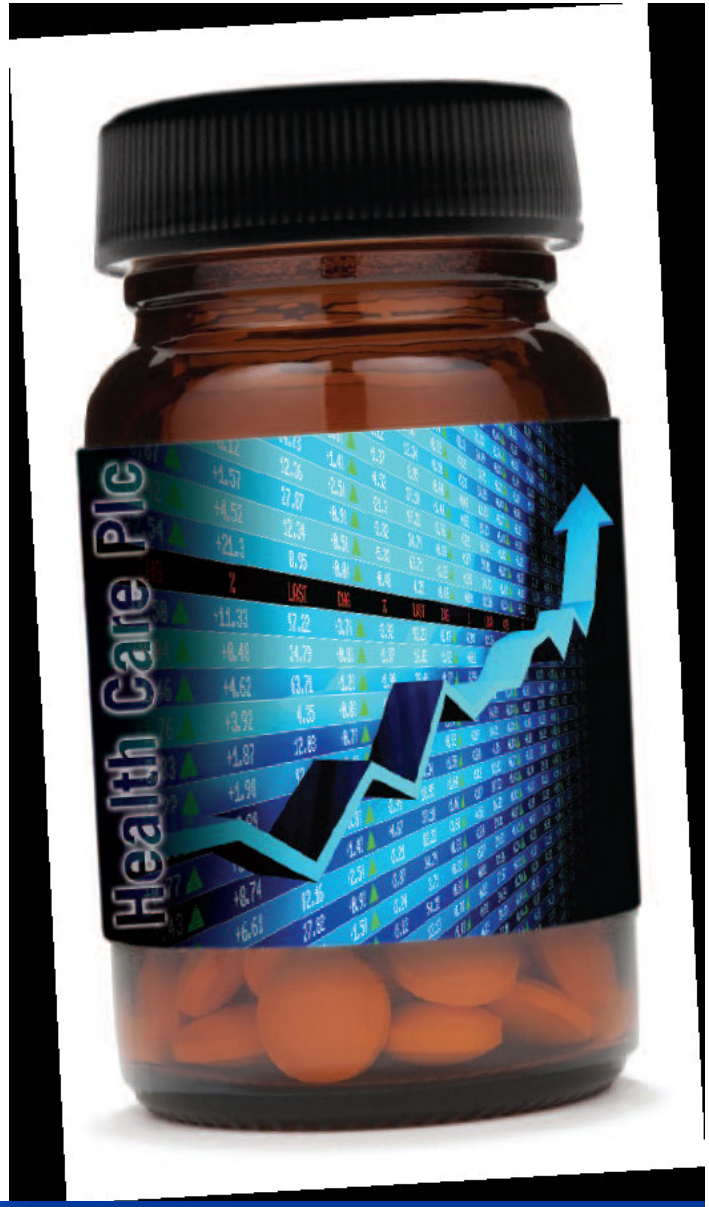
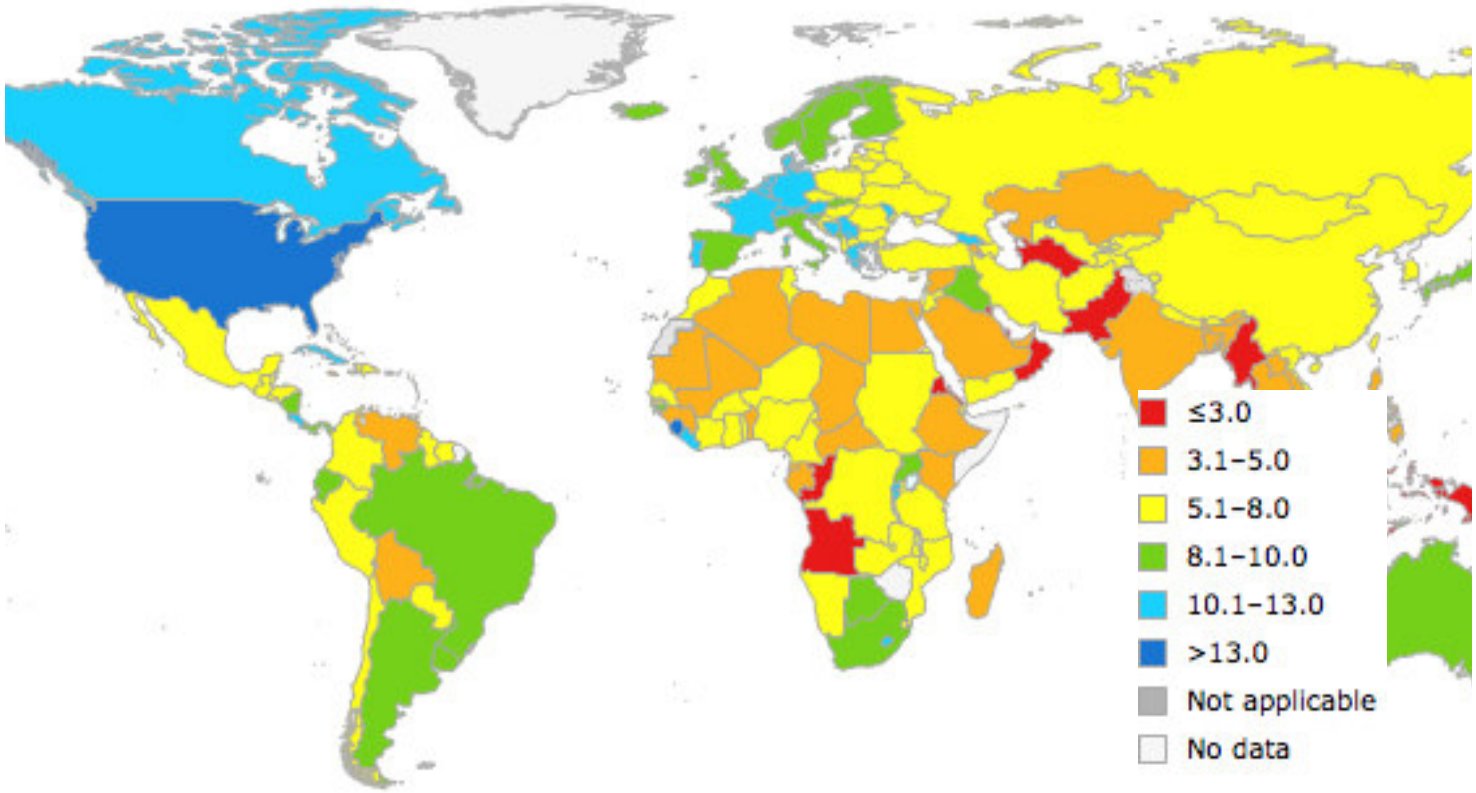
National Health System in the UK

Conference in Firenze, 24 November 2012
"La salute è davvero per tutti?"
Is health for everybody?

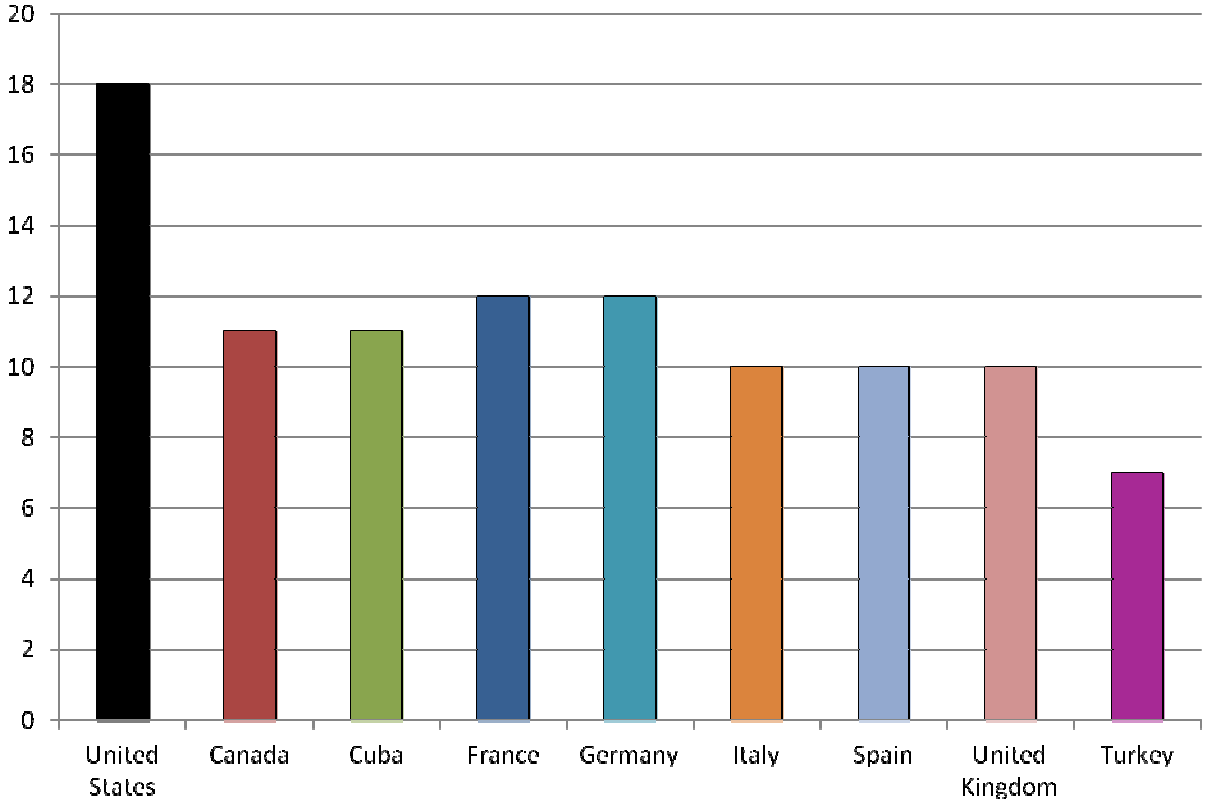
Allyson Pollock, Professor of Public Health Research and Policy
Centre for Primary Care and Public Health
Queen Mary University of London



Total expenditure on health as a percentage of gross domestic product (measured in US$), July 2012, WHO
Angola 2.9%, USA 17.9%

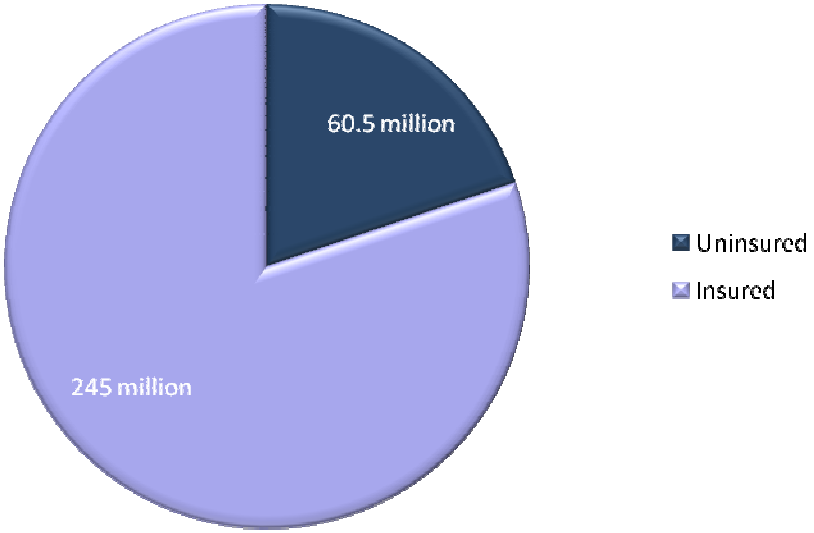


Health Spending % GDP (2010)



Data from WHO Global Health Expenditure Database

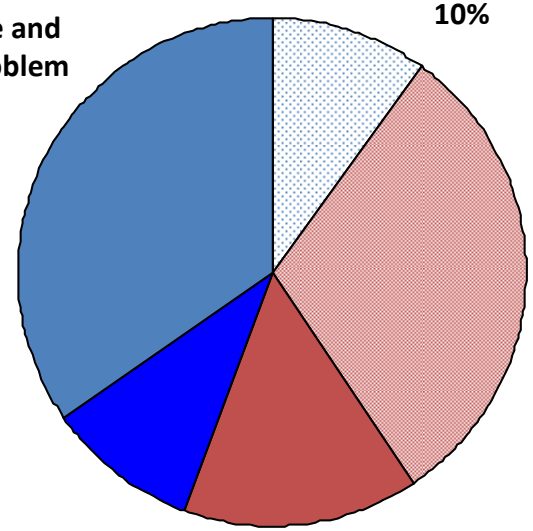
US Health Insurance Coverage



Health Insurance Coverage: Early Release of Estimates From the National Health Interview Survey, January—March 2011 *by Robin A. Cohen, Ph.D., and Michael E. Martinez, M.P.H., M.H.S.A., Division of Health Interview Statistics, National Center for Health Statistics*

Millions are Uninsured **and Underinsured**

177 million adults, ages 19–64



Source: S. R. Collins, J. L. Kriss, M. M. Doty, and S. D. Rustgi, *Losing Ground: How the Loss of Adequate Health Insurance Is Burdening Working Families: Findings from the Commonwealth Fund Biennial Health Insurance Surveys, 2001–2007*, The Commonwealth Fund, Aug. 2008.

HCA

Tenet

Unnecessary cardiac procedures

AstraZeneca

Lilly

Fined for regulatory breaches

Pfizer

FRAUD

gsk GlaxoSmithKline

Improper marketing and coercion of doctors

Medtronic

Illegal incentives to doctors

UnitedHealth Group

Mischarging

Healthcare: Medical Facilities

Rank	Company	CEO	CEO 'compensation'	Revenue (million $)	Profit (million $)	Lobbying
94	HCA Holdings	Richard M Bracken	$5.76 million	32,506.0	2,465.0	$200,000
198	Community Health Systems	Wayne T Smith	$16.175 million	13,817.0	201.9	$80000
272	Tenet Healthcare	Trevor Fetter	$5.85 million	9,601.0	82.0	$565000
339	Universal Health Services	Alan B Miller	$6.43 million	7,534.1	398.2	$0
359	Davita	Kent J Thiry	$10.9 million	6,998.9	478.0	$3,784,000
423	Health Management Associates	Gary D Newsome	$7.1 million	5,822	178.7	120000
444	Kindred Healthcare	Paul J Diaz	$6.4million	5,523.3	-53.5	$1,320,000
484	Vanguard Health Systems	Charles N Martin Jnr	$3.7 million	4,895.9	-10.9	$60000

Fortune 500 : CNN ranking

www.forbes.com

www.BeckersHospitalreview.com

Wholesalers : Healthcare

Rank	Company	CEO	CEO 'compensation' (million $)	Revenue (million $)	Profit (million $)	Lobbying (million $)
14	McKesson	John H. Hammergren	131.19	112,084.0	1,202.0	1.1
21	Cardinal Health	George S. Barrett	10.21	102,644.2	959.0	1.2
29	AmeriSource Bergen	Steven H. Collis	3.18	80,217.6	706.6	0.680

ORGANISING PRINCIPLES OF 1948-1990 NHS

- Universality and equity
- Population Needs Assessment
- Service planning
- Fairness of Funding
- Fairness of Resource Allocation
- Block grants and budgets
- Integration

ORGANISING PRINCIPLES OF MARKETS

Risk Selection and Risk Avoidance

- Risk identification
- Risk prediction
- Risk pricing: the **PREMIUM** the market charges for bearing the risk
- Risk Allocation
- Risk transfer through commercial contract

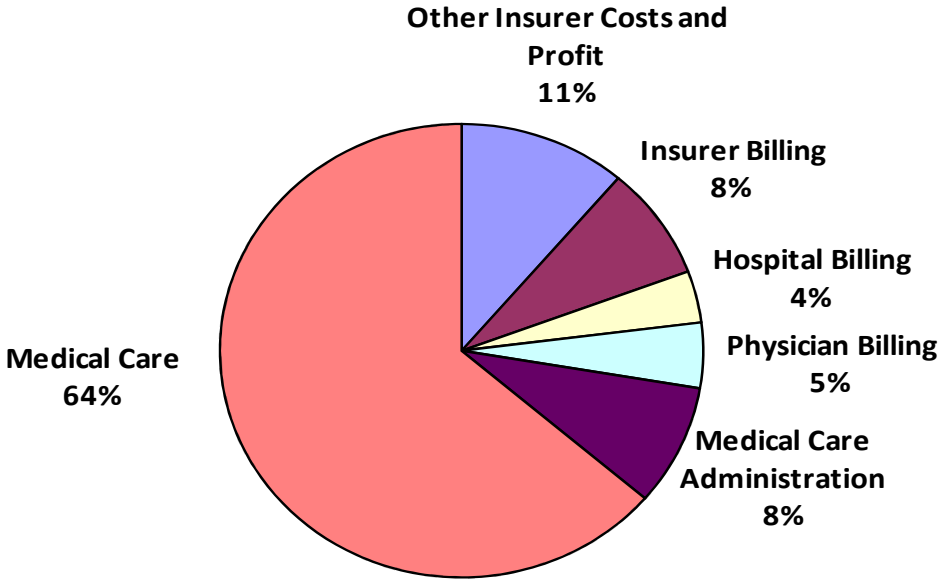
Why Public Private Partnerships don't work

- 1. Risk Selection: denial of care
- 2. Risk segmentation: loss of coverage
- 3. Increased cost : administration, fraud,profit
- 4. Overtreatment and inappropriate treatment
- 5. Loss of innovation
- 6. Rising Inequalities

Risk Selection/Avoidance Strategies

- Gaming and **upcoding**
- Cherry picking
- Cream skimming
- Dumping
- Restricting entitlements
- **Risk sharing**: coinsurance, user charges

Allocation of Spending for Hospital and Physician Care Paid through Private Insurers



Source: James G. Kahn et al, The Cost of Health Insurance Administration in California: Estimates for Insurers, Physicians, and Hospitals, Health Affairs, 2005

Medical Litigation

- % spend on litigation of total health spending, 2001 :
  0.46% US ($6.5 billion)
  0.27% Canada ($237 million).

Health Affairs July 2005 vol. 24 no. 4 903-914

- Access to care reduced
  - Hospitals reducing their services as insurance premiums unaffordable

- Quality of care is jeopardised
  - Physicians order tests for litigation purposes, not medical need
  - No incentive to improve patient care and discussion of errors suppressed by fear of litigation

- Healthcare costs are increased

US department of Health and Human Services : Addressing the Healthcare Crisis 2003

Insurance Premiums

TABLE 2. Medical Malpractice Liability Average Premium Increases by Specialty (Date is When Survey Was Taken, Compared to Previous Period)

Specialty	July 2000	July 2001	July 2002
Internists	18%	10%	25%
General Surgeons	15%	10%	25%
Obstetrician/Gynecologists	12%	9%	20%

SOURCE: Medical Liability Monitor. The data reflect an average for the listed specialties in all states. Averaging disguises the different experiences in states that have reformed their litigation systems and those that have not.

US department of Health and Human Services
'Confronting the New Health Care Crisis: Improving Health Care Quality and Lowering Costs By Fixing Our Medical Liability System July 2002'

Fortune 500

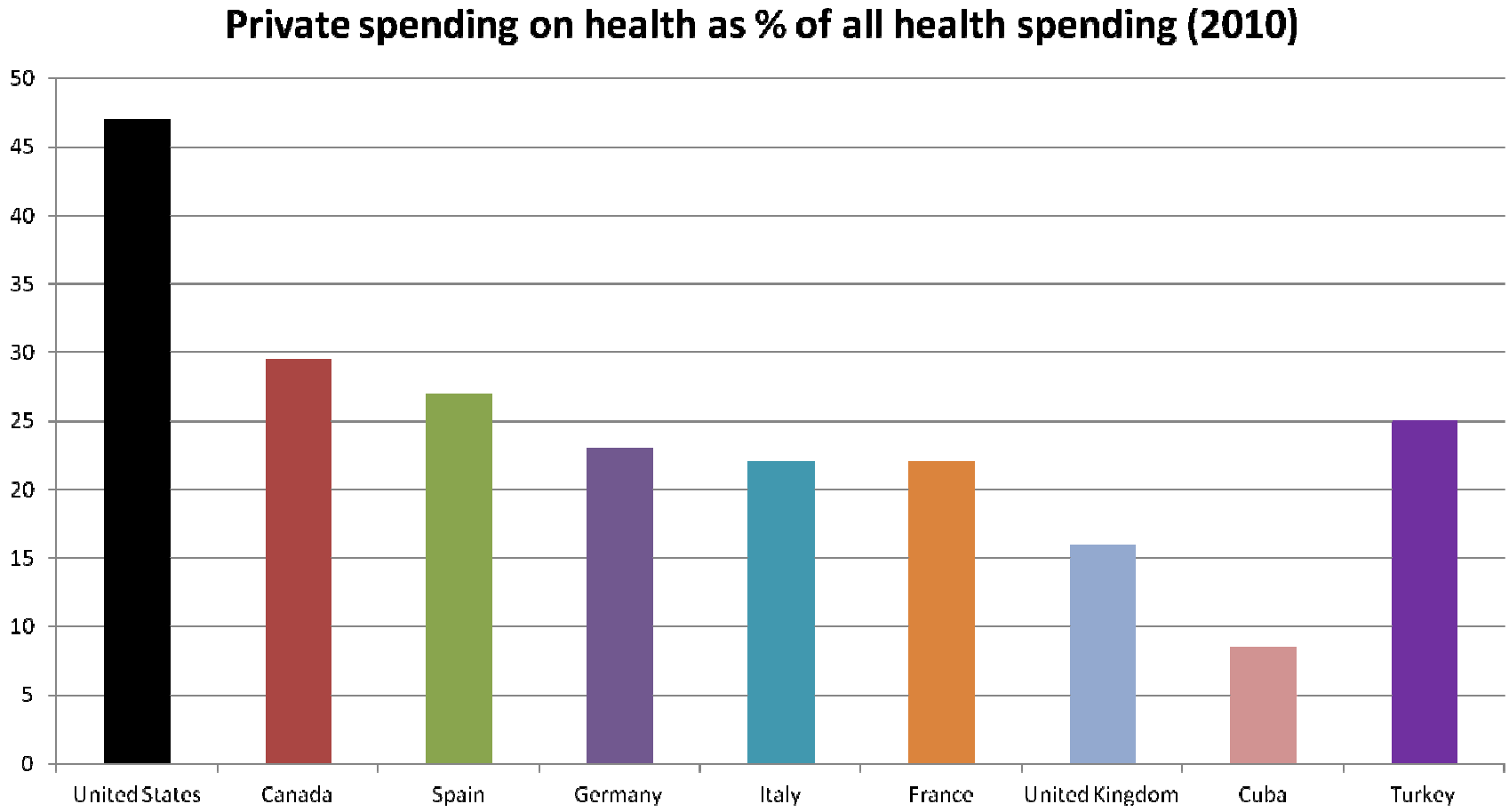
Annual ranking of America's largest corporations by revenue, compiled since 1955 by Fortune magazine . In the top 500:

- 8 x Medical Facilities
- 6 x Pharmacy services
  - 1. Medco health solutions – Revenues $70,063 million, Profit $1,455 million, lobbying $2,990,0001.
- 11 x Insurance and managed care
  - 1. United health Group - Revenues $101,862 million, Profits $5,142 million, lobbying $1,470,000
- 3 x Wholesalers Healthcare

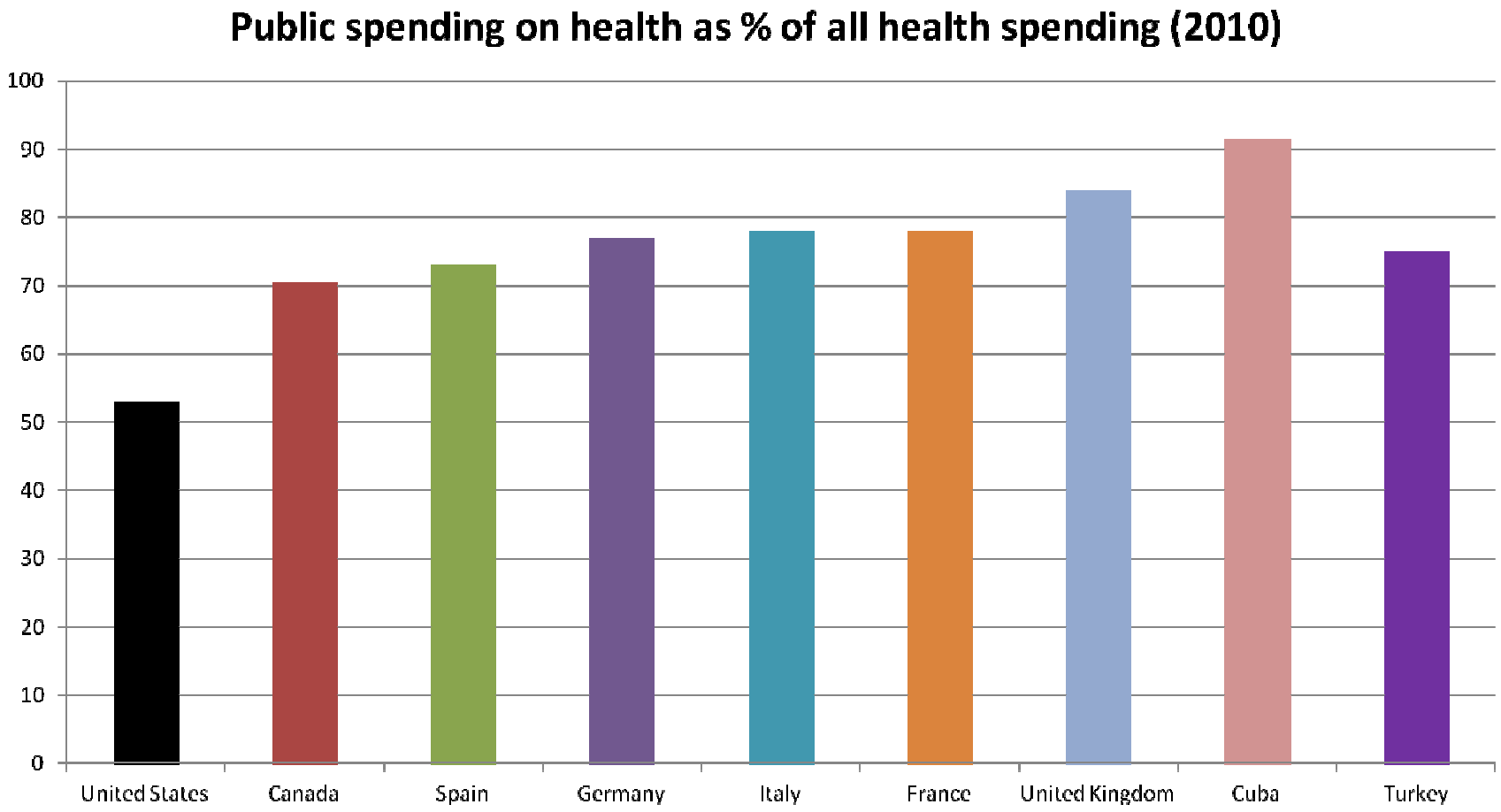
Top 10 by Lobbying

1. American Hospital Association
2. Alliance for Quality NH care
3. Kindred Healthcare
4. Federation of American Hospitals
5. National Association of Children's Hospitals
6. American Healthcare Association
7. California Hospital Association
8. University of Pittsburgh Medical Centre
9. Premier Inc
10. Tenet Healthcare

http://www.opensecrets.org



Data from WHO Global Health Expenditure Database
http://apps.who.int/nha/database/StandardReport.aspx?ID=REPORT_2_WHS

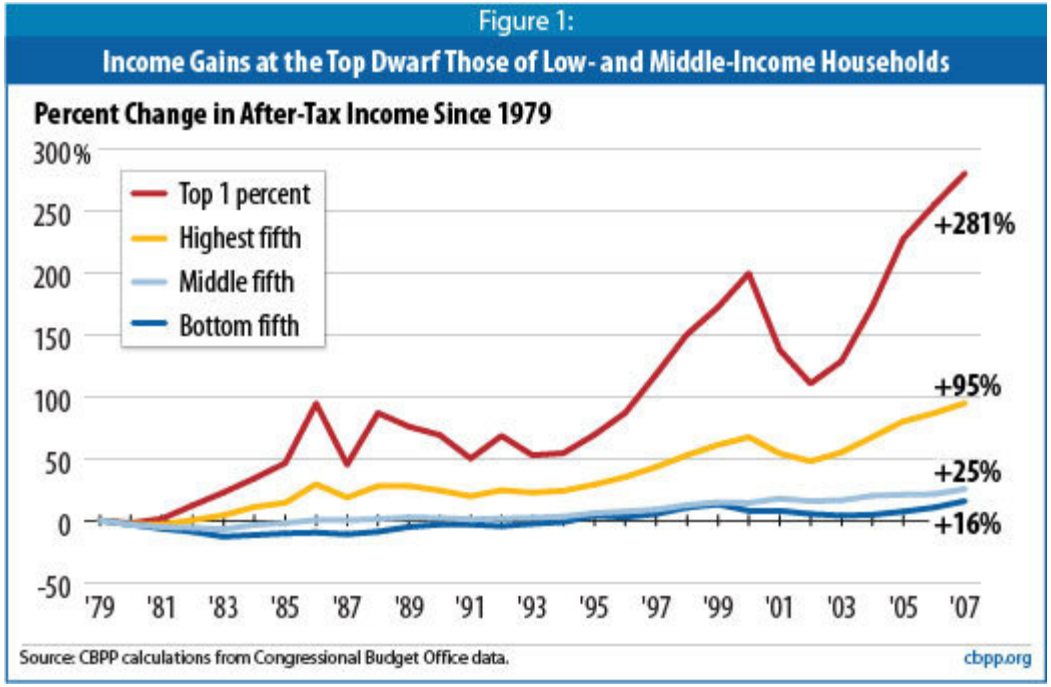


Data from WHO Global Health Expenditure Database
http://apps.who.int/nha/database/StandardReport.aspx?ID=REPORT_2_WHS

Estimated sources of excess costs in US market system of health care (2009) (US Institute of Medicine report, 2012)
(Total spending at 2009: $2.9 trillion; 50 million Americans cannot get health insurance)

Category	Sources	Excess Costs
Unnecessary Services	• Overuse—beyond evidence-established levels • Discretionary use beyond benchmarks • Unnecessary choice of higher-cost services	$210 billion
Inefficiently Delivered Services	• Mistakes—errors, preventable complications • Care fragmentation • Unnecessary use of higher-cost providers • Operational inefficiencies at care delivery sites	$130 billion
Excess Administrative Costs	• Insurance paperwork costs beyond benchmarks • Insurers' administrative inefficiencies • Inefficiencies due to care documentation requirements	$190 billion
Prices That Are Too High	• Service prices beyond competitive benchmarks • Product prices beyond competitive benchmarks	$105 billion
Missed Prevention Opportunities	• Primary prevention • Secondary prevention • Tertiary prevention	$55 billion

Income Inequalities in US



Maternal Mortality in US

• Maternal mortality ratios have increased from 6.6 deaths per 100,000 live births in 1987 to 13.3 deaths per 100,000 live births in 2006.

• The USA spends more than any other country on health care, and more on maternal health than any other type of hospital care.

• Despite this, women in the USA have a higher risk of dying of pregnancy-related complications than those in 40 other countries - the likelihood of a woman dying in childbirth in the USA is **five times greater than in Greece**, **four times greater than in Germany, and three times greater than in Spain**.

•African-American women are nearly four times more likely to die of pregnancy-related complications than white women.

• During 2004 and 2005, more than 68,000 women nearly died in childbirth in the USA.

•Each year, 1.7 million women suffer a complication that has an adverse effect on their health.

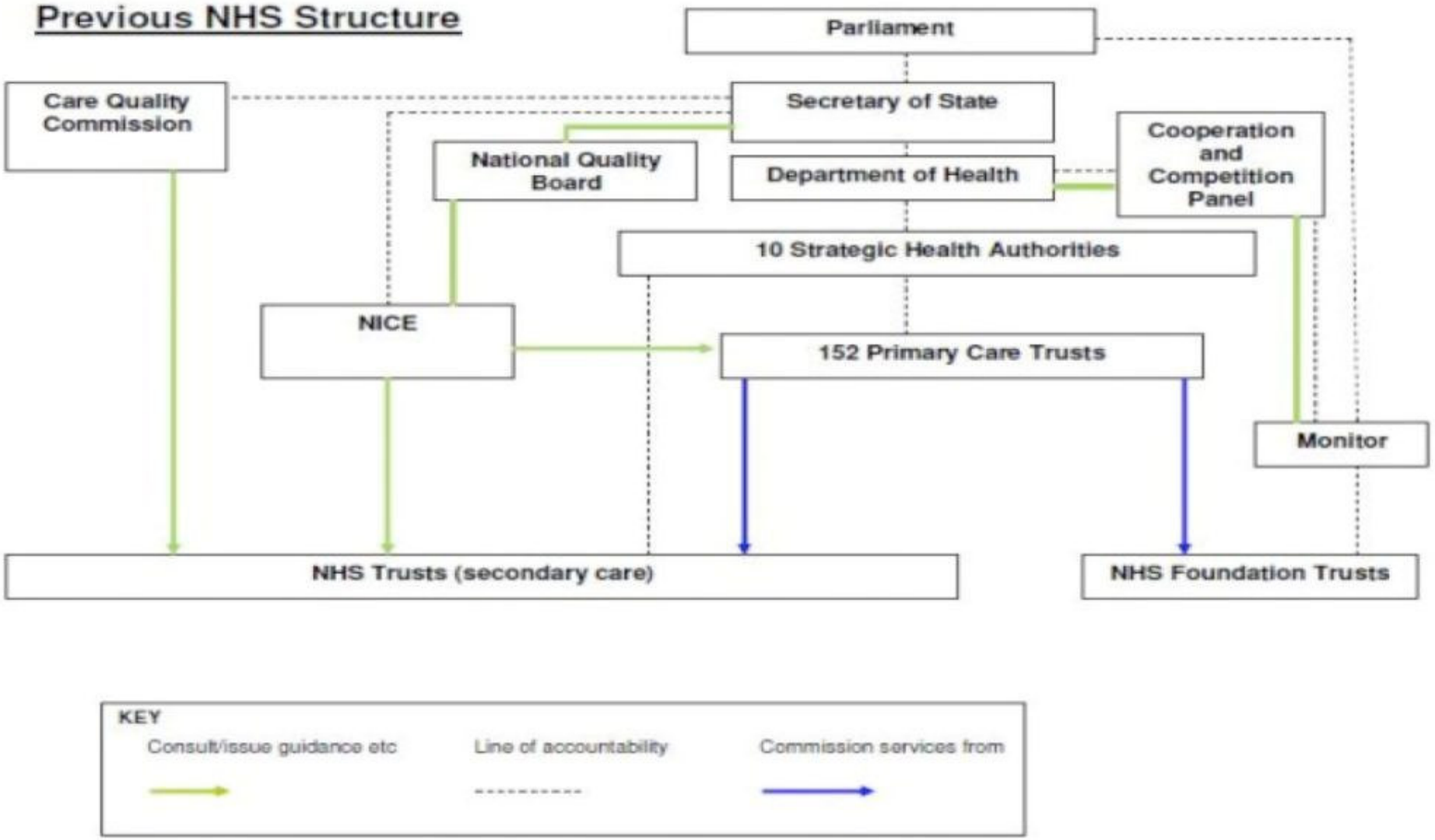
Source - Deadly Delivery, The Maternal Healthcare Crisis in the US, Amnesty International 2011.

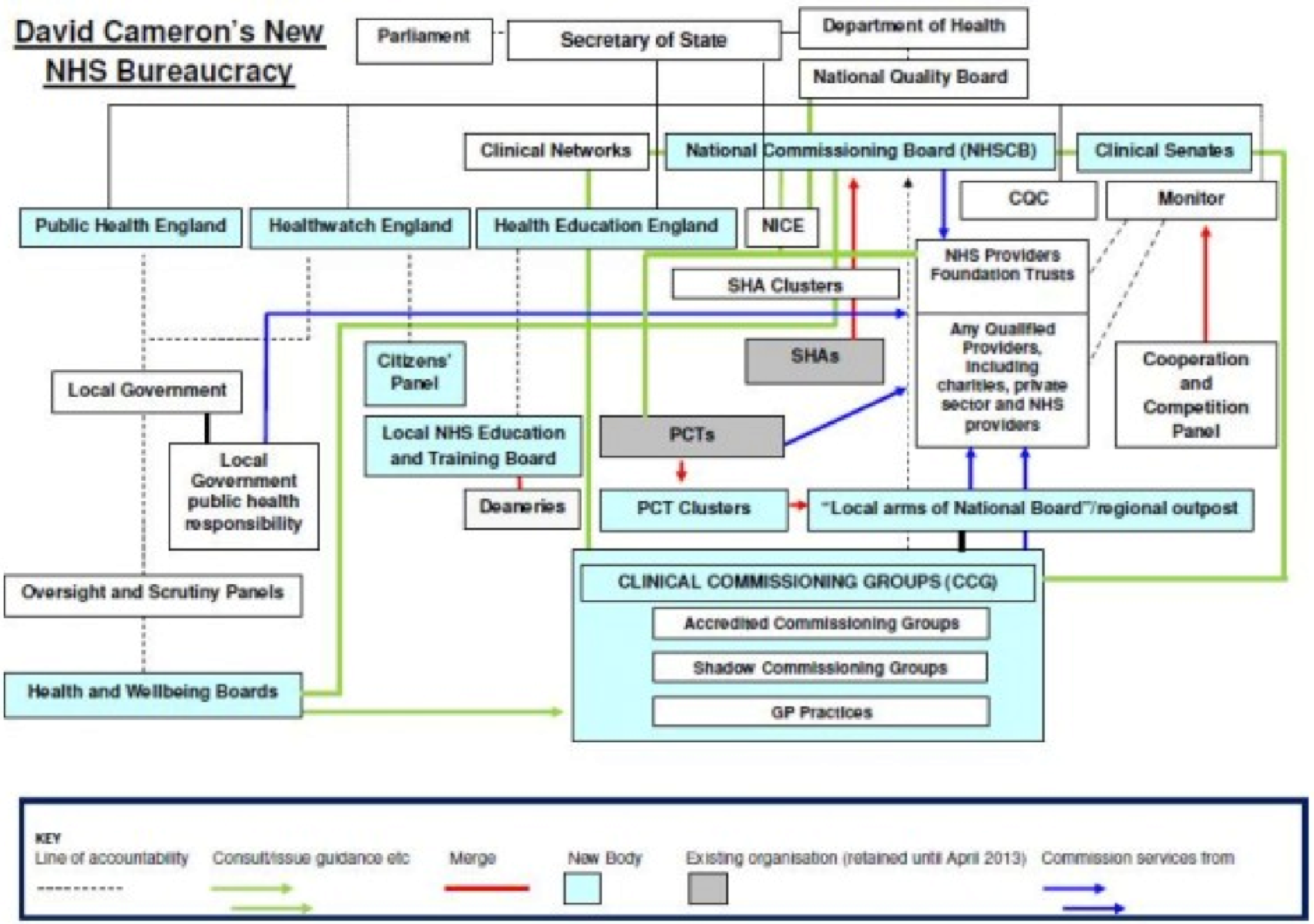
Abolishing the NHS:
Health and Social Care Bill 2011

- End of duty upon Sec of State to provide comprehensive care
- End of duty upon Sec of State to ensure services free at the point of delivery and prohibit charges
- Establishing **insurance funds**, GP consortiums power to enter into joint ventures and introduce commercial competition and charges

Insurance pools, Risk Selection and GP consortium (US social insurance style)

- Selection of members: enrollees
- Selection of benefits and entitlements
- Risk sharing – user charges and coinsurance
- Time limits on care


Previous NHS Structure
Parliament
Care Quality Commission
Secretary of State
National Quality Board
Department of Health
Cooperation and Competition Panel
10 Strategic Health Authorities
NICE
152 Primary Care Trusts
Monitor
NHS Trusts (secondary care)
NHS Foundation Trusts
KEY
Consult/issue guidance etc
Line of accountability
Commission services from


David Cameron's New NHS Bureaucracy
Parliament
Secretary of State
Department of Health
National Quality Board
Clinical Networks
National Commissioning Board (NHSCB)
Clinical Senates
CQC
Monitor
Public Health England
Healthwatch England
Health Education England
NICE
NHS Providers Foundation Trusts
SHA Clusters
Any Qualified Providers, including charities, private sector and NHS providers
SHAs
Citizens' Panel
Cooperation and Competition Panel
Local Government
Local NHS Education and Training Board
PCTs
Local Government public health responsibility
Deaneries
PCT Clusters
"Local arms of National Board"/regional outpost
Oversight and Scrutiny Panels
CLINICAL COMMISSIONING GROUPS (CCG)
Accredited Commissioning Groups
Shadow Commissioning Groups
GP Practices
Health and Wellbeing Boards
KEY
Line of accountability
Consult/issue guidance etc
Merge
New Body
Existing organisation (retained until April 2013)
Commission services from

Four stages of NHS privatisation

- **Phase I** Efficiency & management
  1979 control moves away from professionals
  Griffith's supermarket management reforms

- **Phase II** Internal market
  1991 purchaser/provider split
  public corporations REVERSED IN SCOTLAND, NHS REFORM (SCOTLAND) Act 2004 1998

- **Phase III** PFI - PPPs
  1992 privatise asset base & non-clinical services

- **Phase IV** NHS Plan
  2000 privatise clinical services- foundation trusts
  pricing- financial flows, DTCs etc
  local pay bargaining - GP/ consultant contracts
  service unbundling- like post office

	Universalism **Risk pooling and social solidarity**	**'New' Universalism** **'Targeting' Market mechanisms**
Methods of funding	**Progressive taxation** - Social insurance - Central taxation	**Regressive taxation** - Private insurance - Local taxation - Charges
Resource allocation	**Risk pooling – geographic** allocations on basis of population needs	**Individual** - Capitation payments based on risk
Service provision	**Cross subsidisation of services and treatments** - Block budgets, salaries, state ownership	**Service unbundling** - Pricing and competition - DRG
Organisation	**Planning authorities** - 1º, 2 º, 3 º levels of service within a geographic population - Not- for- profit	**Providers/ Companies** - enrollees/ members - combine insurance + provider
Accountability	**National and local electorate, users, staff**	**Shareholders, boards**

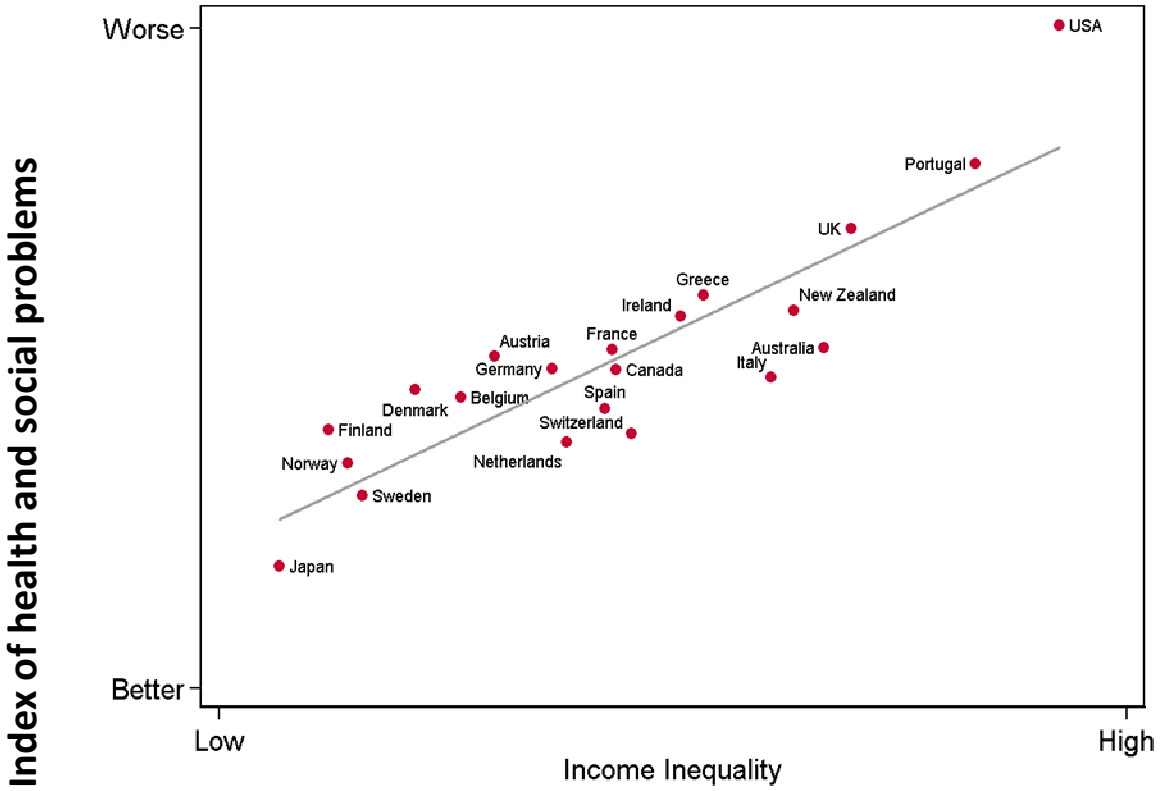
Life Expectancy is Longer in More Equal Rich Countries

Source: Wilkinson & Pickett, The Spirit Level (2009)

Health and social problems are worse in more unequal countries

Index of:

- Life expectancy
- Math & Literacy
- Infant mortality
- Homicides
- Imprisonment
- Teenage births
- Trust
- Obesity
- Mental illness
  – incl. drug & alcohol addiction
- Social mobility



Wilkinson & Pickett, The Spirit Level

Markets are problematic for public health because they …

- Undermine public health methods rooted in universality and equity
- Restrict public health focus to those who get access and not those who do not
- Equal access for equal need no longer primary purpose
- Risk selection means inequities will grow

When can we trust public health research?

- universality
- no risk selection
- no commercial conflicts
- adopt highest scientific standards

Why Public Private Partnerships don't work

- 1. Risk Selection: denial of care
- 2. Risk segmentation: loss of coverage
- 3. Increased cost
- 4. Overtreatment and inappropriate treatment
- 5. Loss of innovation
- 6. Rising Inequalities

Pricing Data : The Tariff

- low quality and unreliable data
- methods questionable
- the key driver for the artificial creation of deficits and hospital closures

How the State reigns in Risk Selection

- Risk Adjustment for price – evidence poor
- Risk Equalisation funds for insurance: compensation- evidence poor
- Value for money and risk transfer: pseudo scientific mumbo jumbo
- (Based on private sector techniques)

Capital value and unitary payments for signed PFI projects in Northern Ireland, England and Wales (1990-2008; n=500)