Speech Transcript

Perspectives on Health Care Reform in the U.K.

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Thank you so much for inviting me here to The Brookings Institution, truly one of the world's most respected centres of critical and creative thinking.

We need that sort of thinking now more than ever.

On both sides of the Atlantic, we face significant challenges.

Most pressing of all is the need to deal with the immediate fallout of the financial crisis and the long term problems of sovereign debt.

Getting our respective houses in order will dominate politics in North America and across Europe for the rest of this decade.

But while this must be our main priority, it cannot be our only priority.

I believe, and my government believes, that another priority must be to secure the protection and improvement of the health of our citizens. Central to that task in Britain is the role of the National Health Service. For over 60 years, the NHS has been a central fact of life in providing healthcare, from cradle to grave.

The Conservative Party and the NHS

Now, some may question why a Conservative Health Secretary is so supportive of the National Health Service - well, let me take you back to its origins.

In 1944, Winston Churchill, as Conservative Prime Minister of a coalition government, defined the future of the British health service as: "our policy is to create a national health service in order to ensure that everybody in the country, irrespective of means, age, sex or occupation, shall have equal opportunities to benefit from the best and most up-to-date medical and allied services available." So there is nothing novel in a Conservative explaining our commitment to universal health coverage.

Today, decades later, I can tell you that our commitment to the NHS, providing high-quality care for all, free at the point of use, based on need and not ability to pay, is unchanged. The social solidarity remains instrumental to cohesion in our society and to our sense of security.

It is, in my view, part of the 'One Nation' tradition of Conservatism; an understanding that, for those who have, is the obligation to support those who have not.

In no respect is that obligation more real and necessary, than in healthcare.

I have been on the front line of health reform in England for over 8 years. First in opposition and now in government.

I am proud that my Party's commitment to the NHS, and the public's trust in our commitment, has been strongly reinforced over that time.

And, in the face of the immense challenges the NHS and all healthcare systems face – of demographic change, technological advance, rising public expectations and fiscal consolidation – our Coalition Government's commitment to support the NHS through rising real-terms resources and comprehensive modernisation has also been unequivocal.

Over that time, as I learnt more about comparative health systems, I've spoken with health ministers from all over the world. One thing that becomes instantly clear is that we all start from a different place in terms of organisation and finance.
Sometimes, very different structures and presumptions about how healthcare is best financed and provided.

Here in America, I hear both praise for the NHS and criticisms of its effects. On the positive side, the concept of universal access to healthcare is often admired.

On the other: I hear a critique of the nature of State control of healthcare. US commentators chastise 'socialised medicine', because patients cannot choose their doctor or are denied a drug treatment, and the supposed lack of choice and control over their healthcare as experienced by patients.

Many of us in Britain, while committed advocates of the NHS values and principles, are now equally committed to reforming a system long characterised by 'command and control', bureaucratic processes, lack of choice and innovation, limited choice and poor relative outcomes.

The White Paper, "Equity and Excellence: Liberating the NHS" was focused on achieving the pursuit of quality and improved outcomes, through innovation, patient-centred services and clinical leadership.

Combining equality of access with excellence in delivering through responsive, outcomes-focused care.

A Common End
I know enough not to believe that any health system can be transplanted from one country to another. It is, however, perverse not to seek to understand shared values and experience, and to learn from it.

I do not see a desire in the US to adopt a NHS structure; and we in Britain do not intend to adopt US healthcare funding, organisation or structures, but we can recognise shared values. For example, the social responsibility to provide universal access to healthcare; the imperative to reduce health inequalities; public responsibility for health protection, promotion and improvement; and a need to impact on the wider determinants of health.

Now in England, we already have universal access. That one's in the bank. But it is not universally excellent; nor universally responsive to patients. So our focus is on quality and on providing a personalised service built around the needs and wishes of the individual.

I'd like to share some lessons from our experience, just as I have taken such a lot from yours. Specifically from thought leaders such as Professor Michael Porter and the late Barbara Starfield.

And from the experiences of places like the Cleveland Clinic and Kaiser Permanente.

The reason we can learn so much from each other is that so many of the issues we face are common to all countries.

But to these, I believe there are also some common solutions:

- a comprehensive shift to measuring, publishing and improving health outcomes;
- the creative use of incentives and quality-based competition;
- a focus on prevention and on public health; and
- better information and far better use of IT;

In the UK, responsibility for healthcare is devolved to the individual nations of England, Scotland, Wales and Northern Ireland.

In England, we have embarked on a comprehensive programme of modernisation that incorporates all of these things.

A programme of modernisation based around three principles:

- Shared decision-making between patients and clinicians – for patients, “no decision about me, without me”;
- giving power and budgets directly to clinically-led local commissioning groups;
- and a focus, system-wide and at all levels on the measurement and improvement of health outcomes.

Health outcomes are the things that really matter most to patients. Things like survival rates, recovery rates, whether people can live independently and with dignity. A patient's overall experience of healthcare.

Outcomes

Everything we do flows from this principle.

We are putting patients more in control of their own care - of where, by whom and even, where appropriate, how they are treated - because it will lead to better outcomes.

And we are giving power to design and buy in local health services to doctors and other healthcare professionals because they are best placed to improve health outcomes.

Critically, this enables us to ensure that as clinicians make the decisions which determine the use of services and resources across healthcare, they do so in the context of taking a collective responsibility for using budgetary resources to optimise service design to meet the needs of their patients and the needs of their population.

Through Clinical commissioning groups and accountable care organisations, we are, in both the US and in England focusing on the benefits of bringing clinical decision-making and control over resources together in order to secure the efficient and effective improvement of services for patients.

I am here in Washington, primarily, to attend the annual meeting of the Commonwealth Fund. Now, if you read their report, our National Health Service comes out very well.

- More people in England can get a same or next day appointment than in other countries.
- More people feel they spend enough time with their doctor when they see them.
- And almost nobody has serious problems paying their medical bills.

But if you dig a little deeper, the picture is not quite so rosy.

- We perform poorly compared to almost all other European countries on "*mortality amenable to healthcare*" - where we could save lives, but we don't.
- The premature mortality rate from all respiratory diseases is above the European average, and more than twice as high as it is in France or Sweden.
- And five-year survival rates are below the OECD average for cervical, breast and colorectal cancers.

And internally, across England, there is an unacceptably high variation in the quality of outcomes that patients receive.

We know this because, for the first time, we have started to measure health outcomes.

Last December, we published the first NHS Atlas of Variation in Healthcare. It compares 24 sets of clinical outcomes data across all 152 NHS districts. Immediately, huge variations, unexplained by local differences in population, became apparent.

- A 5-fold variation in the proportion of diabetes patients receiving the recommended level of care;
- A 4-fold variation in emergency admissions for under-18s due to asthma;
- A 4-fold variation in the number of emergency bed-days for patients with the respiratory disease, COPD;
- And, in a separate survey, death rates following bowel cancer surgery can be as low as below 2% or as high as over 15%, depending on which hospital you are treated in;

While there is truly excellent care and world-leading medicine to be found in the National Health Service, there is also too much that is just not good enough, in terms of outcomes and in terms of the personal care given to patients.

England is, of course, far from unique. The same is true in every country in the world. The quality of care varies.

The Outcomes Framework
So what do we do about it? How do we narrow the gap between the best and the worst while raising the bar for everyone?

For us, it all starts with the NHS Outcomes Framework. The Outcomes Framework isn't a list of targets set in Westminster by politicians. Nor is it a strict set of rules that will bind the hands of doctors, undermining their professional judgement.

Rather, the Outcomes Framework is about being clear about what I want every healthcare organisation, ever purchaser or provider, every person who works within the growing NHS family to work towards in their day-to-day working lives.

- Reducing avoidable mortality - for example, measuring one and five year survival rates after cancer diagnosis, or 30 day mortality after stroke;
- enhancing recovery after treatment - for example, measuring patient-reported outcomes such as recovering mobility or reduction of pain following knee replacement. Or the 6 month status of stroke patients;
- improving the quality of life for people with chronic conditions - measured, for example, by EQ5D, which asks about things like pain, mobility, whether you can do usual activities, anxiety and self-care;
- maximising safety - for example, minimising 'never events' and reductions in healthcare-acquired infections;
- and continually improving patients' experience of their own healthcare - for example, through patient surveys.

The Outcomes Framework will help clinicians and managers to come together, pulling their organisation in the same direction.

They are deliberately broad so as to cover all areas of health care.

To flesh out the detail, NICE - the National Institute for Health and Clinical Excellence - is developing a library of condition specific Quality Standards.

We already have quality standards for diabetes, breast cancer and 10 other conditions, with another 16 currently in development and a further 120 to come.

This will mean that, over time, clinicians will be able to see just what excellent care, based on the latest evidence and the best global practice, really means. And be in a position to judge whether or not they are delivering to that standard.

But crucially, these Quality Standards only say what needs to be achieved, not how to achieve it. That responsibility must rest with local clinicians with local knowledge and an understanding of the needs of their communities.

In time, everything will flow from these outcome objectives. The reputation of clinicians, the success or failure of providers - and a proper regulatory regime for individual hospitals and other providers is an important part of the new system - everything will depend on how well they can deliver against these outcomes.

There are three main reasons for this.

First, a line of accountability will run from providers, through local and national purchasers and to the Secretary of State, based all the way on the NHS Outcomes Framework and its complementary measures of progress.

The second reason is because we are changing the way we pay for care.

At the moment, hospitals or other healthcare providers are paid for every episode of care. So if a hospital messes up and a patient is readmitted for further treatment, they get paid twice. Not that a hospital would think this way, but they actually have a perverse incentive not to provide the best care.

So we are progressively introducing a new payment system that will pay for results; which will encourage and reward the best care through quality increments and best practice.

[data on fragility hip fractures?]

That will incentivise integrated services, designed around the pathway of care, irrespective of primary and secondary care divisions. [e.g. Cystic fibrosis]

So if you deliver excellent care for your patients and improve outcomes you stand to get paid more than if you don't.

The emphasis moves from the quantity of care, to its quality.

Next year, this new payment system will include, for the first time:

- adult mental health, the first in the world to do so,
- improving access to Psychological therapies,
- ambulance services,
- radiotherapy and chemotherapy,
- and community services, such as podiatry.

The third reason that outcomes will matter most is patient choice.

We will be doing more than just measuring health outcomes, we will publish them. This new wealth of data will help providers compare their performance with their peers and drive changes where necessary. It will help purchasers to employ the very best providers and to keep track of their performance.
But perhaps most importantly, it will empower patients to take control of their own care.

So if they need surgery, they will be able to choose not only the best hospital, but the best consultant team for their type of operation.

Or if they have a long-term condition like diabetes, they will be able to choose which local provider is able to offer them care that fits around their needs and wishes.

This choice will place a huge incentive on providers to up their game. The basic principle here is *the money follows the patient*. And if providers want to attract the patients, then they need to offer them the best care.

In some cases, this might mean a patient travelling further to a better hospital. But if it's important, then it will be worth it. And it will be the choice of the patient to do so.

Another aspect of this is information technology. All the information in the world is no good if people can't read it, understand it and make decisions based upon it.

So we are opening up the market for innovative IT companies or healthcare providers to develop products that people can use.

The Department of Health is currently holding a competition to find the best healthcare apps and to encourage the development of new ones.

I want people to be able to easily see and compare the record of different institutions and different consultant teams. We have the technology, we will soon have the data, and I am very excited to see what happens when the two come together, to empower patients and energise clinical services.

This is what Michael Porter refers to as value-based competition. Providers of care competing on the quality of what they can offer patients, not the price at which they can provide it to purchasers.

And I think that the work we are doing here - the Outcomes Framework, the Quality Standards, the new payment system for whole pathways of care - these are areas where we and other health systems, including here in America, can share experience.

Public Health

But as well as re-focussing the treatment side of healthcare, we need to do far more on prevention. On public health.

In Britain,

- 1.6 million people are dependent on alcohol.
- Smoking claims seven thousand lives every month.
- Almost a quarter of adults are now obese.

And it's the poor who disproportionately bear the brunt of ill health.

We can't just wait for people to get sick and crowd our hospitals.

It's far better for them, far better for the Health Service and far better for society, to keep people healthy. Or at least actively manage them to keep them from getting any worse.

So we are also reforming public health.

Of course, this is easier said than done and is not wholly within the power of any government or healthcare institution.

I can't force people to stop drinking or to take up exercise.

But we can do much more to make healthy behaviour easier and more effective.

When someone weighs up the list of pros and cons, we can add a few more pros to the list.

And we can do more to manage those who at the most risk.

I read an article in The New Yorker ['*The Hot Spotters'* by Atul Gawande, 24/01/11] recently about how Dr Jeffrey Brenner, a physician in Camden, New Jersey, used a statistical analysis of Emergency Room admissions.

He found that, "*one per cent of the hundred thousand people who made use of Camden's medical facilities accounted for thirty per cent of its costs*".

With a bit more digging and a lot of hard work, he started focussing on helping that 1%. His focus was not cutting costs, although that was a welcome side-benefit. His goal was to improve the quality of people's lives.
It's something we are also doing too.

In Yorkshire and Humber in the North of England, the Ambulance Service there gives local NHS districts a monthly breakdown of their top 10 most frequent callers.

These people are then given intensive, personalised help. Not only to manage any chronic conditions, but to look at their lifestyle, their diet, their home. To look at the whole person rather than just treating the immediate symptoms.

The result is far better care for patients as well as - for this group - a 60% fall in unplanned admissions, a 20% reduction in bed days and a halving of ambulance journeys.

Better care for patients. Better value for taxpayers.

By analysing the data and intervening early we can prevent often catastrophic outcomes before they happen.

Improving health will be the result of a locally-led partnership between clinical commissioning of healthcare services, and local government, the latter providing social care services and public health leadership.

Integrating them, so as to prioritise preventative care; making health and personal care more joined-up and impacting on the social determinants of health: education, employment, poverty, housing and the environment.

These local partnerships will be mirrored by national leadership in setting evidence-based standards and outcomes for the NHS and through Public Health England, leading on national health protection, such as pandemic flu preparedness, tobacco control and screening; and in promoting health improvement, as in the Responsibility Deal and Change 4 Life - just as "Let's Move" is leading health improvement campaigns here in the US.

Conclusion

Let me sum up. While some aspects of our healthcare systems may be different, we all face common challenges. And working out the best way forward will mean finding some common solutions. We have a lot to learn from each other. Us for you and, I believe, you from us.

- By focussing on outcomes,
- by aligning every incentive behind improving those outcomes,
- by being open and transparent,
- by putting as much emphasis on prevention as we do on treatment...

... I believe we can achieve great things. Far better quality of care for patients and a far better deal for those who pay for care, be it through taxes or insurance premiums.
As we face up to the challenges of rising demand and cost pressures in both the US and UK, I believe we can both draw on increasing evidence that we can achieve higher quality and reduced cost through clinically-led, accountable services, incentivised to innovate around the needs and expectations of patients.

Delivering quality and value in improving health outcomes for all.
Thank you.