, medical technology and staff remuneration
- Lack of consumer responsiveness and of consumer choice
- Long, (and getting longer), waiting times and waiting lists for elective surgery
- Clinical productivity penalised by the system
- A centralist public bureaucracy while Thatcher conservatives value market forces
- Widely varying efficiency levels
- Effectiveness unmeasured

The Vector of Care 1987



Social Care Organizations

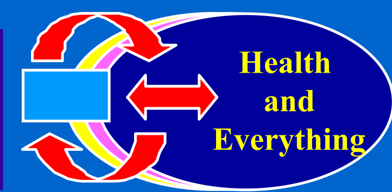
Primary
Care
Doctors

Community Services

Acute
Care
Hospitals

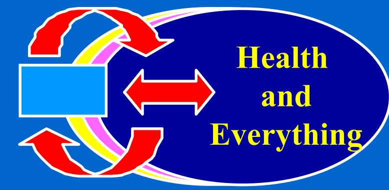
Long Term Care Facilities

Primary and Community Care



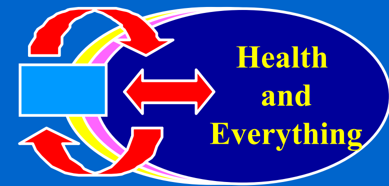
- GP services
- Community Nursing
- Health Visiting
- Examples of Community Health Professionals
  - Dentists
  - Podiatrists
  - Pediatricians
  - Geriatricians
  - Psychologists
  - Physiotherapists
  - Psychiatrists
  - Occupational Therapists

The Thatcher Reforms (1987)



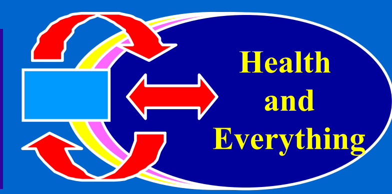
- Introduction of Managed Competition
  - Market forces will increase quality and efficiency
- Purchaser Provider Split
  - Districts purchase services for their population
  - Doctors in group practice can hold funds to purchase
- Hospitals and Community Units
  - become providers of services
  - and become independent Trusts

King's Fund Predictions 1987



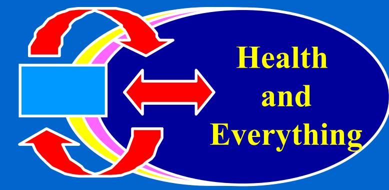
- Two hospitals will become trusts before the 1991 elections
- GPs will not agree to purchase services
- Central authority will be reinforced despite the claimed decentralization
  - From bureaucracy to hypocrisy

The Newham Case



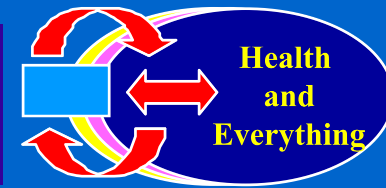
- 1987: Integrated District
  - a stable long-serving team
  - collaboration among the units
  - coordination of services
- 1988: Purchaser Provider Split
  - The DGM and MOH become the purchaser
  - The rest of the team are a single (abandoned) provider
- 1989: Purchaser merge into larger HAs
  - The former DGM is retired
- 1992: Hospital & community services split

Lessons from the Thatcher Reforms



- There are always unexpected consequences when one tries to change a complex system
  - Changing funding flow had such consequences.
- Changing the structure made existing relationships more difficult and put pressure on new organizations
  - Health Authorities had very little more authority. In fact it merely increased the adversarial nature of the relationships

NHS:1997



Minister of Health

Department of Health

Financing with strict cost control

8 Regions

citizen committees

80 Health Authorities

Family Health Service Authorities (GPs)

Contractual Relation

majority of gps are members of purchasing groups

400 Trusts:
hospitals, community service
mental health service

NHS Care

The PUBLIC

NHS Care

The Vector of Care 1997

Social Care Organizations

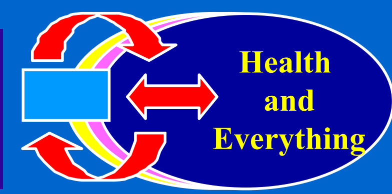
Primary
Care
Doctors

Community Services

Acute
Care
Hospitals

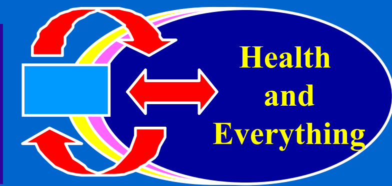
Long Term Care Facilities

GP Practices Expand



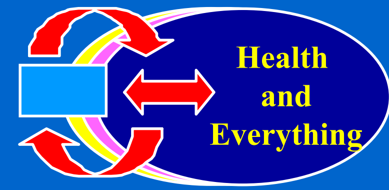
- Primary Care Teams Grow
  - Community Nurses
  - Psychological Counsellors
  - Visits by Community Professionals

Immediate Pressures 1997



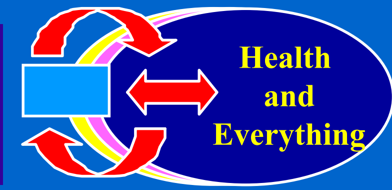
- Problems of coordination and access continue
  - Emergency admissions rising at 5% per quarter during 1997
  - Waiting lists growing by 5% per annum
  - Conflicts between purchasers and providers
  - Widespread public anxiety about mental health services
- Market forces have not solved the problems
  - Looming financial crisis
  - Drug bills rising by 9% per annum
  - Big pay demands

"The New NHS" 1997 White Paper



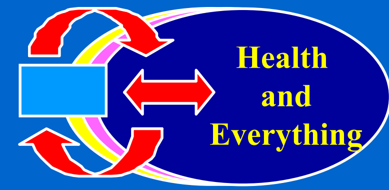
- Essential Principles
  - Collaboration replaces managed competition
  - Involve all GPs in commissioning
  - Strengthen central control over quality and access to care
- Assumptions
  - Competition has generated bureaucracy and inequity
  - To manage resources best devolve budgets to doctors
  - Find a better way to monitor quality of clinical care

Main Features of the White Paper



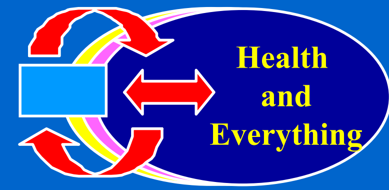
- Primary Care Groups led by GPs for 100,000
  - PCGs to take over commissioning all health services
  - No more GP fundholding
- PCGs to become Primary Care Trusts (PCTs)
  - Over 5 year period to 2003
  - Merge with community service trusts
- Health Authorities
  - to develop local Health Improvement Programs (HIPs)
  - with PCGs and Local government and NHS trusts
- Formation of
  - National Institute for Clinical Excellence (NICE)
    - guidelines
  - Commission for Health Improvement (CHImp)
    - inspection
- NHS Direct
  - an ask a Nurse service

Orderly Transition from PCG to PCT



- **Level 1:** Advisory to health authority (HA) while managing own budget for prescribing costs and cash limited part of general medical services
- **Level 2:** Sub-committee of HA with devolved budget to commission most hospital and community health services (HCHS). Budget remains ultimate responsibility of HA
- **Level 3:** Free standing commissioning agency with its own delegated budget. Accountable to HA for commissioning most hospital and community health services
- **Level 4:** A primary care trust holding a full integrated capitated budget covering all hospital, community and general medical services. Also responsible for managing most community services and all GMS activity and payments previously made under the national GP contract

Main Features of the White Paper



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Setting, Delivering & Monitoring Standards

National Institute for Clinical Excellence

National Service Frameworks

Clear standards of service

Patient and Public Involvement

Professional self-regulation

Clinical Governance

Lifelong Learning

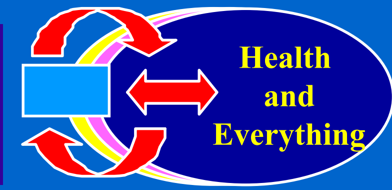
Dependable local delivery

Patient and Public Involvement

Commission for Health Improvement
National Performance Framework
National Patient and User Survey

Dependable local delivery

Main Features of the White Paper



- Primary Care Groups led by GPs for 100,000
  - PCGs to take over commissioning health services
  - No more GP fundholding: Collaboration
- PCGs to become Primary Care Trusts (PCTs)
  - Over 4 year period to 2002
  - merge with community service trusts
- Health Authorities
  - to develop local Health Improvement Programs (HIPs)
  - with PCGs and Local government and NHS trusts
- Formation of
  - National Institute for Clinical Excellence (NICE)
    - guidelines
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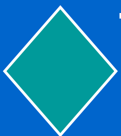


The NHS 2005

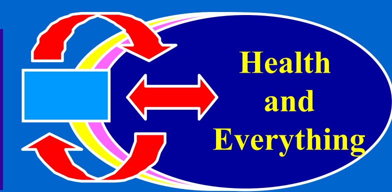
Social Care Organizations

Primary
Care
Groups

Acute
Care
Hospitals

Long Term Care Facilities

Primary Care Trusts



- Take over control of remaining community services
- GP practices expand even more
  - Clusters of practices include community care professionals
  - Control long term care beds for the elderly
  - Control some short stat non-acute bedded facilities

NHS:2002-2003

Minister of Health

Department of Health
NHS Executive

4 Regional Offices

Social Services Inspectorate

Financing with strict cost control

28 Strategic Health Authorities

Health Inspectorates
CHI
NICE

150 -200
Primary Care Trusts

Local Authority Social Services Departments

200
NHS Trusts:
hospital services
mental health services

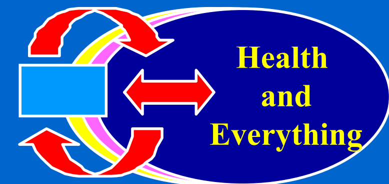
General practitioners

NHS Care

NHS Care

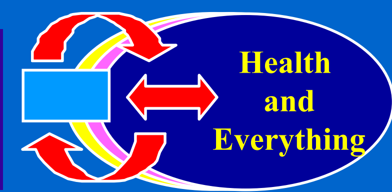
The Public

Some Cautions



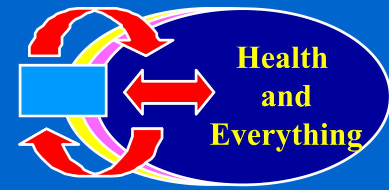
- We become so excited when we think we understand a new idea, that we think it should be implemented. (This change and others like it is quite risky.
- Primary Care Drs remain independent contractors
  - Community services are a secret strength of the NHS and could be in trouble
  - Why should primary care be better able to control the hospitals than health authorities?

A Brief History of GP Roles



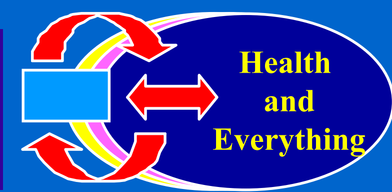
- Green Paper:
  - PC Orgs will be run by community
  - Scale: local emphasis 100,000
- White Paper:
  - PCGs will be dominated by GPs
  - Scale: 100-200,000
- PCT Structure:
  - PCTs will have a mixed non-executive board.
  - Executive board will be dominated by GPs
  - Scale: 100- 400,000 (Average 250,000+)
- New Reality:
  - Chief Executives are rarely GPs.
  - More former chief execs applying
  - More mergers expected (350,000+ average)

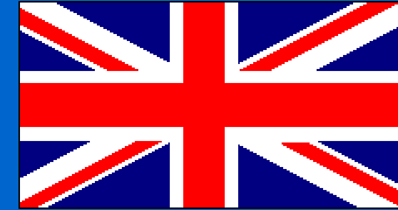
Complex Adaptive Systems



- We believe that health care systems are best described as complex adaptive systems
  - high degree of non-predictability
  - non-linear development
  - can become unstable after interventions
  - self-organize to new stability
  - best described in "Towards a New Perspective" downloadable from our web site
    - http://www.healthandeverything.org

For More About the UK





Seventh Annual

Canada - United Kingdom Exchange Programme

Dates: June 24-28 2002
Location: London England
Cost: $4,000 CAN

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