UK's Hospital Trusts: how have 25 years of reform affected performance

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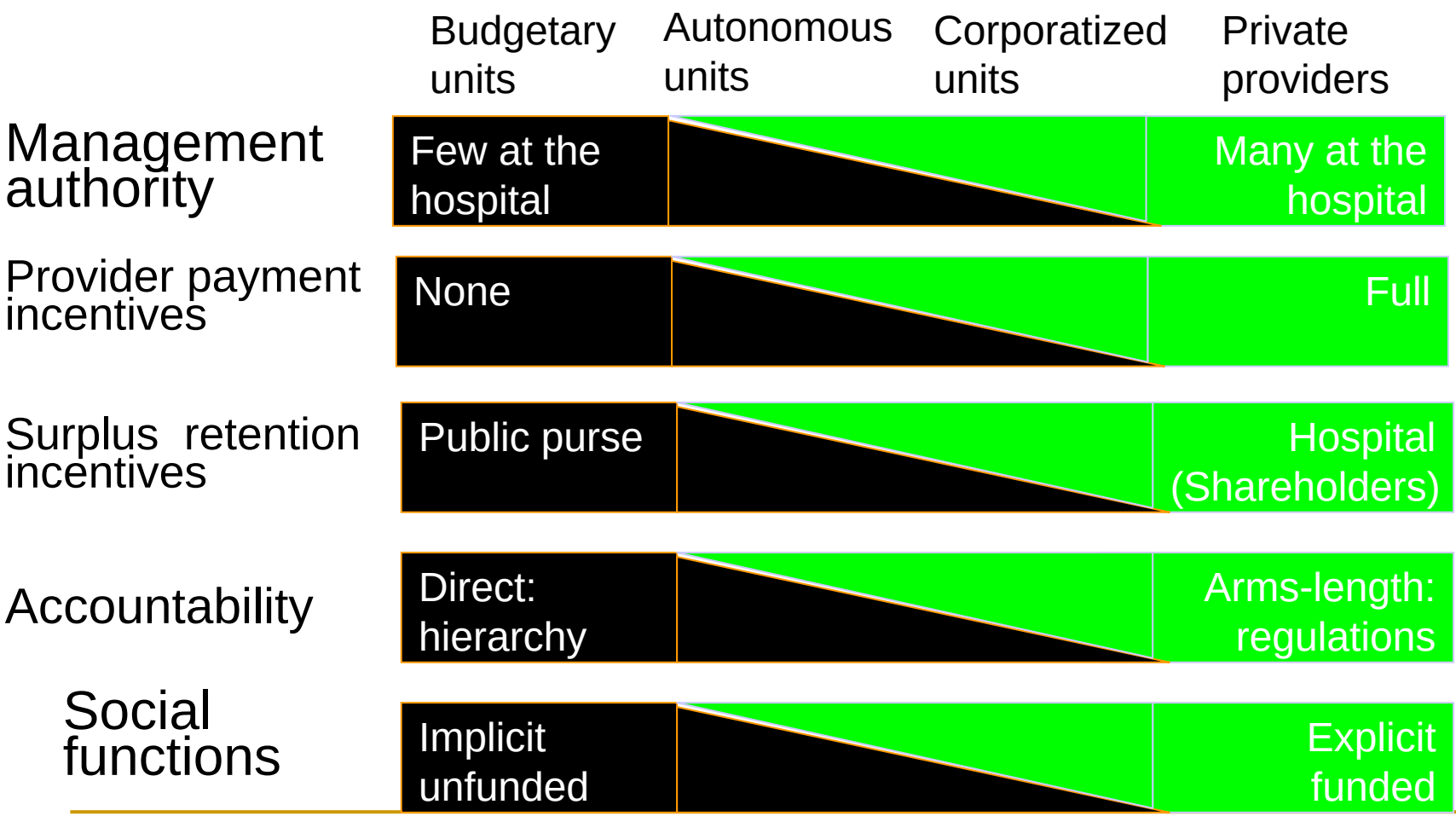
UK Reform objectives in 3 Waves of Hospital Reform from 1983-2009

1. 1980s: efficiency, under budget restraint
   - Internal management strengthening, drawing on private sector management practices
2. 1990s: efficiency, under budget restraint
   - Internal market reforms & hospital autonomy
3. 2000s: quality, responsiveness under fast budget growth
   - Re-invigorated internal market; hospital autonomy; stakeholder participation; independent regulation

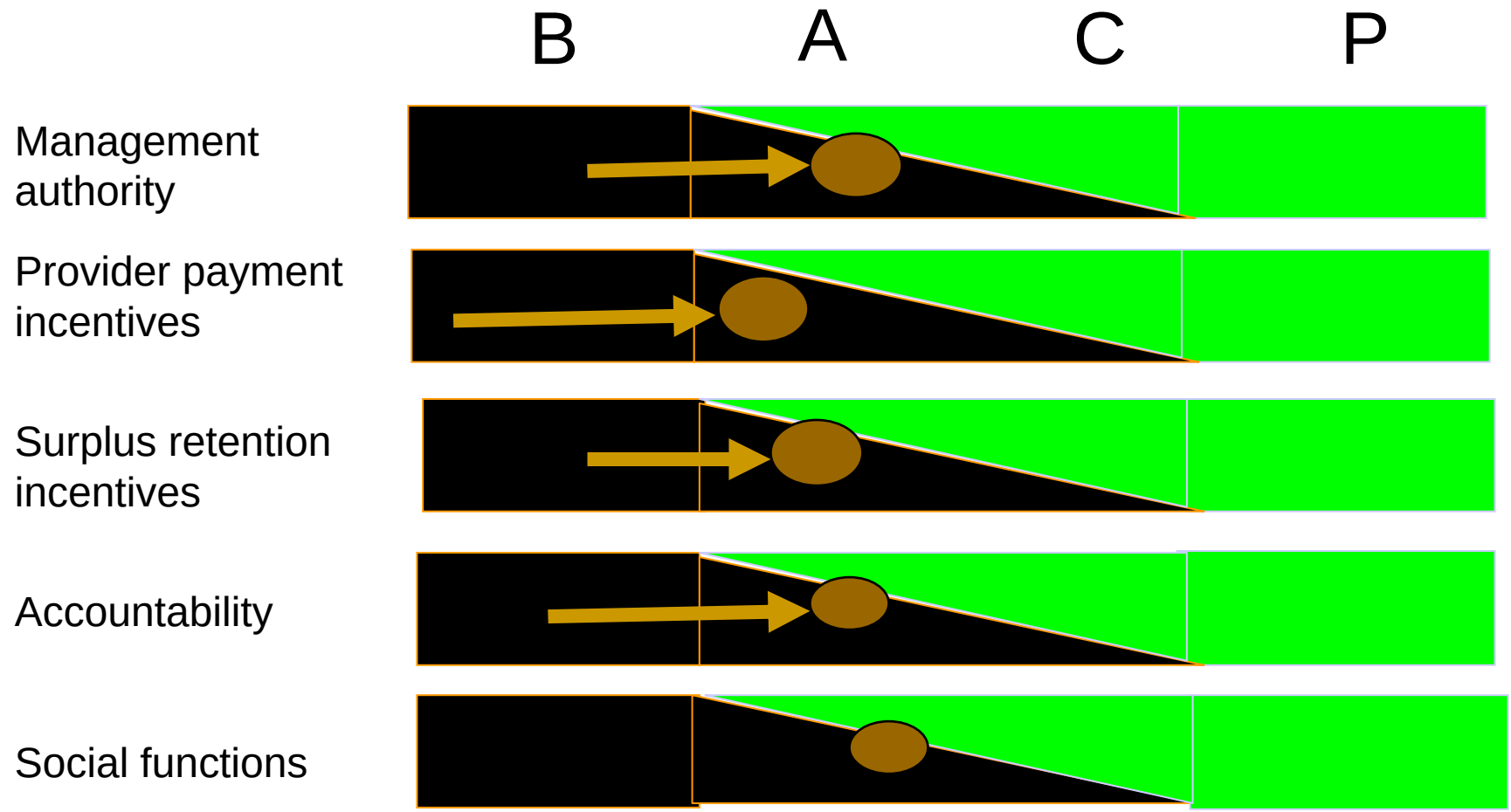
Changes to Public-Private Interface under Hospital Reform 1983-2009

- Since 1980s: private wards in public hospitals
  - Small share of hospital: <2% of beds
  - No cross-subsidy from public services
  - No mixing of public-private in single episode of care
  - Same standards of clinical services
- Since 1990s: private finance initiative
  - Long-term contract to build hospital and operate non-clinical services
- Since 2000s: private revenue, subject to ceiling

Dimensions of Organizational Reform



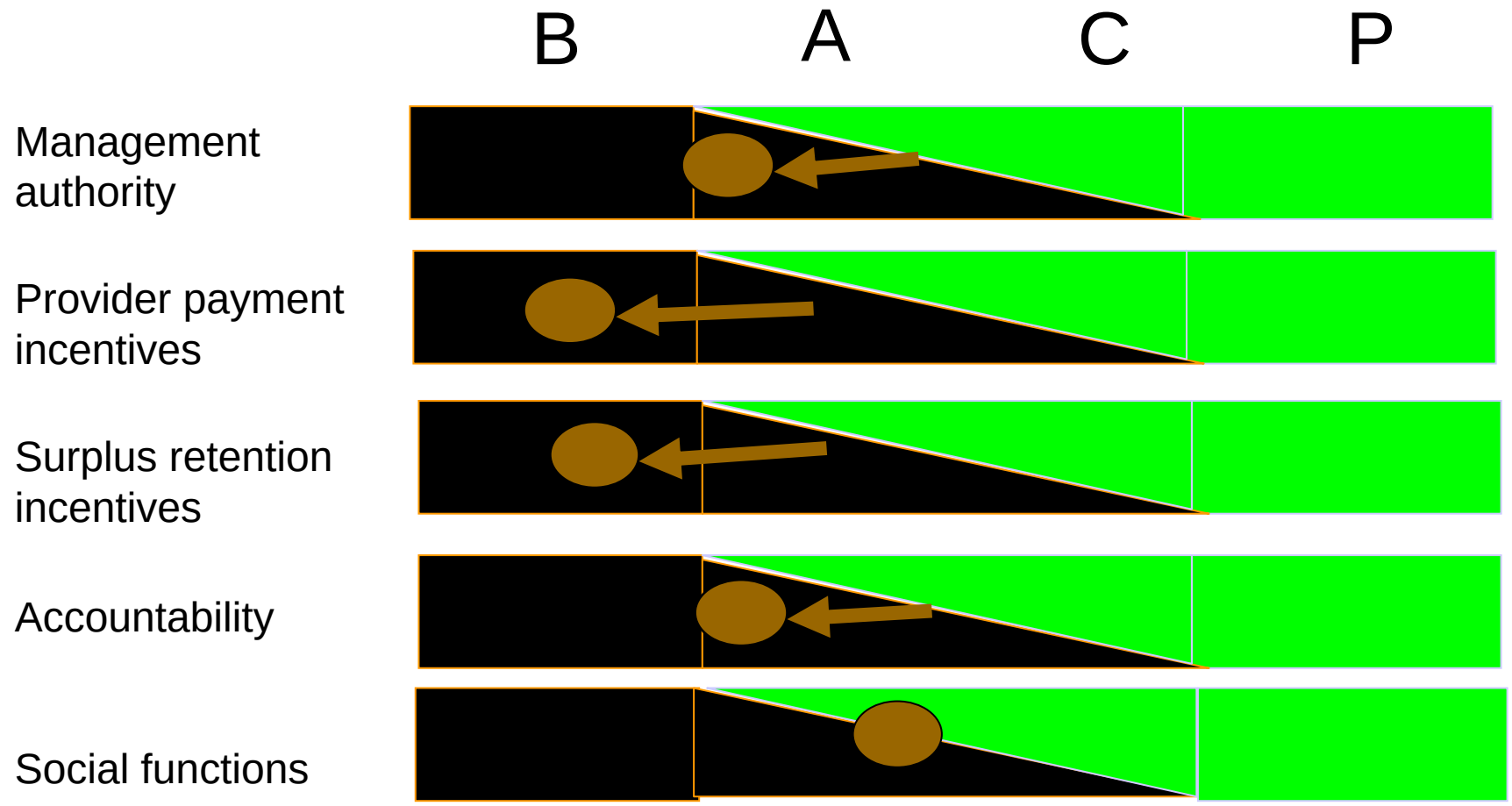
UK NHS Trusts 1991: cautious reform implementation



Results 1984-1994

- Increase in management capacity in 1980's laid foundations for later reform
- Increase in technical efficiency
- More competition than expected - price competition reduced clinical quality marginally
- Social functions – access fully protected, teaching & research explicitly funded
- Purchaser capacity and performance weak
- Politics of accountability little changed
- Service rationalization remained highly political

UK 1995-1999 – reversal of marketizing reform



Systemic reforms 1998-2002

- Devolution to Scotland, Wales, NI
- Increased emphasis on quality, clinical outcomes and evidence based medicine (NICE, HCC/CQC, service frameworks)
- Performance targets, with pro-active monitoring and accountability
- Arms-length performance assessment and regulation (HCC/CQC “star ratings”)
- Primary care trusts – commissioners, community health service providers, stewards and providers of primary care

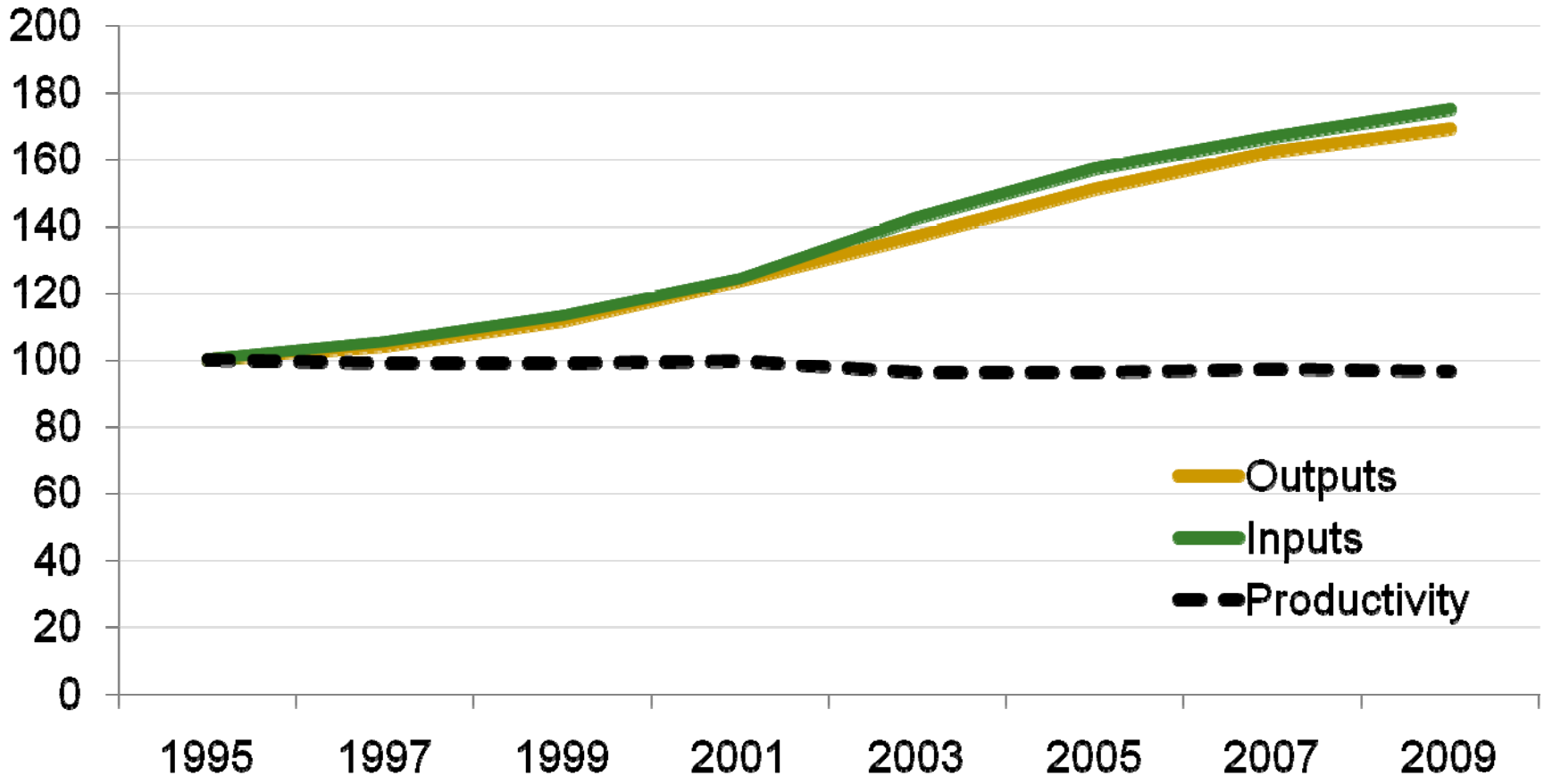
England: new wave of reform 2000-02

- Increased concern about lower clinical outcomes than EC & USA e.g. cancer, CHD
- Rising public discontent with waiting times; “hotel services”, privacy, information....

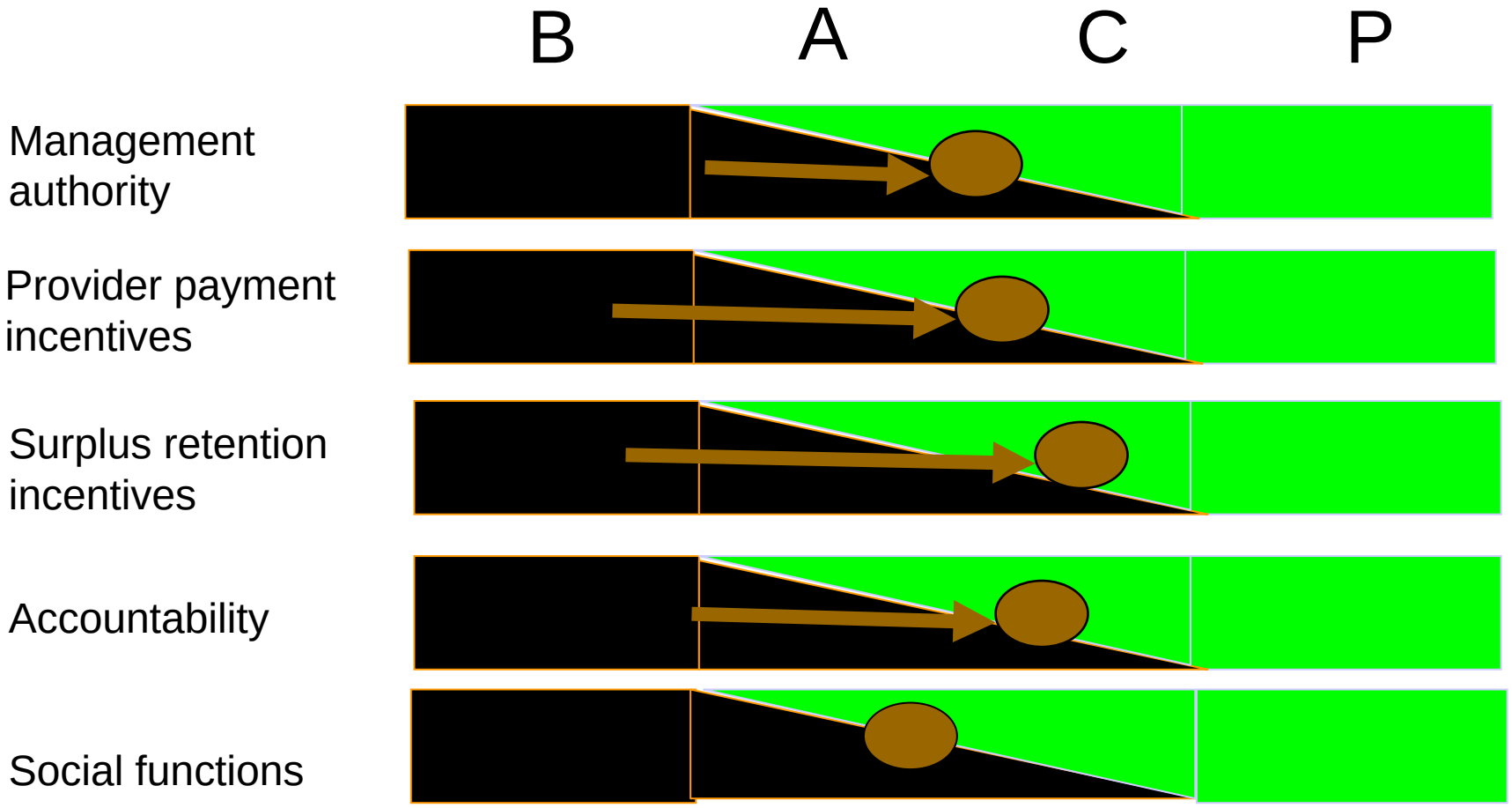
→ **HUGE spending increase + NHS Plan**

- BUT NHS Trust efficiency and productivity declined when funding increased
- So a new round of hospital autonomy, “payment by results”, private outsourcing, competition and further independent regulation occurred

Inputs, Outputs & Productivity: NHS in England



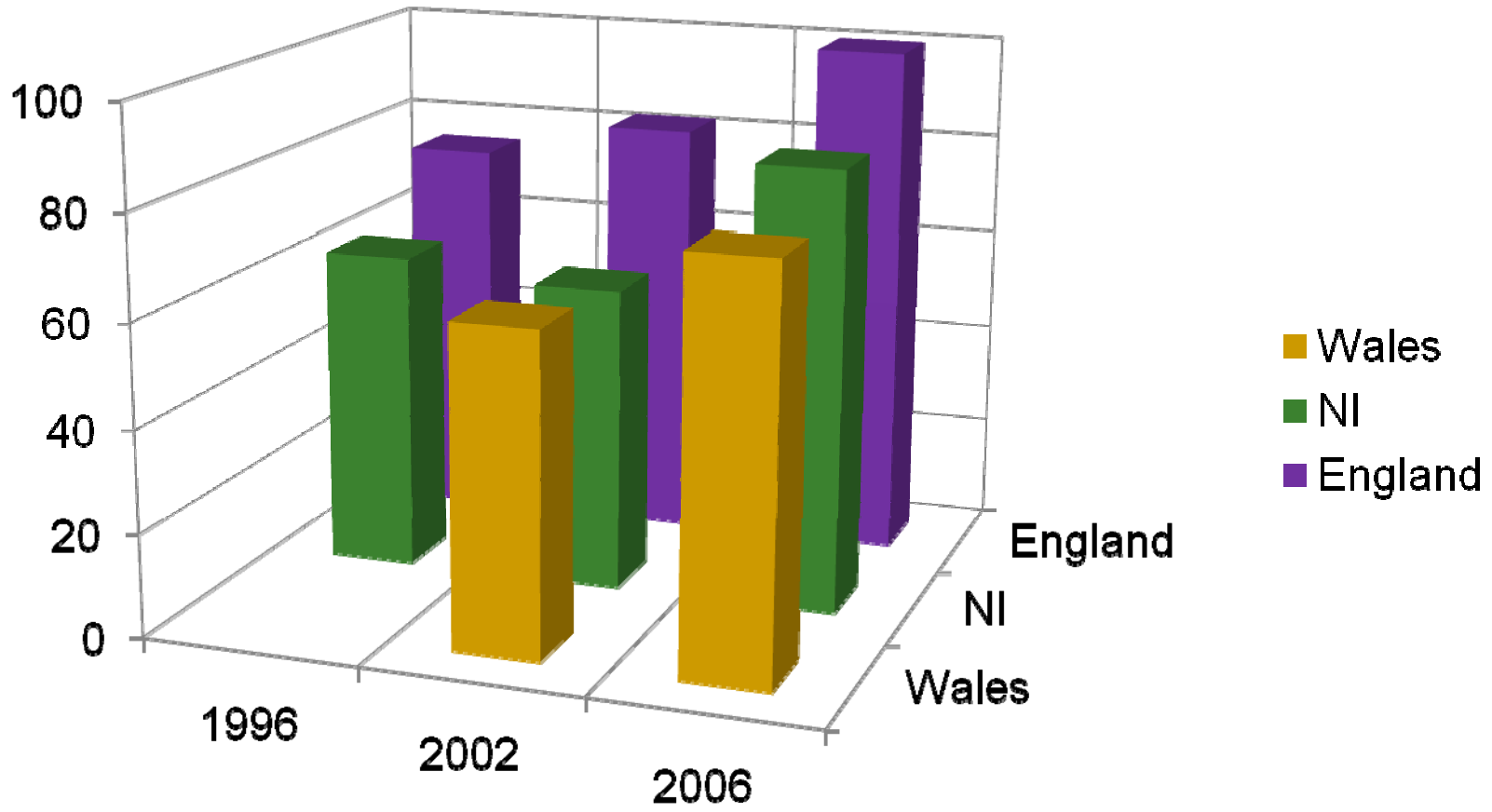
Renewed hospital reform in England: Foundation Trusts 2004-2009



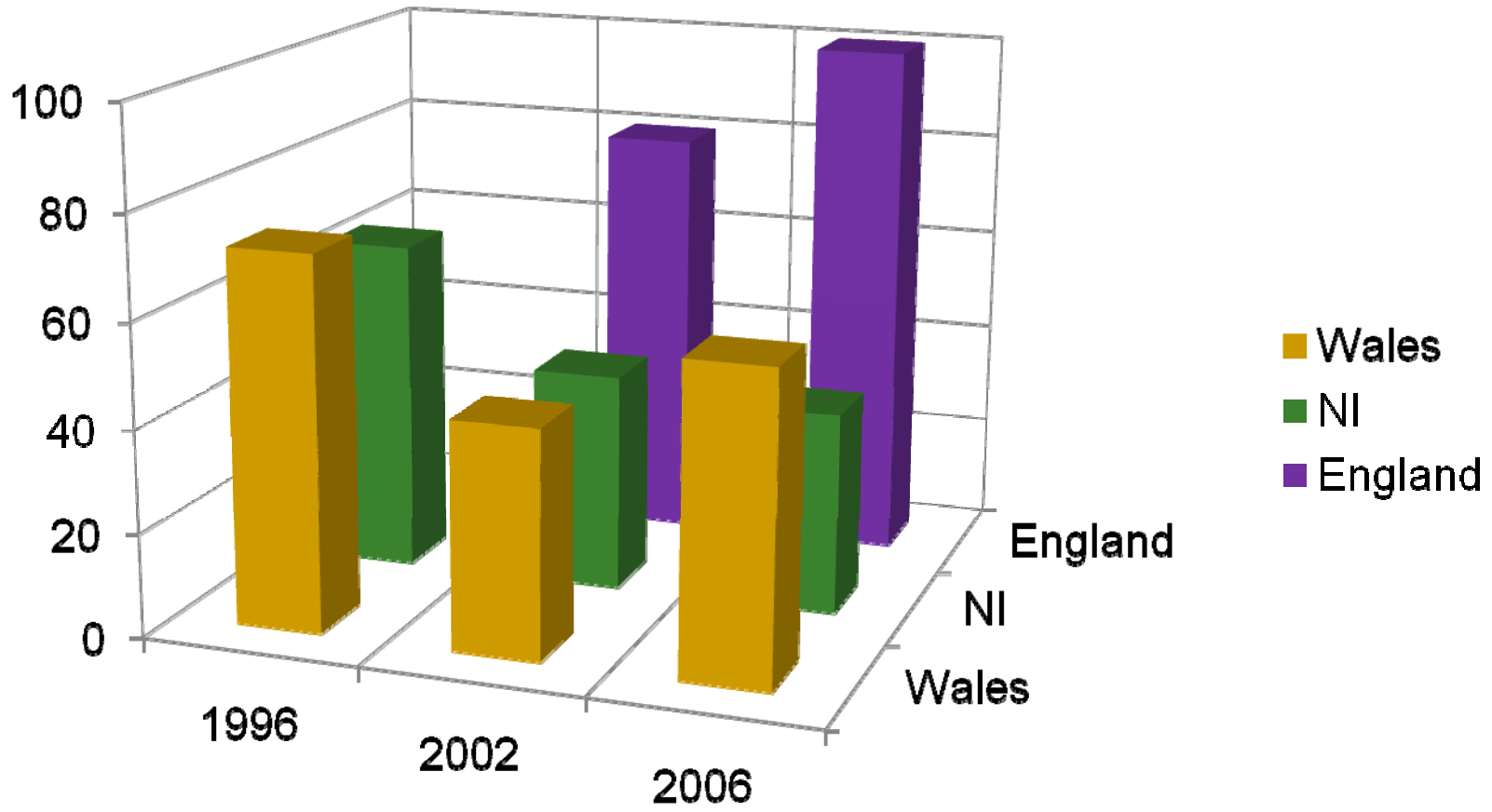
England: Results 2000-2009

- Targets + capacity increase reduced waiting times, increased some quality aspects
- Payment reform reduced unit costs slightly
- Competition under fixed prices may have increased clinical quality, improved outcomes
- Foundation Trust reform results less clear
  - Application process reduced unsustainable capital investment, but cases of “cheating” on quality, and breach of private earnings limits
- Quality has increased but independent regulator may not have contributed much

Percentage waiting <6 months for day case or inpatient treatment



Percentage waiting <3 months for outpatient consultation



UK conclusions

- Changes in performance were achieved through a mix of reforms, reviewed & revised
- Multiple policy levers were applied to achieve improvement across multiple dimensions in a complex system - both marketizing reforms and stronger central direction and regulation

- Key catalysts:
  - **Management learning – continuous, organic**
  - **Better performance measurement**

Measures, targets & standards for waiting lists & waiting times

1990's: Numbers waiting

2000-06: Maximum waiting times

– separate targets for inpatient/daypatient treatment and outpatient consultation

2007-now: Maximum time from GP Referral-to-Treatment – patient pathways

UK Outlook

- Unavoidable severe fiscal consolidation

but health sector relatively protected

- No appetite for major structural change
- Renewed look at hospital rationalization, especially in largest cities
- Renewed focus on reduction in management and non-clinical positions
- Dissatisfaction with regulation: multiple agencies, methodology concerns
- 100% Foundation Trusts, private outsourcing

Spending projections to 2014/15 (% change in budget limit)