Managing health care in a rural landscape

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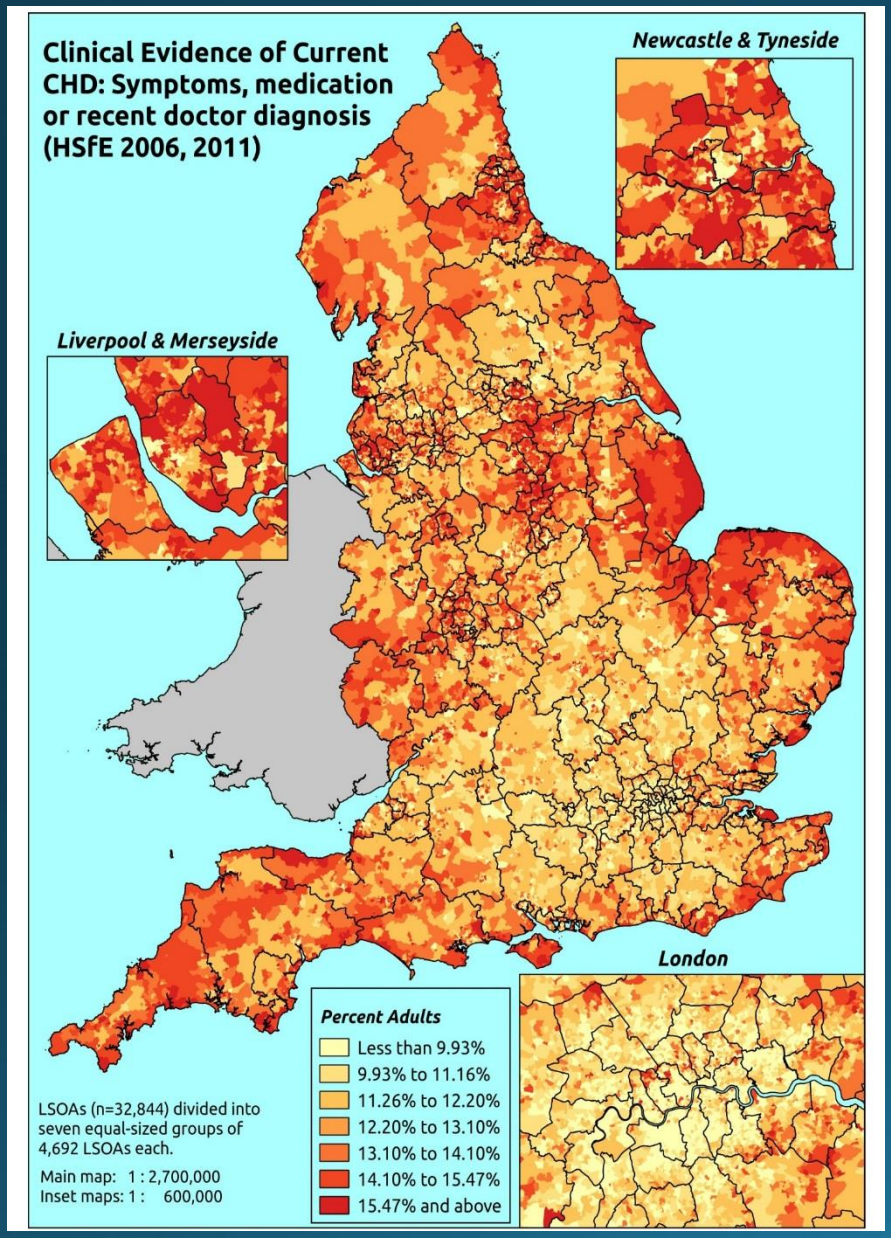
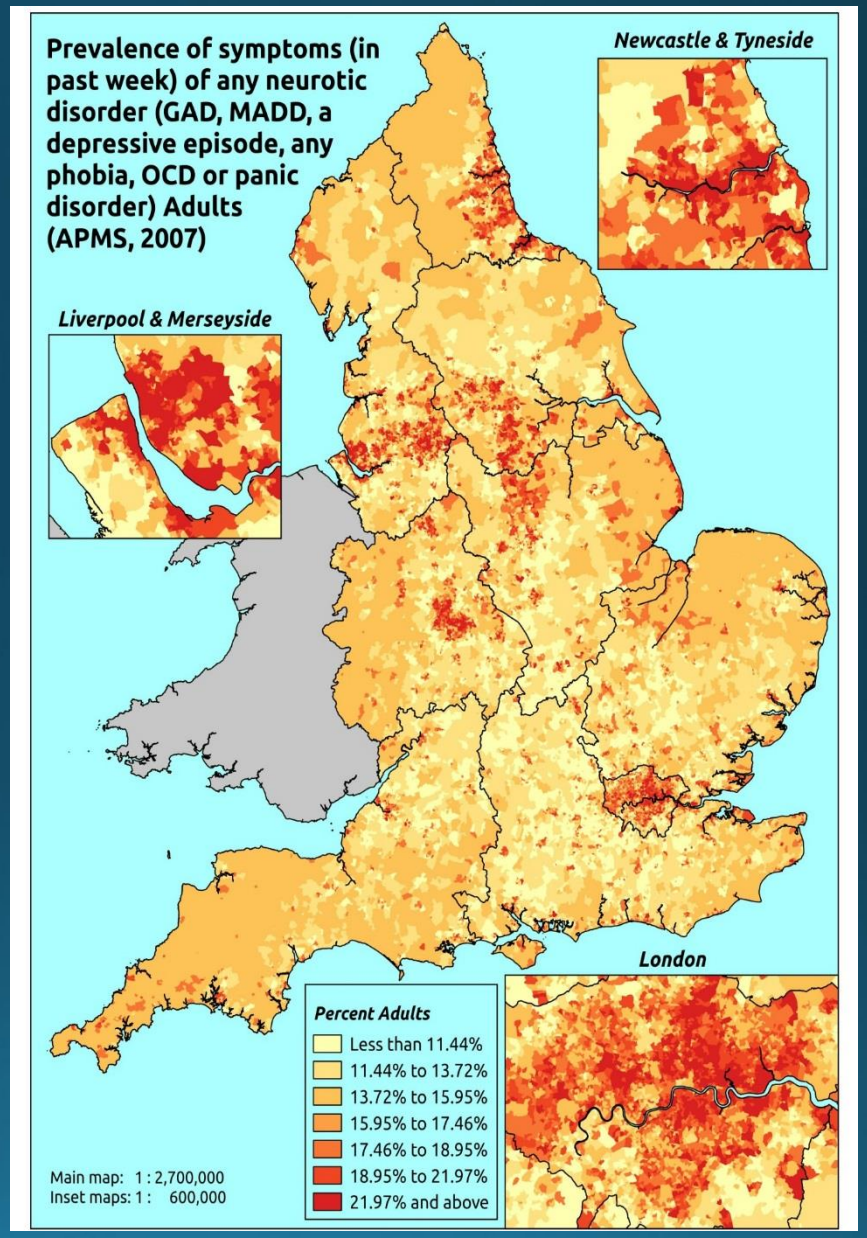
Outline

- The NHS: Two equity principles
- Which definition drives the distribution of NHS resources?
- What does this mean for the South West?

The NHS: Two equity principles

- *Health care equity*: health care resources should be geographically distributed to ensure 'equal opportunity of access to health care for people at equal risk' (i.e. respond to *crude* disease prevalence with adjustments)
- *Health equity*: resource allocation should 'contribute to the reduction of avoidable inequalities in health' (i.e. respond to standardised disease prevalence)
- Are the two principles reconcilable?
- Health care equity complicated by different distributions of different diseases (though most chronic degenerative diseases are primarily driven by demography)


Clinical Evidence of Current CHD: Symptoms, medication or recent doctor diagnosis (HSfE 2006, 2011)
Newcastle & Tyneside
Liverpool & Merseyside
London
Percent Adults
Less than 9.93%
9.93% to 11.16%
11.26% to 12.20%
12.20% to 13.10%
13.10% to 14.10%
14.10% to 15.47%
15.47% and above
LSOAs (n=32,844) divided into seven equal-sized groups of 4,692 LSOAs each.
Main map: 1 : 2,700,000
Inset maps: 1 : 600,000


Prevalence of symptoms (in past week) of any neurotic disorder (GAD, MADD, a depressive episode, any phobia, OCD or panic disorder) Adults (APMS, 2007)
Newcastle & Tyneside
Liverpool & Merseyside
London
Percent Adults
Less than 11.44%
11.44% to 13.72%
13.72% to 15.95%
15.95% to 17.46%
17.46% to 18.95%
18.95% to 21.97%
21.97% and above
Main map: 1 : 2,700,000
Inset maps: 1 : 600,000

Which definition drives the distribution of NHS resources?

Mortality, morbidity and allocations for PCTs with the youngest and oldest demographic profiles, 2012-13

				Crude Mortality Rate (per 100,000)					
PCT Name	%pop>75	Average IMD	All Cause Standardised Mortality Ratio SMR	All Cause	Cancer	Circulatory	Cancer Spend per QOF cancer patient	Cancer Spend Per new Cancer Case	Per Capita Allocation 2012/13
Dorset	13.12%	14.62	84.52	1,173	334	399	£3,987.94	£13,598.84	£1,726.76
Torbay Care Trust	11.91%	26.82	97.38	1,301	341	433	£4,777.58	£15,955.31	£1,944.80
Hastings and Rother	12.01%	26.83	98.53	1,307	375	486	£5,653.83	£17,160.90	£1,942.30
East Sussex Downs and Weald	12.08%	16.69	88.08	1,173	311	456	£5,160.51	£17,031.38	£1,727.85
Great Yarmouth and Waveney	10.93%	24.59	96.84	1,162	318	386	£4,115.63	£13,921.83	£1,785.70
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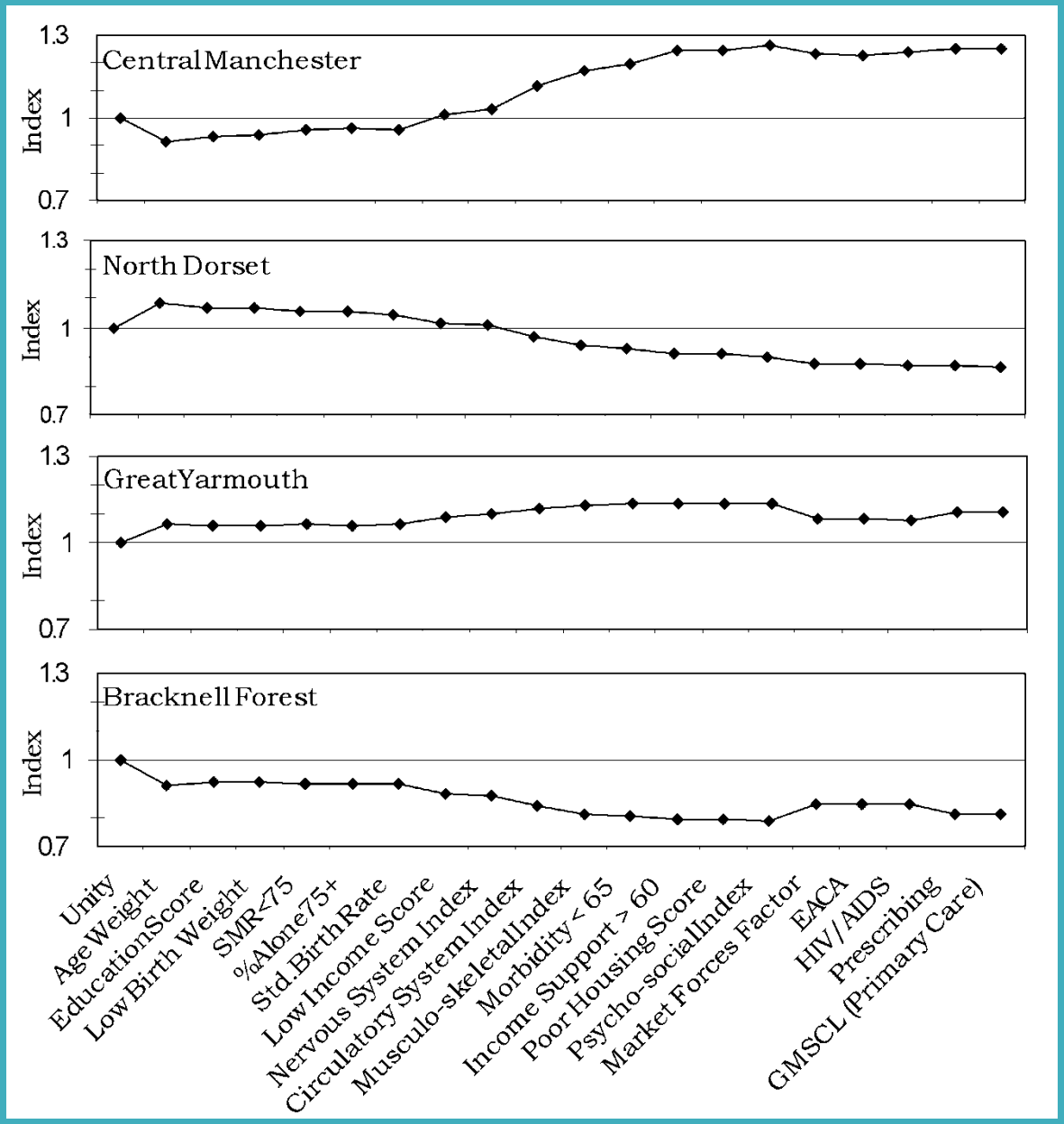
Camden	4.05%	25.43	93.61	498	147	154	£11,320.82	£37,051.02	£2,056.65
City and Hackney Teaching	3.96%	41.28	97.34	503	139	168	£8,286.32	£28,069.80	£2,323.85
Lambeth	3.93%	31.24	109.06	529	151	157	£8,462.32	£34,021.30	£2,115.23
Newham	3.72%	41.84	114.46	565	148	188	£9,721.38	£28,582.04	£2,396.11
Tower Hamlets	3.37%	39.59	109.67	467	137	147	£14,842.15	£48,961.54	£2,142.57

Technical objections to the approach to resource allocation

- The current distribution of funding owes much to the HIGHLY flawed 'AREA' formula that was introduced in 2002 and which guided allocations until 2009
- Two-step procedure used to model age-related and additional needs (deprivation) effects, the latter effectively cancelling the former out
- PCTs with more ageing populations would usually have been better off if there were no weightings at all!

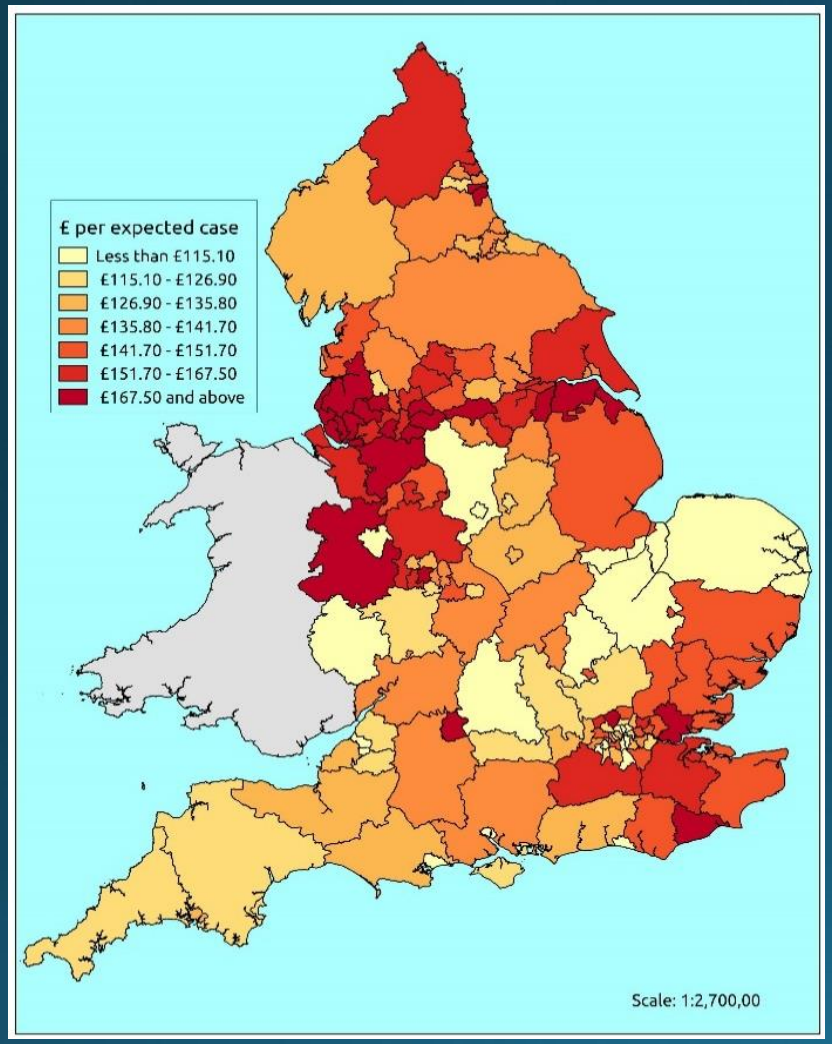


Sequentially Incorporated factors in the AREA Capitation Formula

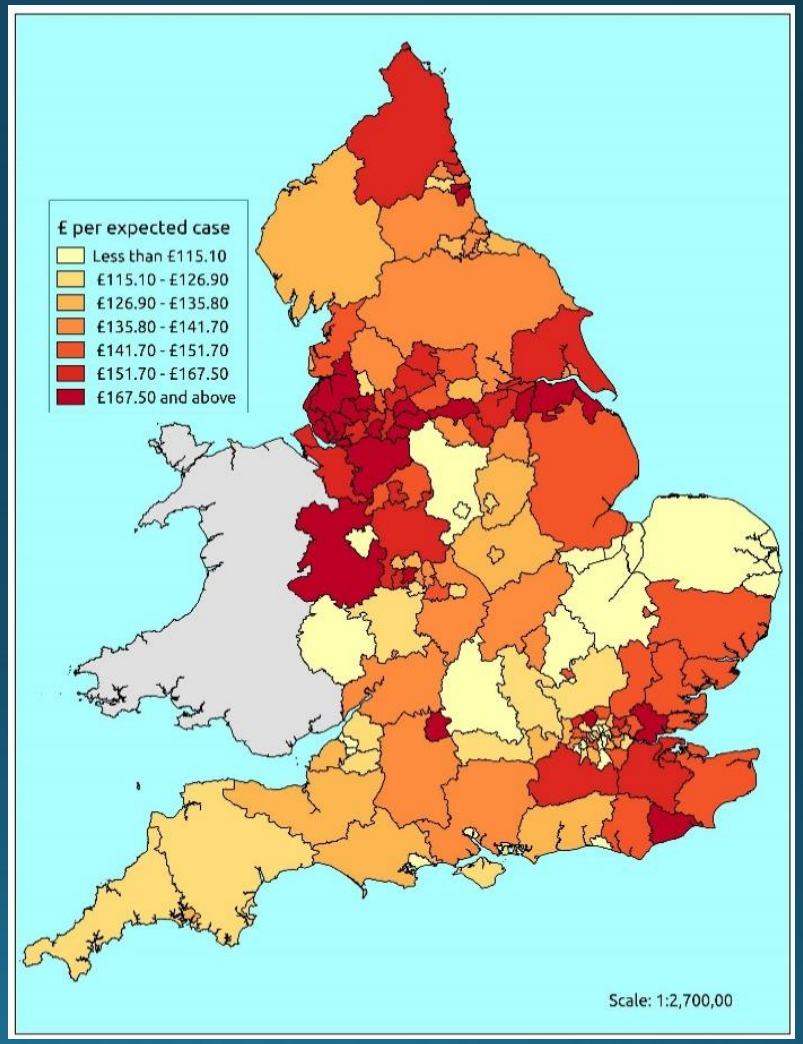
Evidence-based objections

- *Can* the NHS play a significant role in addressing health inequalities?
- Some preventive interventions are effective – but they are also very CHEAP!
- Most of the factors associated with health inequalities have little to do with the delivery and distribution of *health care*
- Justification of additional funding due to inverse care law – evidence is equivocal

Map of PBC CHD Prescribing expenditure per expected CHD case



Map of PBC CHD Total expenditure per expected CHD case



Moral objections

- How can we reconcile the goal of vertical equity with institutionalised ageism?
- E.g. cancer. UK's relatively poor performance largely accounted for by poor outcomes in the elderly
- Hospitals with the poorest funding contexts & oldest catchment populations had significantly higher standardised hospital mortality (and significantly lower numbers of staff) in 2013

- November, 2013. Paul Baumann announces that deprived areas will continue to get the most money as the new formula will adjust for "unmet need"
- Strong lobbying to get additional GP funding into deprived areas (to deal with 'deep-end' problems)
- Rural areas *may* get an adjustment in the future for unavoidable additional costs (e.g. of providing community services) but this will be peanuts compared to the 'need' element of the formula
- Plus ça change, plus c'est la même chose!

What does this mean for the South West?

- Historic underfunding?
- A need to do things differently?
  - Proactively work with local organisations providing social care to reduce inappropriate hospitalisation (though social care allocations are also very low in the SW)
  - Consider innovative approaches to e.g. intermediate care, dementia services, delivery of chemotherapy, transport
  - Digital health care (telemedicine, telemonitoring, telecoaching) – e.g. remote video consultations between healthcare professionals and patients either in patients' own homes, nursing homes (Airedale Foundation Trust)
- A case for more active lobbying?