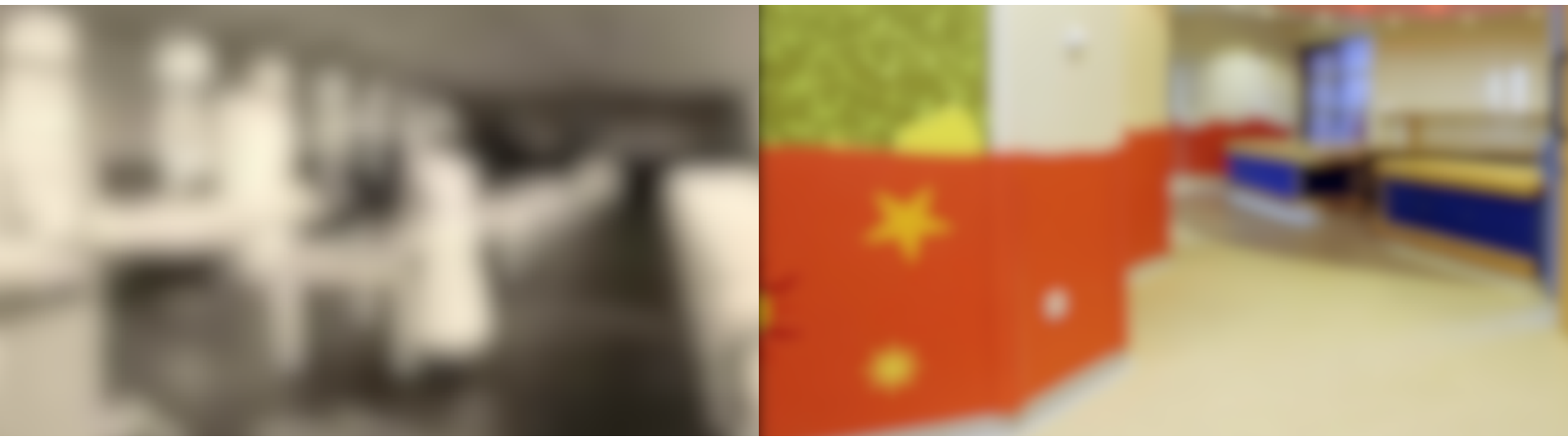
April | 2013



What opportunities for health creation are there to improve the accessibility and sustainability of health services in the UK?

1499 words

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I wrote this essay with the aim of exploring what lies in store for the health service in the future, and what improvements can be made to actually change the system which seems unsustainable. I wrote it with a child health slant as I hope work in paediatrics in the future, and it seems the problem on non-communicable disease in children does not receive as much attention as care of the elderly.

Michael Pittilo Student Essay Award 2013

When the NHS was founded, nearly half of the population died before the age of 65, and hospitals were designed around people with 'single organ' or infectious diseases(1). Now, infectious diseases have become easier to prevent or cure, but chronic non-communicable diseases - such as asthma and diabetes– have become more common(2). This non-communicable disease pandemic threatens the sustainability of our health system(3), and this essay sets out to identify how to circumvent this threat with an emphasis on child health.

The pressure on the health service is clear: three quarters of hospital consultants report being under more pressure now than three years ago and over a quarter of medical registrars report an unmanageable workload(4). Emergency admissions have increased by 37% in the last decade, yet the number of general and acute beds has fallen by a third compared to 25 years ago(4). Although the average length of hospital stay for patients was gradually reduced to compensate for this, this has now levelled off and has even started to increase in some age groups(4). All this comes in the face of NHS cuts of £20bn by 2015 and possibly £50bn by 2019-20(5).

Although a Department of Health spokesman said: "*The NHS…is…on track to make the £20 billion savings target while keeping waiting times low, performing more tests and reducing infections even further*"(6), the chief economist at the King's Fund stated the former target was "*barely achievable*" and the latter was "*frankly undoable*"(7). Waiting times have actually consistently risen from an all-time low since 2011(8), and in the Stafford Hospital scandal patients were "*let down by a culture that put cost-cutting and target-chasing ahead of the quality of care"*(9). Understaffing is prevalent(10, 11), with 17 hospitals not having enough staff "*to keep people safe and meet their health and welfare needs*" in 2013(12).

Although the greatest burden of non-communicable disease is in the elderly(13), care of chronic disorders in these patients has been high on the policy agenda in many European countries for the past decade(13, 14). Indeed, many of the ideas contained in the Government response to the Stafford Hospital scandal to improve older people's care were already in train(15, 16). In contrast, systems to deliver care to children with chronic disorders have attracted little attention(17), despite a similar increase in non-communicable disease(17), and there is a real sense among professionals and organisations that services for children and young people in the NHS have a low priority(18). For example, the UK Quality and Outcomes Framework incentivises chronic care treatment of adults yet contains almost no measures for children(17, 19), despite the finding that child mortality rates in the UK are worse than most other developed countries in Europe(17, 20), and that 2000 children's lives could be saved each year if the UK could match the performance of Sweden(21) - with improvement also likely to reduce health equality at all ages(22). The president of the Royal College of Physicians of Child Health recently stated that "*we have failed to adapt system to changing epidemiology - we're caught in 50yr old model*"(23).

So how can we change our model to be more suited to non-communicable disease? To make change happen you need three things: a sense that we have no option but to change, a given considering the aforementioned financial pressures and poor performance; a vision of what we might move to; and a plan of what we will do today to move towards the vision(24). So what is the vision? A recent article in the BMJ stated that for health systems to survive, successful innovations must spread(3). Perhaps then, looking at other countries will lead to improvements.

The most significant recurrent factor in avoidable child mortality in the UK is a failure to recognise severe illness at the point of first contact between the child and the healthcare services, especially in doctors without any special knowledge of children's health(2, 25). In the UK, 50–60% of GPs have had no formal postgraduate paediatric training(26), despite up to 40% of consultations being with children and families(18), and although A&E departments dedicated to children and young people provide good care, the experience of children entering adult A&E departments can be quite different(18). Lack of knowledge or confidence in primary care is also reflected by the number of unnecessary admissions: with 36% of referrals to paediatricians potentially avoidable(26), which puts pressure on hospitals.

In contrast, in Sweden, most GPs receive at least three months' specialist training in paediatrics, being required to train either in paediatrics or in obstetrics and gynaecology, and often work in multiprofessional care centres, working closely – or collocated – with paediatricians and children's nurses(17). Integration of primary and secondary services is also recognised elsewhere, such as Japan - where *Renkei* (which means cooperation and integration in Japanese) between different sectors has been one of the major concerns in healthcare(27) - and the Netherlands - where transmural care was introduced in the early 1990s to provide care based on 'cooperation and coordination between general and specialised caregivers'(17, 27).

In Sweden, improved integration came about in response to perceived excessive decentralisation of services, with professionals working in separate organisations(17). Increasing specialisation has been observed in the UK – with 61 approved medical specialties in the UK compared to only 30 in Norway(4) – and although it has contributed to increasing survival rates for single conditions, it can remove consultants from the general medical admitting role and impair provision of continuity of care(4).

Although highly specialised care is needed for certain disorders, such as childhood cancers, common non-communicable diseases can be cared for in the community to enable children and their families to live as normally as possible(17). This idea of dehospitalisation is similar to what has been found in care of the elderly, with the idea of 'right patient, wrong bed', where acute wards were reported to poorly meet the needs of non-communicable chronic diseases(14). Despite the high cost of hospitalisation, the NHS has been slow to develop comprehensive, effective alternatives to admission(4), but they do exist.

For example, community-based care from nurses seems to be at least as effective as, and possible less expensive than, care delivered by a GP or paediatrician, and although present in the UK this isn‘t extensive(17). In Italy there is an initiative (*Assistenza Domiciliare Pediatrica*) to ensure as much care as possible for children with chronic disorders is delivered at home, such as those needing parenteral nutrition, oxygen therapy, or frequent blood sampling(17). Self-management may also offer families greater control over their lives, less reliance on medical interventions, and potentially reduced morbidity(3), and may be aided by new forms of patient communication, such as the CollaboRhythm platform and use of mobile phones(3). The premise for the future must be that the NHS is there for children and young people, rather than that the child or young person is there for the service(18).

Although there is a broad consensus that integrating primary and secondary care and shifting many non-acute health services from hospital-based to community-based delivery could improve access and reduce costs, most countries have yet to do so(17). So, what can we do to bring about this change today? Firstly, we need to know why it isn’t happening. Consensus views of the difficulties encountered include: resistance to change(17), especially in countries that have long established and well entrenched health systems such as the hospital-centric model of the UK(3); financial disincentives to cooperation, with community services led by non-physicians possibly being viewed as a threat (both financially and in terms of job security)(3); as well as organisational boundaries preventing cooperation between providers(3, 17). Early assessments in Sweden revealed similar problems - especially with physicians – but implementation was eased by allowing sufficient time for change, maintaining motivation by focusing strongly on quality improvement, and developing supportive policy and providing adequate funding(17).

Although adequate funding may not seem feasible given austere NHS cuts, introduction of integrated models in Sweden and the Netherlands emphasised its importance(17). Savings are also predicted through greater efficiency, co-location and the benefits it brings, and through the joint planning and commissioning of services (18). Funding needs to be part of a larger strategy to reassure or overcome the objections of staff if change is to succeed(3), along with having evidence that changes resonate with the public, are scientifically sound, and show evidence for potential reductions in mortality and morbidity(3). An important first step in this is the systematic evaluation of the quality of child health service, with very few examples available in European countries(18).

In conclusion, although the nature of diseases seen in children has changed over the last few decades, very little address has been paid to this problem in the UK. More will needs to be apportioned to this problem as the non-communicable disease pandemic is not exclusive to the elderly population and potential for improvement in care of children is both evident and necessary. Crucial to this are improved primary care provision – through improved postgraduate paediatric training and/or integration – and expansion of community care initiatives.

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