Application of expanded Principal-Agent models to standing setting and monitoring in the NHS

Care Quality Commission (CQC)

More recently (post 2013) it has moved back to 7 as methods have now been agreed and there is consensus on the approach.

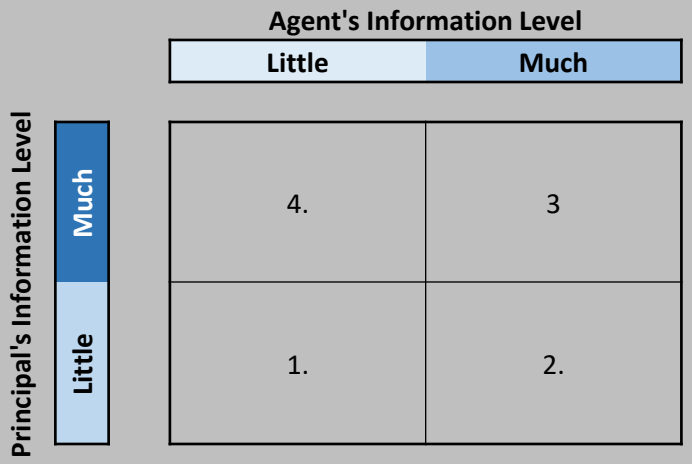


Figure 1: The Waterman and Meier expanded Principal-Agent model (i) ***Goal Conflict***

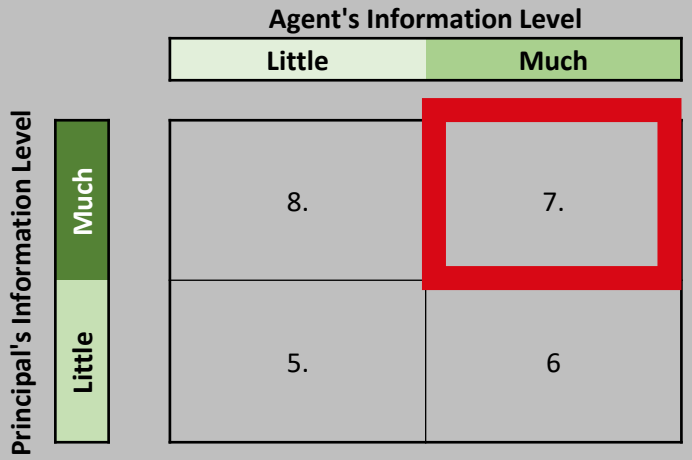


Figure 2: The Waterman and Meier expanded Principal-Agent model (i) ***Goal Consensus***

Application of expanded Principal-Agent models to standing setting and monitoring in the NHS

National Institute for Health and Care Excellence (NICE)

NICE starts at 6 as there is goal consensus and it has specialist knowlege

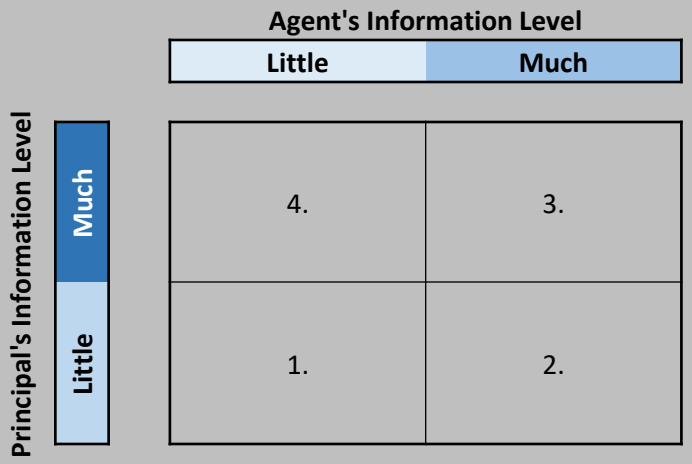


Figure 1: The Waterman and Meier expanded Principal-Agent model (i) ***Goal Conflict***

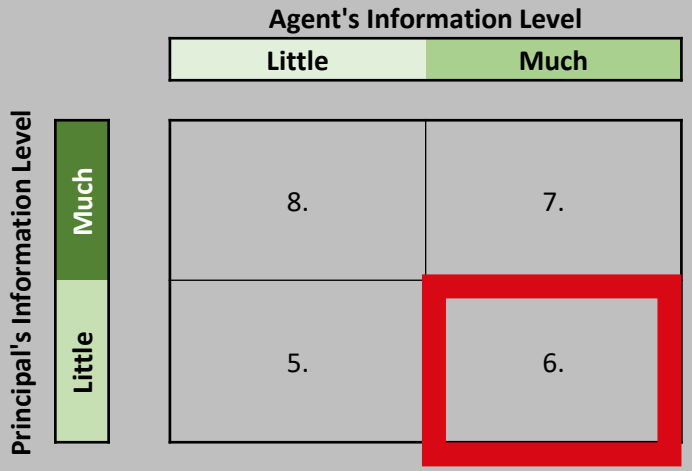


Figure 2: The Waterman and Meier expanded Principal-Agent model (i) ***Goal Consensus***

Application of expanded Principal-Agent models to standing setting and monitoring in the NHS

National Institute for Health

"There was no attempt at all to interfere," says Sir Michael Rawlins, actually, ministers realised the value of having us, as it were, a fig leaf for them – the 'blame quango' – they found that very useful. So it genuinely was independent."

Professor Sir Mike Rawlins founding chair of NICE 1999-2102

Figure 2: The Waterman and Meier expanded Principal-Agent model (i) ***Goal Consensus***

Application of expanded Principal-Agent models to standing setting and monitoring in the NHS

National Institute for Health and Care

NICE star
consensu

Right from the start *"NICE had a clear intellectual paradigm"*

Albert Weale Professor of Politics and public policy

	Agent's Information Level: Little	Agent's Information Level: Much
Much	4.	3.
Little	1.	2.

terman and Meier expanded Principal-
Goal Conflict

	Agent's Information Level: Little	Agent's Information Level: Much
Much	8.	7.
Little	5.	6.

terman and Meier expanded Principal-Agent model (i) ***Goal Consensus***

Application of expanded Principal-Agent models to standing setting and monitoring in the NHS

National Institute for Health and Care Excellence (NICE)

NICE moves to 7 with expanded number of Principals as part of the NHS reforms in 2013. They consider that they have specialist knowledge as well ie NHS England and Public Health England

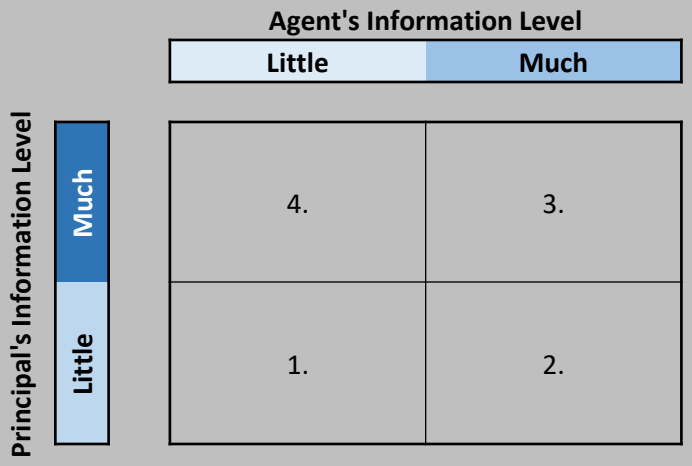


Figure 1: The Waterman and Meier expanded Principal-Agent model (i) ***Goal Conflict***

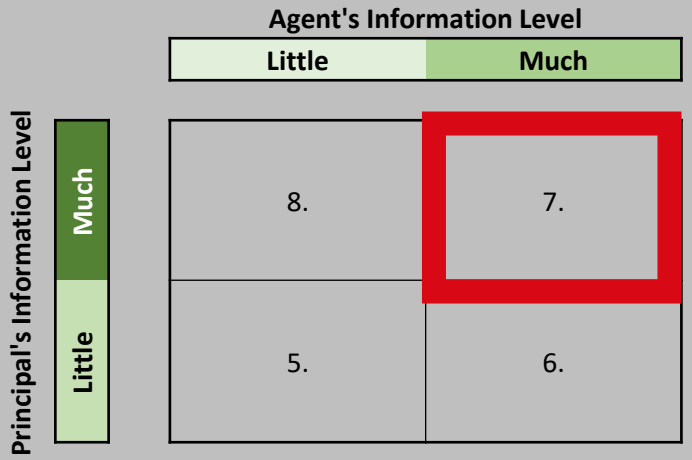


Figure 2: The Waterman and Meier expanded Principal-Agent model (i) ***Goal Consensus***

Application of expanded Principal-Agent models to standing setting and monitoring in the NHS

National Institute for Health and Care Excellence (NICE)

NICE moved to 3 in 2013 as new Principals have different goals (NHS England) eg cost effectiveness versus cost containment

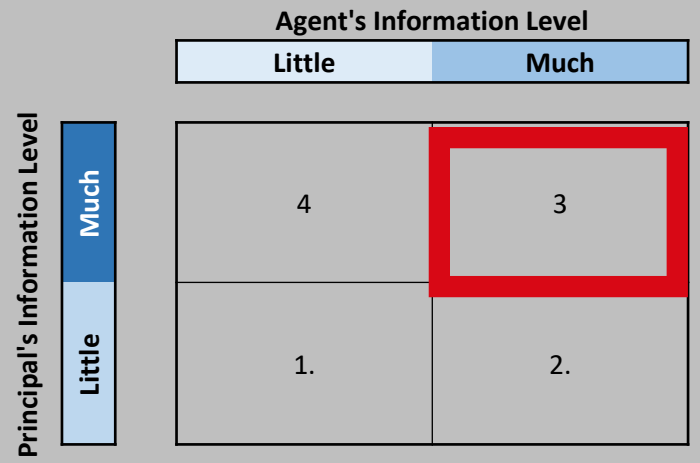


Figure 1: The Waterman and Meier expanded Principal-Agent model (i) ***Goal Conflict***

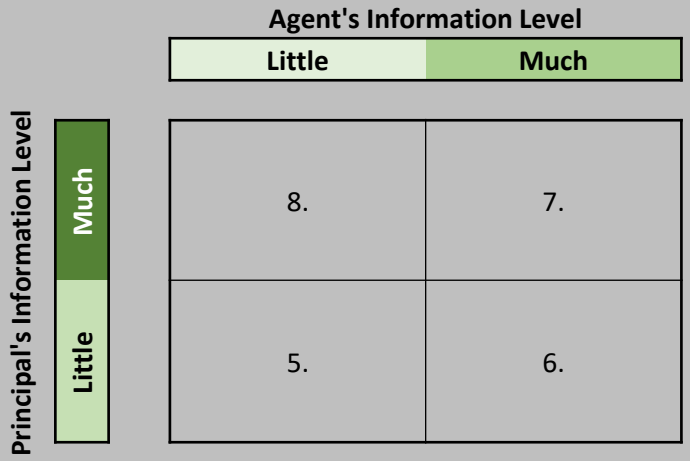


Figure 2: The Waterman and Meier expanded Principal-Agent model (i) ***Goal Consensus***

Conclusions of the findings from Principal - Agent modelling (Waterman and Meier broader framework) (i).

Application of the Waterman *Meier framework enabled an understanding and description of the dynamic relationship between central government and* organisations in the NHS and may predict when tensions will arise in the future

It should be noted that two organisations moved to position 3 before being disbanded……NICE moved there in 2013 although recently NICE and NHS England have launched a consultation document on changing NICE's methodology to address cost impact as well as cost effectiveness. So it may well move back to position 7 in the future.

Conclusions of the findings from Principal - Agent modelling (Waterman and Meier broader framework) (ii).

NICE did move back to 7

CQC has remained

New organisations were established - NHS Improvement was set up in April 2008 to drive clinical service improvement, but was merged into NHS Improving Quality in 2013. But from 1 April 2016, NHS Improvement became the operational name for an organisation that brought together: Monitor, NHS Trust Development Authority, Patient Safety (from NHS England), National Reporting and Learning System, Advancing Change Team and Intensive Support Teams. In 2018 it became clear that the organisation, while maintaining its statutory independence, was for practical purposes to be merged with NHS England

Overview

Governance (politics, structures and organisations and finance)

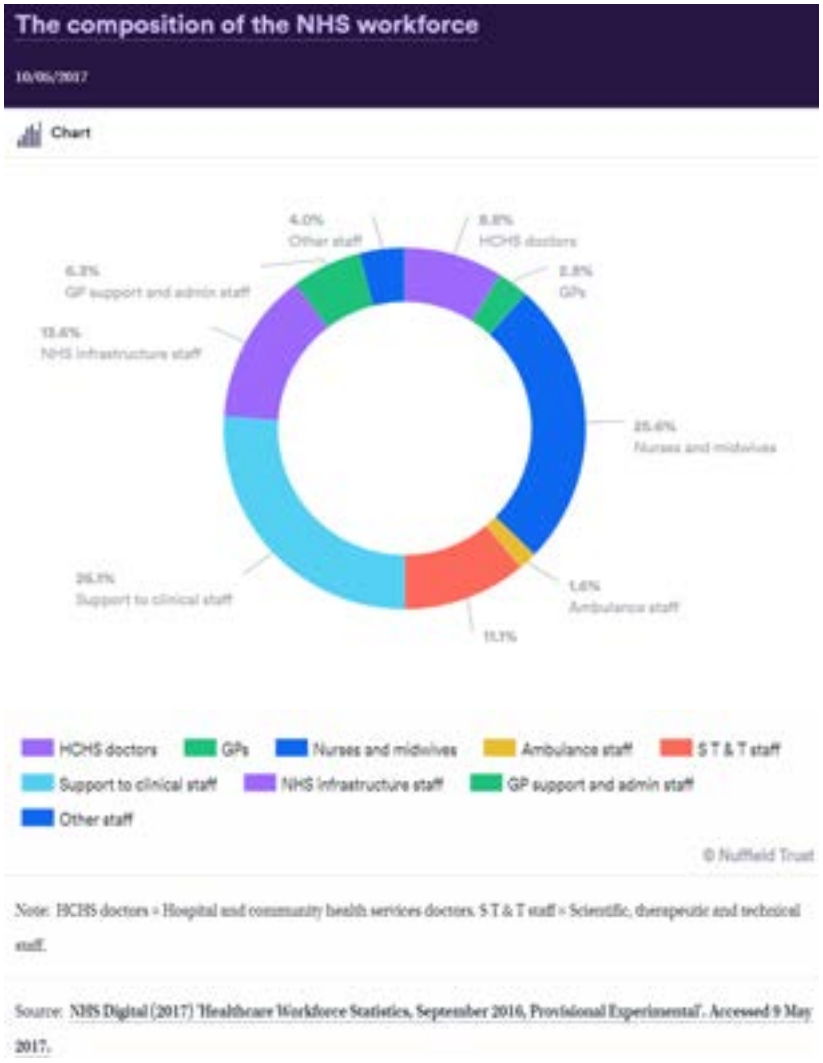
Clinical workforce, clinical practice and innovation

Patient and public expectations and involvement

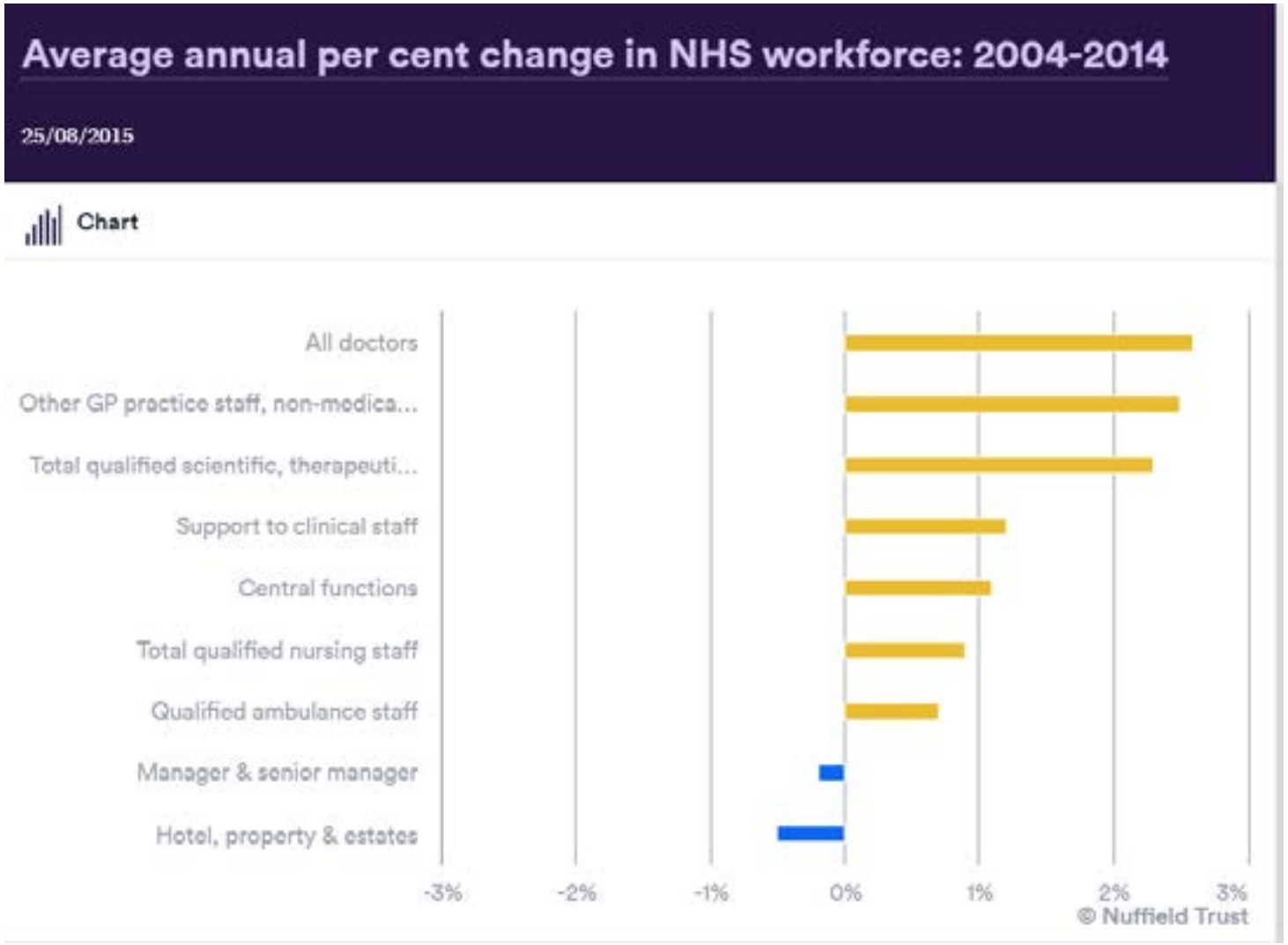
Outcomes and equity

Based on my 40 years experience of the NHS in UK concentrating on the last 20 years. A personal (political science) perspective based on a series of case studies.

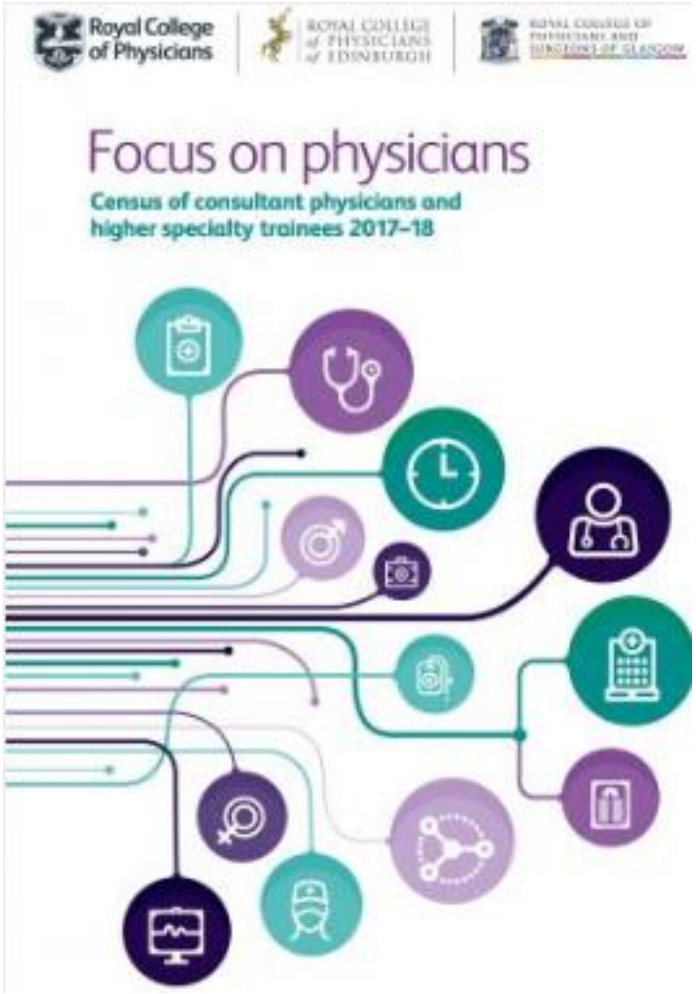
NHS Workforce



A new work force



A workforce crisis ?

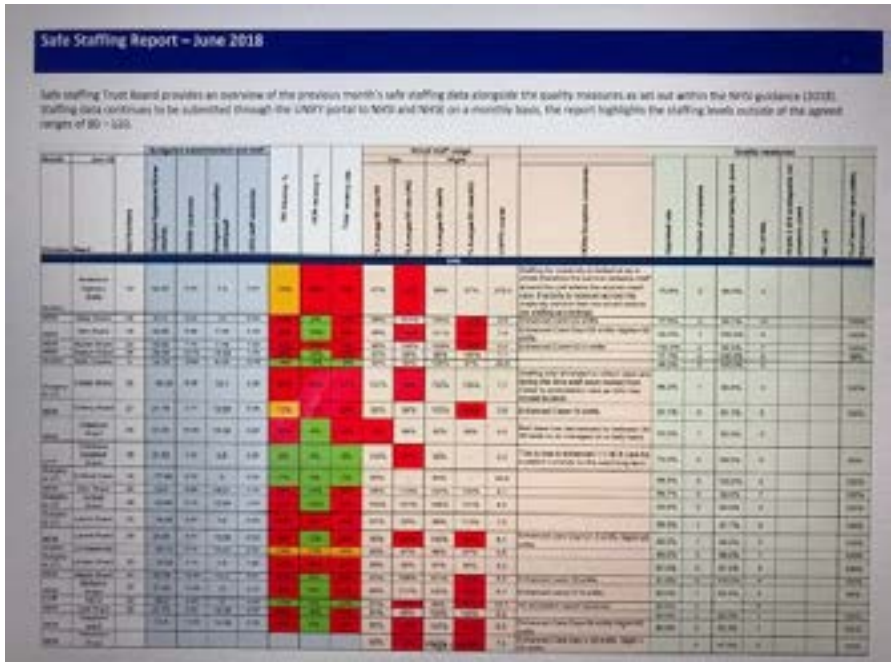


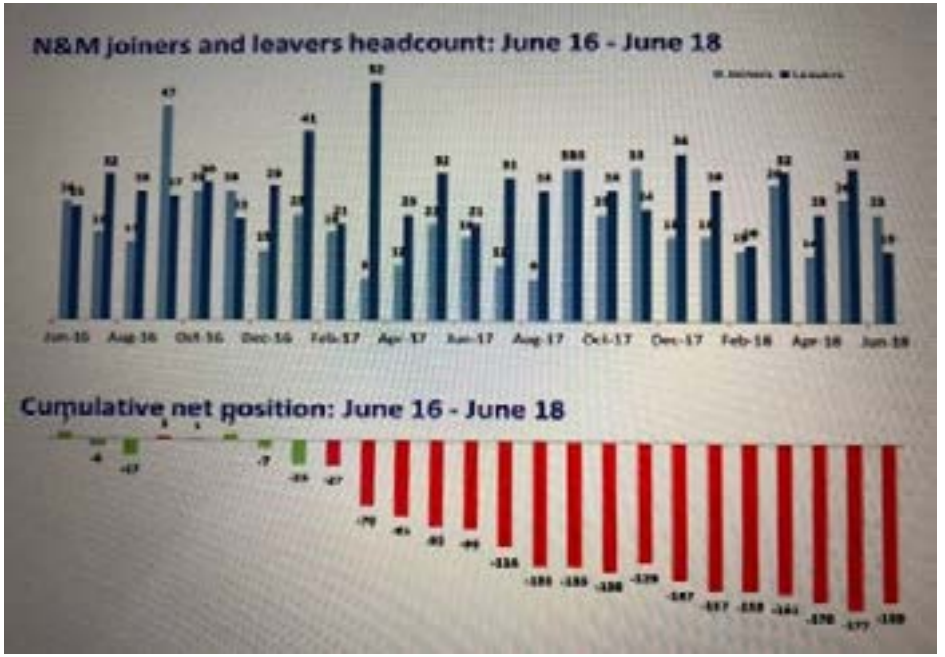
Key points

The census revealed continuing pressure on the medical workforce and the systems in which we work. This pressure is demonstrated by ongoing problems with rota gaps, unfilled posts and high levels of reported sickness absence:

- 45% of advertised consultant posts went unfilled due to a lack of suitable applicants
- 53% of consultants and 68% of trainees said rota gaps occurred frequently or often, with significant patient safety issues in 20% of cases
- Trainees reported that a fellow junior doctor was absent due to sick leave in 46% of their on-call shifts
- Both consultants and trainees estimated that they worked on average 10% more than they were contracted to work
- The number of consultants working less than full time (LTFT) has risen to 23%. This was particularly noted among older consultants who have moved to LTFT, supplementing those working this way on a longer term basis. The number of trainees working LTFT rose to 15%.

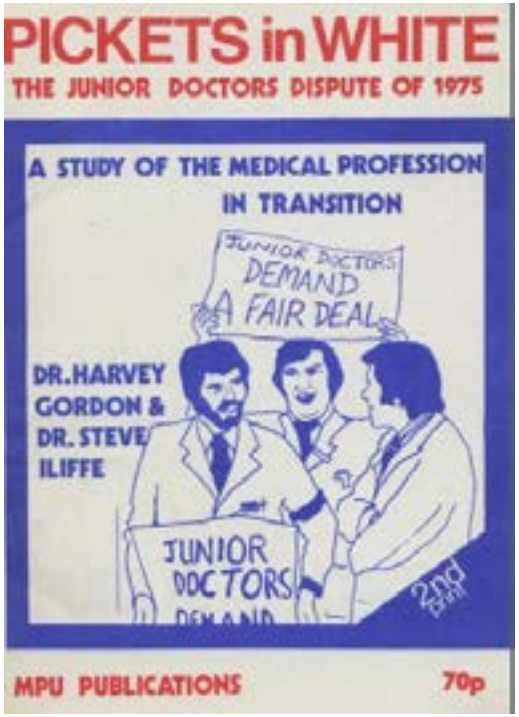
A workforce crisis ?





Lewisham and Greenwich NHS Trust Board Papers June 2018

First Doctor's Strike 1975



Second Doctors Strike 2016

NHS staff crisis 'worse than cash woes'

By Nick Triggle
Health correspondent

10 June 2016 | Health

The growing crisis in workforce morale is a greater risk to the NHS than the financial problems it is grappling with, a leading health expert says.

Nigel Edwards, chief executive of the Nuffield Trust think tank, warned staff shortages, disputes with government and bullying were creating a "toxic mix".

He said if the problems persisted, the affinity staff felt for the NHS could be irreparably broken.

The warning comes amid growing tensions between the workforce and ministers.

Junior doctors row: Medical leaders condemn strikes

2 hours ago | Health

Share

Junior doctors will stage a five-day walkout later this month - and the next three months

A national coordinated approach

NHS Employers

YOUR WORKFORCE | CASE STUDIES & RESOURCES | NEWS | BLOGS | EVENTS | CA

Home / Latest news / National health and care workforce strategy unveiled

National health and care workforce strategy unveiled

13/12/2017 10:30:00

A system-wide workforce strategy for the NHS and social care launches today for consultation: *Facing the Facts, Shaping the Future. A Health and Care Workforce Strategy for England to 2027.*

The content has been led and coordinated by Health Education England, but is published as a product of the whole national system including NHS England, NHS Improvement and Public Health England.

The draft strategy looks at the major workforce plans for the Five Year Forward View priorities: cancer; mental health; maternity; primary and community care; and urgent and emergency care.

It also contains recommendations for new programmes including the impact of technological advances, examining how training can be improved to make sure that the workforce is being prepared for the future.

Overview

Governance (politics, structures and organisations and finance)

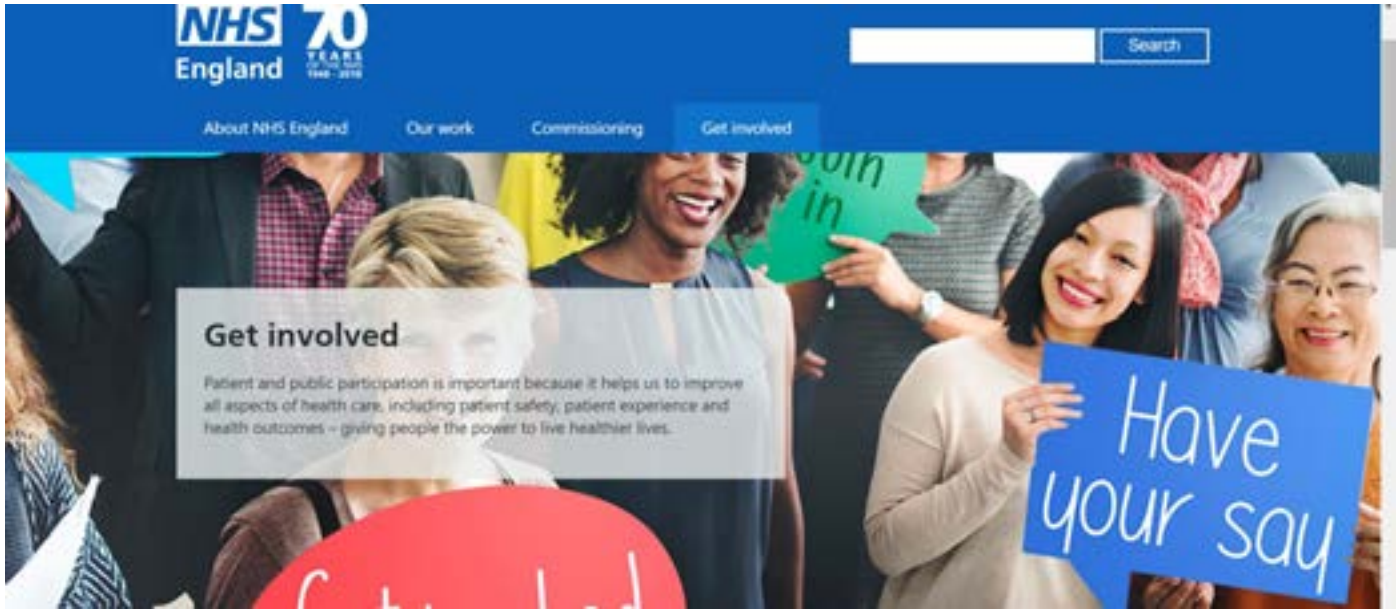
Clinical workforce, clinical practice and innovation

Patient and public expectations and involvement

Outcomes and equity

Based on my 40 years experience of the NHS in UK concentrating on the last 20 years. A personal (political science) perspective based on a series of case studies.

Patients the Public and the NHS



About the Involvement Hub

A source of information for people who want to get involved in our work or enable others to participate.

Guidance for commissioners

Statutory guidance for Clinical Commissioning Groups and NHS England on involving patients and the public.

Surveys and consultations

Have your say on NHS England's current consultations and surveys.

Learning and development

Workshops, webinars and elearning to improve understanding of the healthcare sector and participation.

Good practice

Examples of good practice in involving people in healthcare services and service development.

Resources

A variety of resources to support you in your involvement work, including bitesize guides to participation.

How to get involved →

Why get involved →

Current opportunities →

Situating Patients and Publics in Sustainability Transformation Plans and Integrated Care Systems: An Integrative Historical Review of PPI in Decision-Making in England's NHS *

Clare Coultas, Katharina Kieslich, Peter Littlejohns

Through an integrative historical review of literature we have situated the particular challenges and opportunities for patient and public involvement (PPI) in decision-making in England's NHS through analyses of its trajectory from before Thatcher through to the present day. We frame these analyses using the concept of 'institutional opportunity structures', and thus detail how the involvement of patients and publics has been conceptualised across the different government administrations and NHS reforms.

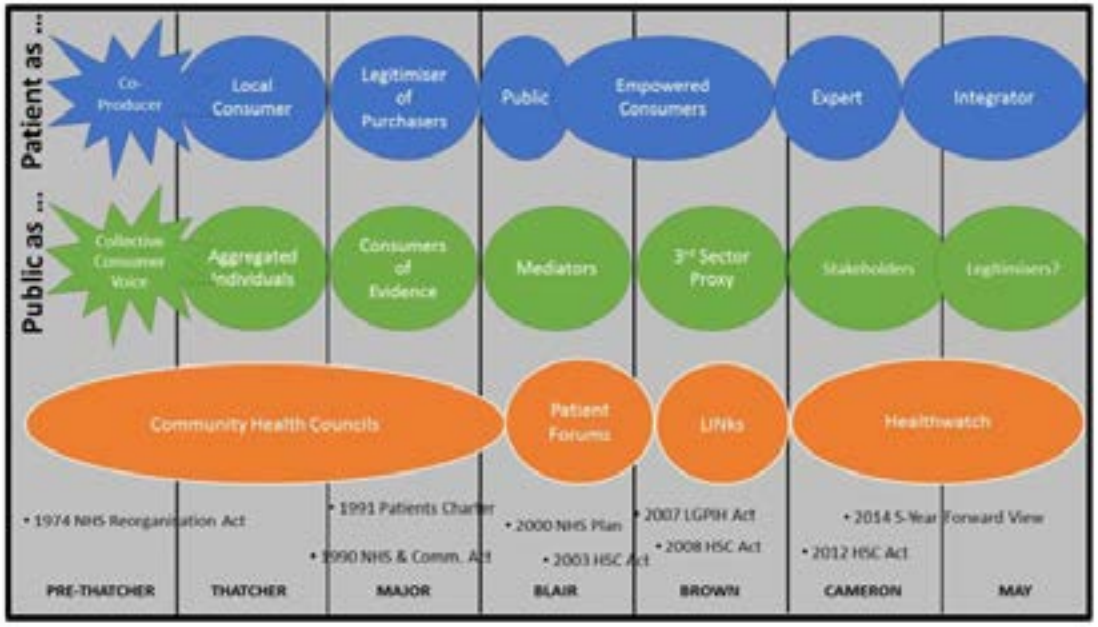


Figure 1: Activism (spiked) and Opportunity Structures (circular) for PPI in NHS Decision-Making

*Submitted for publication – not to be copied

Whatever the size of the health budget balancing the books means that difficult choices have to be made

An emerging approach is through **priority setting** which requires technical judgements of clinical effectiveness (what works) and cost effectiveness (is it value for money)

NHS protest: Tens of thousands march against 'hospital cuts'

4 March 2017 | UK

Share

Who sets the priorities ?

But these “Value for Money” judgements are embedded in a wider set of social (societal) value judgements that underlie justifiable reasoning about priorities, including transparency, participation and justice.

Health Care Policy Makers need to understand public preferences and then explain their decisions to patients, professionals, the public and politicians


Open Access

BMJ Open

Engaging the public in healthcare decision-making: quantifying preferences for healthcare through citizens' juries

Paul A Scuffham,[1] Julie Ratcliffe,[2] Elizabeth Kendall,[3] Paul Burton,[4] Andrew Wilson,[5] Kalipso Chalkidou,[6] Peter Littlejohns,[7] Jennifer A Whitty[8]

Resear

Prioritising patients for bariatric surgery: building public preferences from a discrete choice experiment into public policy

Jennifer A Whitty,[1] Julie Ratcliffe,[2] Elizabeth Kendall,[3] Paul Burton,[4] Andrew Wilson,[5] Peter Littlejohns,[6] Paul Harris,[7] Rachael Krinks,[3] Paul A Scuffham[8]

The National Institute for Clinical Excellence (NICE)

In 1999 NICE was established to provide national guidance on the promotion of good health and the prevention and treatment of ill health. In 2005 it was expanded to include public health functions and in 2013 it become the **National Institute for Health and Care Excellence** covering social care

Core Principles underpinning all NICE Guidance

- Comprehensive evidence base
- Expert input
- Patient and carer involvement
- Independent advisory committees
- Genuine consultation
- Regular review
- Open and transparent process

Picture of the grand architect William Blake – English Poet and Artist (1757-1827)

'God forbid that truth should be confined to mathematical demonstration'

Social as well Scientific Values

NICE Citizens Council

Report of the first meeting of the NICE Citizens Council

Determining "Clinical Need"

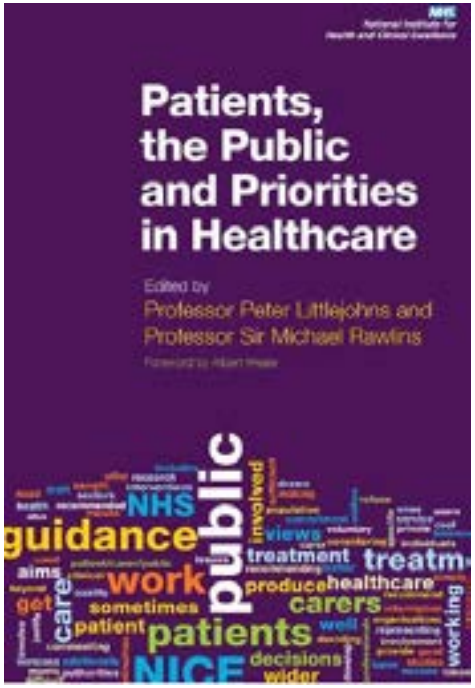
21st-23rd November 2002
Salford

Health Econ Policy Law. 2013 Apr;8(2):145-65. doi: 10.1017/S1744133112000096. Epub 2012 May 1.

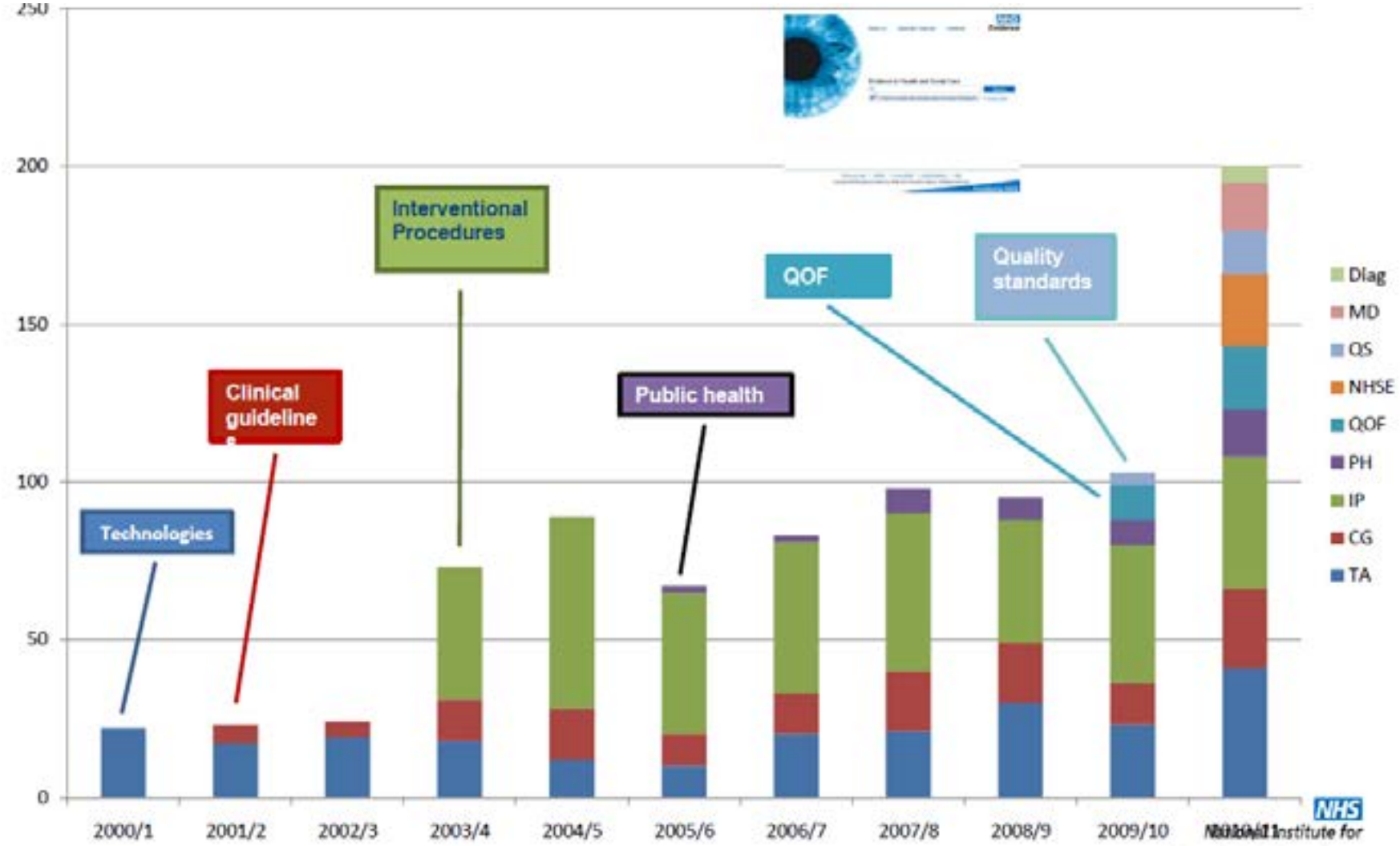
NICE's social value judgements about equity in health and health care.

Shah KK[1], Cookson R, Culyer AJ, Littlejohns P

⊕ Author information



A short History of NICE



I won't let Daddy die

Girl of six raises £4,000 for life-saving drugs the NHS won't provide

Hero helps others fight for cancer drug

By Graham Satchell
BBC Breakfast Reporter

Kate Spall has become an unlikely hero. A 36-year old housewife from Chester, she's become a life-saver to cancer patients around the country.

Life-extending cancer drugs wait for NHS approval

Kate is not a doctor, she has no medical training at all, but she's become successful at obtaining new cancer drugs for patients that have yet to be approved for use on the NHS.

> **An American asked why NICE kills people**

Main photograph: Martin Argles

Sentenced to death by NICE

VIEWPOINT

It's the body that decides which drugs are allowed on the NHS. But in this blistering attack, a leading GP argues the organisation set up to improve care is obsessed by costs, discriminates against the elderly — and ultimately is killing patients

By DR SARAH JARVIS

LIFE-SAVERS DOCTORS CAN'T PRESCRIBE

Conflict of individual and public health ethics

Liver cancer drug 'too expensive'

A drug that can prolong the lives of patients with advanced liver cancer has been rejected for use in the NHS in England, Wales and Northern Ireland.

The National Institute for Health and Clinical Excellence (NICE) said the cost of Nexavar - about £3,000 a month - was "simply too high".

Professor Peter Littlejohns, clinical and public health director at NICE, said they have to assess the cost-effectiveness of care.

Page last updated at 10:00 GMT, Thursday, 19 November 2009

Concern at liver cancer drug decision

A drug that can prolong the lives of patients with advanced liver cancer has been rejected for use in the NHS in England, Wales and Northern Ireland.

The National Institute for Health and Clinical Excellence (NICE) said the cost of Nexavar - about £3,000 a month - was "simply too high".

But Professor Jonathan Waxman, a cancer specialist at the Hammersmith Hospital in London, disagreed with NICE's decision.

Procedural Justice

Provides for 'accountability for reasonableness'. For decision-makers to be 'accountable for their reasonableness,' the processes they use to make their decisions must have four characteristics

Publicity

Both the decisions made about limits on the allocation of resources, and the grounds for reaching them, must be made public.

Relevance

The grounds for reaching decisions must be ones that fair-minded people would agree are relevant in the particular context.

Challenge and revision

There must be opportunities for challenging decisions that are unreasonable, that are reached through improper procedures, or that exceed the proper powers of the decision-maker. There must be mechanisms for resolving disputes; and transparent systems should be available for revising decisions if more evidence becomes available.

Regulation

There should be either voluntary or public regulation of the decision-making process to ensure that it possesses all three of the above characteristics.

Norman Daniels

Mary B. Saltonstall Professor of Population Ethics

HARVARD
School of Public Health

The Gresham College International Workshop 2012

At an international workshop in 2012 collaboration a social values framework was developed.

The process of decision making

Institutional setting (legal and collaborative)
Transparency (clear how decisions are made)
Accountability (who is responsible and to whom)
Participation (all who want to be can be involved)

The *content* of decision making

Effectiveness (does it work)
Cost effectiveness (value for money)
Fairness (to all patients)
Quality of care

Thailand, China, Germany, Switzerland France, South Korea, UK, Norway, USA, Brazil.

Brocher Foundation International Workshop 2015

30 delegates from South Korea, UK, NICE International, USA, Norway, Thailand, New Zealand, China, Sri Lanka, Australia, Brazil, China, South Africa, Germany, Switzerland and the World Bank to specifically look at patient and public involvement

FONDATION BROCHER

Priority Setting for Universal Health Coverage 2016……embracing politics

The Prince Mahidol Award Foundation (Thailand) the World Health Organization, the World Bank, the Global Fund to Fight AIDS, the China Medical Board, the Rockefeller Foundation, the Bill & Melinda Gates Foundation, Conference 2016 in Bangkok n January

This 2016 conference focused on priority setting in the context of Universal Health Coverage (UHC) by discussing important issues, such as exploring how to organize priority setting, linking research and UHC policy, and sharing experiences of priority setting mechanisms between countries.

I organized a session on **“**Accountability, fairness and good governance in priority-setting for UHC”

Research Article

Accounting for Technical, Ethical, and Political Factors in Priority Setting

Katharina Kieslich[1,*], Jesse B. Bump[2], Ole Frithjof Norheim[3], Sripen Tantiv and Peter Littlejohns[1]

[1]Faculty of Life Sciences & Medicine, Division of Health and Social Care Research, King's College London, L
[2]Department of Global Health and Population, Harvard T. H. Chan School of Public Health, Boston, MA, USA
[3]Department of Global Public Health and Primary Care, University of Bergen, Bergen, Norway
[4]Health Intervention and Technology Assessment Program (HITAP), Department of Health, Ministry of Public thaburi, Thailand

CONTENTS

Introduction
Technical Approaches to Priority Setting in Health
The Ethics of Priority Setting
The Politics of Priority Setting
Methods
Case Study: Screening for HLA-B*1502 as a Biomarker for Severe Hypersensitivity Induced by Carbamazepine in Thailand
Case Study: The Cancer Drugs Fund
Concluding Observations
References

Abstract—This article investigates two cases of explore how, in addition to technical considerations, factors shape the allocation of health resources. Fir Thai authorities adjudicated a coverage decision screening, which meets the national cost-effective only some of the conditions it can detect. Sec England's Cancer Drugs Fund to investigate the in decision making and political reality. Our findi concluding observations for policy makers and priority-setting processes. First, we observe that dif produce conflicting recommendations, which mak very complex. Second, we suggest that robust proce and weighing political, ethical, and technical evid because there is no absolute standard by which

How can this approach be made useful ?

The question was how to make “a framework “ useful on a day to day basis for policy makers.

As part of an UK National Institute for Health Research (NIHR) funded programme and in collaboration with University College London we have now converted the framework in to a decision support tool

Aims and objectives of NIHR Project in UK

(Collaboration for Leadership in Health Research and Care – CLAHRC South London)

Test and refine the DMAT with all stakeholders

Assess the role that values play in decision making in a national sample of NHS health institutions – Clinical Commissioning Groups.

Use the DMAT to assess whether “accountability for reasonableness” leads to more acceptable decisions

Open Access Protocol

BMJ Open

Does accountability for reasonableness work? A protocol for a mixed methods study using an audit tool to evaluate the decision-making of clinical commissioning groups in England

Katharina Kieslich, Peter Littlejohns

To cite: Kieslich K, Littlejohns P. Does accountability for reasonableness work? A protocol for a mixed methods study using an audit tool to evaluate the decision-making of clinical commissioning groups in England. BMJ Open 2015;5: e007808. doi:10.1136/bmjopen-2015-007808

• Prepublication history for this paper is available online. To view these files please visit the journal online (http://dx.doi.org/10.1136/bmjopen-2015-007808).

Received: 9 February 2015
Revised: 28 April 2015
Accepted: 20 May 2015

ABSTRACT

Introduction: Clinical commissioning groups (CCGs) in England are tasked with making difficult decisions on which healthcare services to provide against the background of limited budgets. The question is how to ensure that these decisions are fair and legitimate. Accounts of what constitutes fair and legitimate priority setting in healthcare include Daniels' and Sabin's accountability for reasonableness (AfR) and Clark's and Wikler's framework for the identification of social values. This study combines these accounts and asks whether the decisions of those CCGs that adhere to elements of such accounts are perceived as fairer and more legitimate by key stakeholders. The study addresses the empirical gap arising from a lack of research on whether frameworks such as AfR hold what they promise. It aims to understand the criteria that feature in CCG decision-making. Finally, it examines the usefulness of a decision-making audit tool (DMAT) in identifying the process and content criteria that CCGs apply when making

Strengths and limitations of this study

- Study designed to test the effectiveness of dominant frameworks for healthcare priority setting.
- Study designed to examine healthcare priority setting processes at a local (clinical commissioning group, CCG) level.
- Study designed to test the usefulness of a decision-making audit tool (DMAT) in evaluating decision-making processes.
- Study designed to identify current strengths and weaknesses of commissioning processes at a local level.
- Results will make an empirical contribution to the literatures on accountability for reasonableness (AfR), healthcare priority setting and organisational theory.

INTRODUCTION

Methods

Comparative case studies of 12 South-London clinical commissioning groups (CCGs), responsible for making decisions on health service commissioning, and how to prioritise at local levels.

Governance and policy documents along with stakeholder interviews (e.g. CCG decision-makers, public/patient representatives, and Healthwatch) were analysed using the DMAT (Kieslich and Littlejohns 2015), based on a social values framework (Clark and Weale 2012)

Results (i)

The most prevalent themes arising from the CCG documents were patient and public participation, transparency, and quality of care, and therefore a mix of process and content values.

These themes also featured prominently in the interviews, yet in a much more contested way.

Results (ii)

The politics of transparency, participation, and quality of care were a common point of discussion, seen to be only exacerbating with the continued financial pressures and current health care reforms.

Furthermore, the interviews highlighted how within the CCGs, confusion and different interpretations exist about the different roles of different actors, their statutory mandates and the ultimate goal towards which the NHS is steering.

The Decision making Audit Tool (DMAT)

The new online version of the DMAT priorities4health.com developed in conjunction with “Uscreates”

https://www.uscreates.com/

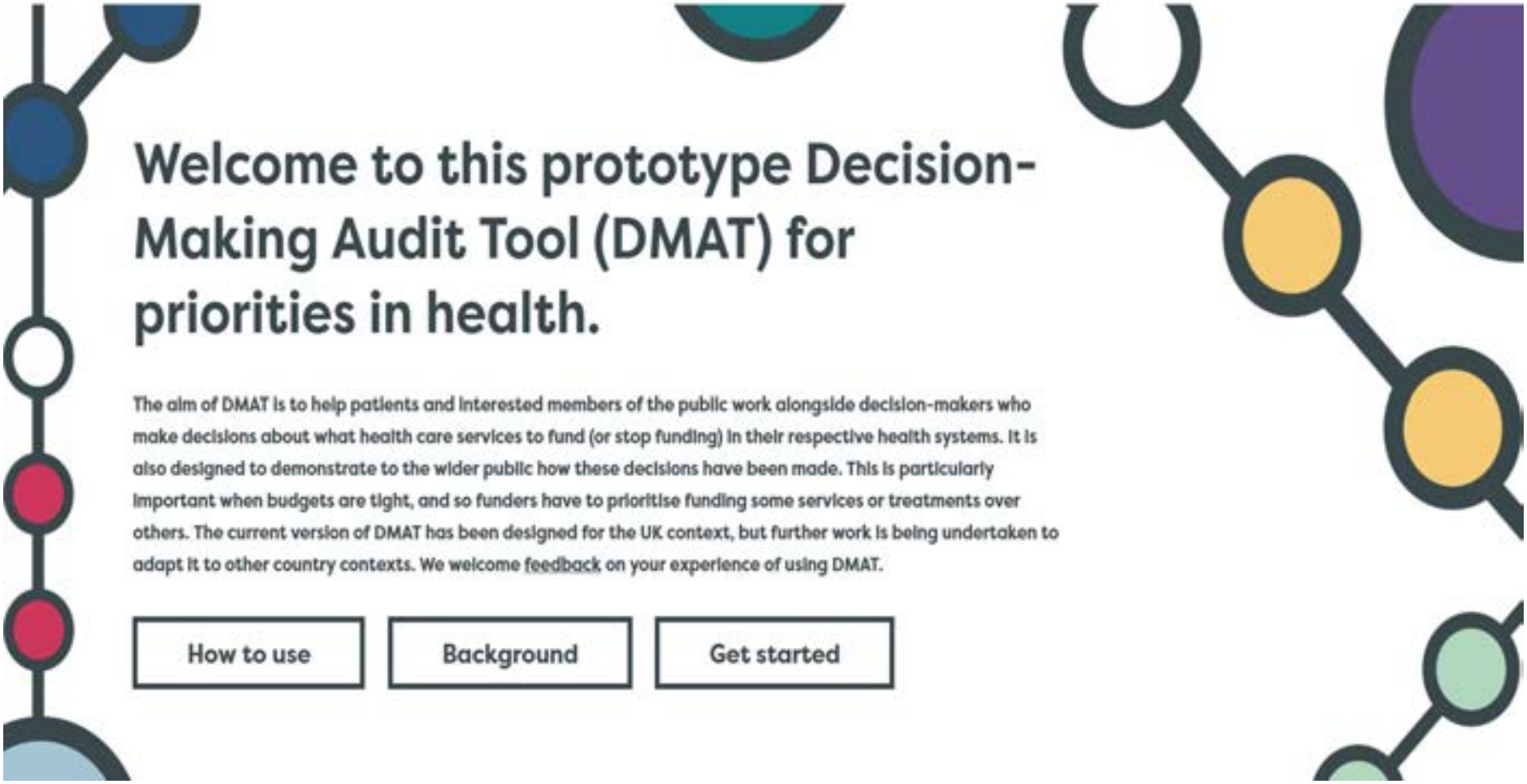
It was launched at the London CLAHRC Research information meeting at the House of Lords in July 2017.

Some of the members of the three London CLAHRCs who attended

More than 100 policymakers, clinicians, researchers, representatives from charities, and patients and service users gathered on Tuesday morning this week at the House of Lords to celebrate the important applied health research being undertaken across London.

The DMAT has been tested in England (see other talk) New Zealand and Chile – plans for further testing in Australia, Sierre Leone, Thailand and Brazil

Decision Making Audit Tool



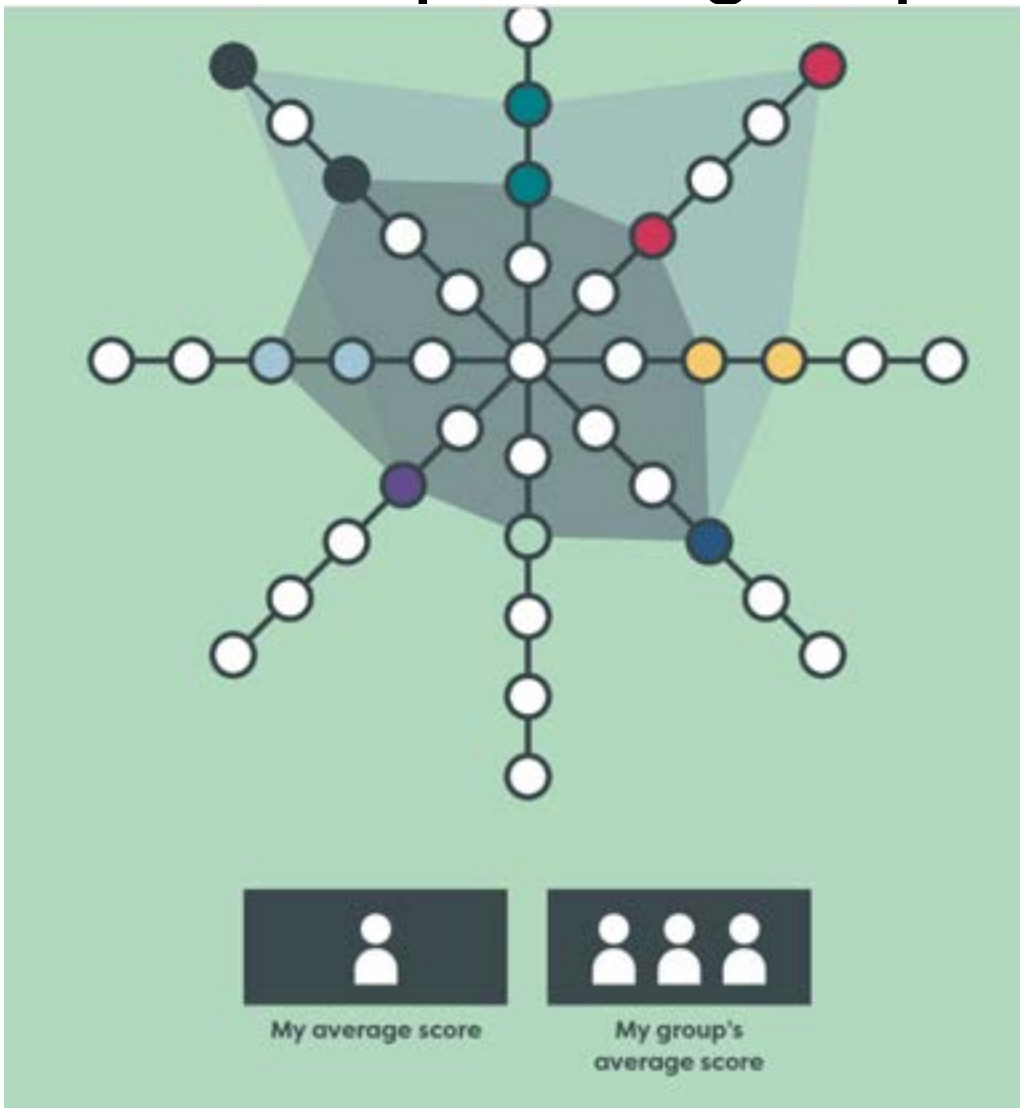
priorities4health.com

8 domains

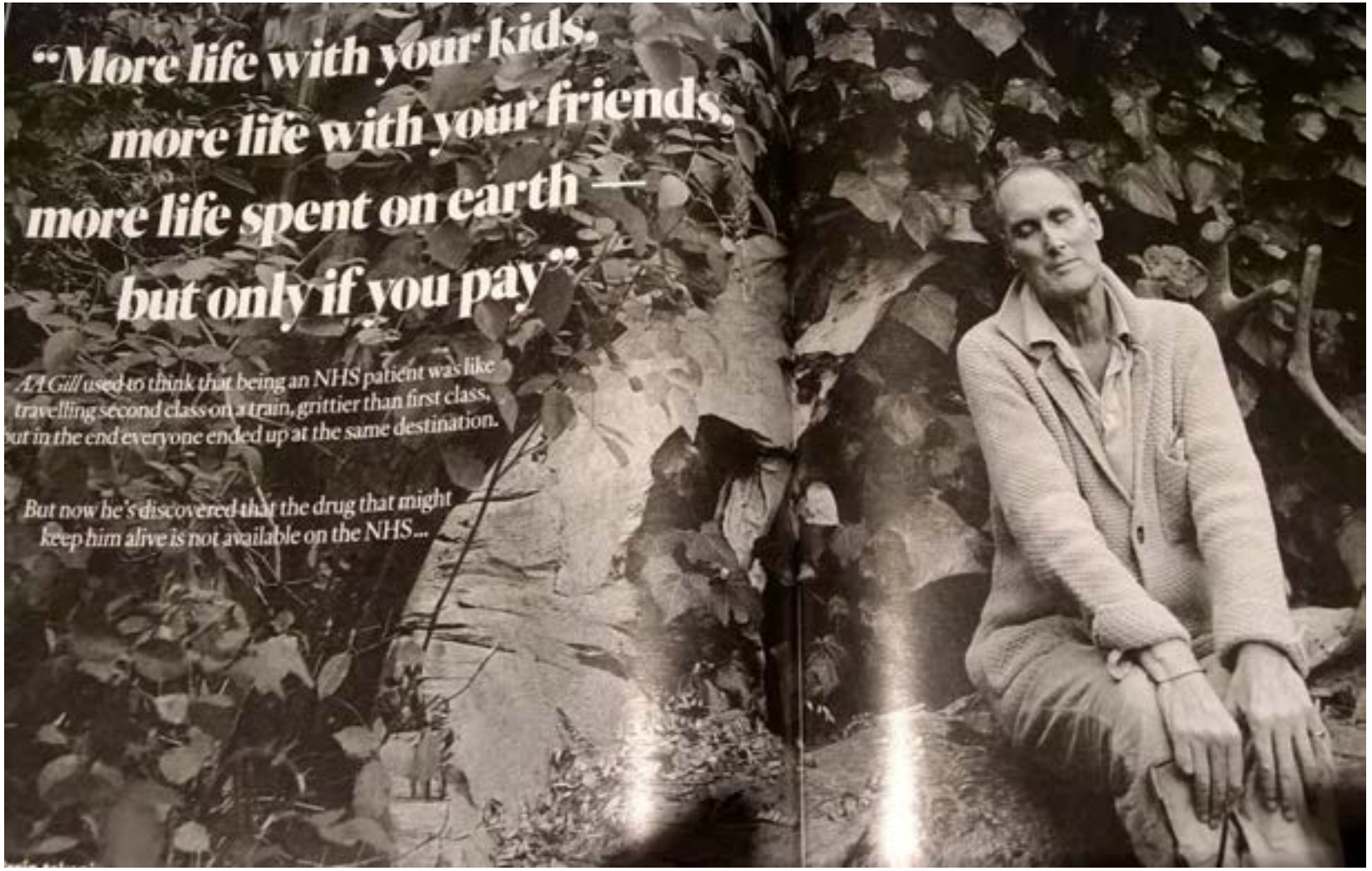

To complete the tool and generate a report, you must provide a response to the questions in all eight domains. However, if you are unable to answer a question, you can click the 'Don't know' option.
1 Institutional setting
2 Transparency
3 Accountability
4 Participation and consultation
5 Clinical effectiveness
6 Cost effectiveness
7 Quality of care
8 Fairness

An example of a content domain

An example of group work



Acceptance of difficult decisions

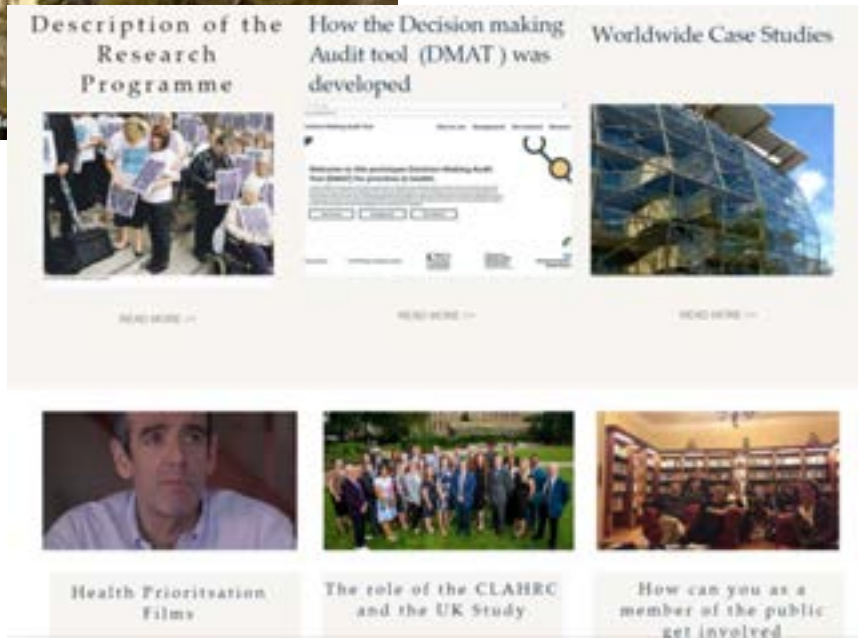


The Lottery of Devolved Cancer Care

To contextualise the need for such a tool the film **“The lottery of Devolved Cancer Care”** was launched at the same time https://youtu.be/gHNYAc6njTA it uses variation in access to expensive cancer drugs in the home countries as a relevant case study for a UK setting. It is based on the circumstances that led Ifron Williams moving from Wales to England to get his treatment.

40 minutes version with more patient experience https://youtu.be/dHv22BLFDSk

Rockefeller Academic Residency 2018



https://www.people4health.com/

ABOUT THE RESEARCH PROGRAMME

In order to create effective and sustainable health systems many countries are introducing ways to prioritise health services which involves making difficult decisions concerning who gets (and who does not get) healthcare interventions. Priority setting requires technical judgements of clinical effectiveness (what works) and cost effectiveness (is it worth the money). But these judgements are embedded in a wider set of social (societal) value judgements that underlie justifiable reasoning about priorities, including fairness, responsiveness to need and nondiscrimination, and obligations of accountability and transparency. Even when these decisions are based on the best available evidence they face legal, political, methodological, philosophical, commercial and ethical challenges. Through international, multidisciplinary, collaborative working we are developing new ways of addressing these concerns. To generate public acceptance of the need for health prioritisation we have developed a novel way of encouraging key stakeholders, including patients and the public, to become involved in the prioritisation process. Through a multidisciplinary collaboration involving a series of international workshops (funded by the Nuffield Trust, the Wellcome Trust and the Brocher Foundation) we have applied ethical and political theory (including accountability for reasonableness) to develop a practical way forward . We have tested this approach in a range of Clinical Commissioning Groups (responsible for commissioning health services) in England using a mixed methods approach. Out of the first workshop emerged a social values framework that consists of content and process values that has been converted into a decision-making audit tool (the DMAT). Working with a design company we have

2012 workshop at Gresham College

I'm a paragraph. Click here to add your own text and edit me. I'm a great place for you to tell a story and let your users know a little more about you.

READ MORE >>

2015 Workshop at Brocher Foundation

I'm a paragraph. Click here to add your own text and edit me. I'm a great place for you to tell a story and let your users know a little more about you.

READ MORE >>

Rockefeller Foundation Bellagio Centre 2018

I'm a paragraph. Click here to add your own text and edit me. I'm a great place for you to tell a story and let your users know a little more about you.

READ MORE >>

Overview

Governance (politics, structures and finance)

Clinical workforce, clinical practice and innovation

Patient and public expectations and involvement

Outcomes and equity

Pondering the future

Based on my 40 years experience of the NHS in UK concentrating on the last 20 years. A personal (political science) perspective based on a series of case studies.

Health Care System Performance Rankings

July 13, 2017

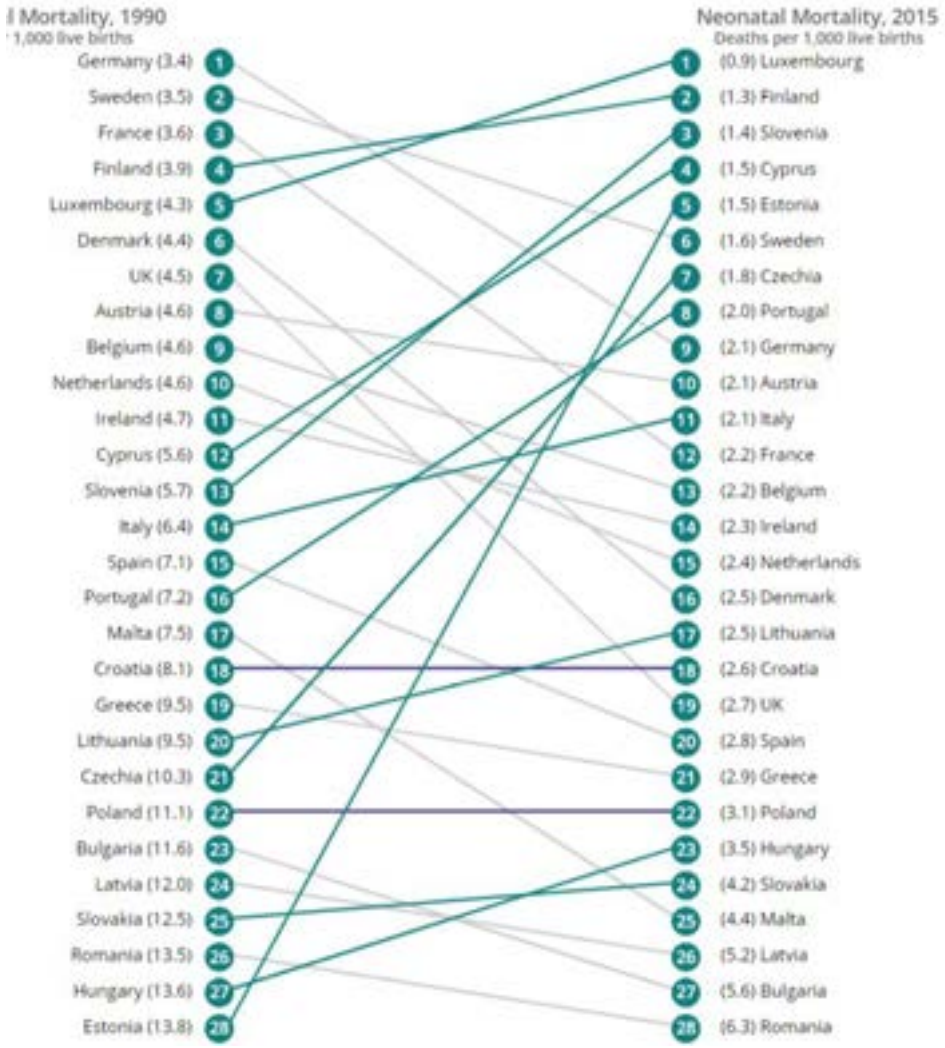
Health Care System Performance Rankings

	AUS	CAN	FRA	GER	NETH	NZ	NOR	SWE	SWIZ	UK	US
OVERALL RANKING	2	9	10	8	3	4	4	6	6	1	11
Care Process	2	6	9	8	4	3	10	11	7	1	5
Access	4	10	9	2	1	7	5	6	8	3	11
Administrative Efficiency	1	6	11	6	9	2	4	5	8	3	10
Equity	7	9	10	6	2	8	5	3	4	1	11
Health Care Outcomes	1	9	5	8	6	7	3	2	4	10	11

UK drops in European child mortality rankings

The UK has dropped several ranks in the European Union rankings of child mortality since 1990, recent analysis of WHO and ONS data has found.

13 October 2017



Cancer survival in Europe 1999–2007 by country and age: results of EUROCARE-5—a population-based study

*Roberta De Angelis, Milena Sant, Michel P Coleman, Silvia Francisci, Paolo Baili, Daniela Pierannunzio, Annalisa Trama, Otto Visser, Hermann Brenner, Eva Ardanaz, Magdalena Bielska-Lasota, Gerda Engholm, Alice Nennecke, Sabine Siesling, Franco Berrino, Riccardo Capocaccia, and the EUROCARE-5 Working Group**

Summary

Background Cancer survival is a key measure of the effectiveness of health-care systems. EUROCARE—the largest cooperative study of population-based cancer survival in Europe—has shown persistent differences between countries for cancer survival, although in general, cancer survival is improving. Major changes in cancer diagnosis, treatment, and rehabilitation occurred in the early 2000s. EUROCARE-5 assesses their effect on cancer survival in 29 European countries.

Methods In this retrospective observational study, we analysed data from 107 cancer registries for more than 10 million patients with cancer diagnosed up to 2007 and followed up to 2008. Uniform quality control procedures were applied to all datasets. For patients diagnosed 2000–07, we calculated 5-year relative survival for 46 cancers weighted by age and country. We also calculated country-specific and age-specific survival for ten common cancers, together with survival differences between time periods (for 1999–2001, 2002–04, and 2005–07).

Findings 5-year relative survival generally increased steadily over time for all European regions. The largest increases from 1999–2001 to 2005–07 were for prostate cancer (73·4% [95% CI 72·9–73·9] *vs* 81·7% [81·3–82·1]), non-Hodgkin lymphoma (53·8% [53·3–54·4] *vs* 60·4% [60·0–60·9]), and rectal cancer (52·1% [51·6–52·6] *vs* 57·6% [57·1–58·1]). Survival in eastern Europe was generally low and below the European mean, particularly for cancers with good or intermediate prognosis. Survival was highest for northern, central, and southern Europe. Survival in the UK and Ireland was intermediate for rectal cancer, breast cancer, prostate cancer, skin melanoma, and non-Hodgkin lymphoma, but low for kidney, stomach, ovarian, colon, and lung cancers. Survival for lung cancer in the UK and Ireland was much lower than for other regions for all periods, although results for lung cancer in some regions (central and eastern Europe) might be affected by overestimation. Survival usually decreased with age, although to different degrees depending on region and cancer type.

Interpretation The major advances in cancer management that occurred up to 2007 seem to have resulted in improved survival in Europe. Likely explanations of differences in survival between countries include: differences in stage at diagnosis and accessibility to good care, different diagnostic intensity and screening approaches, and differences in cancer biology. Variations in socioeconomic, lifestyle, and general health between populations might also have a role. Further studies are needed to fully interpret these findings and how to remedy disparities.

Lancet Oncol 2013

Published Online
December 5, 2013
http://dx.doi.org/10.1016/S1470-2045(13)70586-3

See Online/Comment
http://dx.doi.org/10.1016/S1470-2045(13)70566-7

See Online/Articles
http://dx.doi.org/10.1016/S1470-2045(13)70548-5

See Online for an author interview with Roberta de Angelis

*Members of the EUROCARE-5 Working Group are listed in the appendix

Centro Nazionale di Epidemiologia, Sorveglianza e Promozione della Salute, Istituto Superiore di Sanità, Rome, Italy (R De Angelis MSc, S Francisci PhD, D Pierannunzio PhD, R Capocaccia MSc); **Analytical Epidemiology and Health Impact Unit** (M Sant MD, P Baili MSc), **Evaluative Epidemiology Unit** (A Trama MD, F Berrino MD), **Department of Preventive and Predictive Medicine, Fondazione IRCSS Istituto Nazionale dei Tumori, Milan,**

Healthcare Access and Quality Index based on mortality from causes amenable to personal health care in 195 countries and territories, 1990–2015: a novel analysis from the Global Burden of Disease Study 2015

Summary

Background National levels of personal health-care access and quality can be approximated by measuring mortality rates from causes that should not be fatal in the presence of effective medical care (ie, amenable mortality). Previous analyses of mortality amenable to health care only focused on high-income countries and faced several methodological challenges. In the present analysis, we use the highly standardised cause of death and risk factor estimates generated through the Global Burden of Diseases, Injuries, and Risk Factors Study (GBD) to improve and expand the quantification of personal health-care access and quality for 195 countries and territories from 1990 to 2015.

Findings Between 1990 and 2015, nearly all countries and territories saw their HAQ Index values improve; nonetheless, the difference between the highest and lowest observed HAQ Index was larger in 2015 than in 1990, ranging from 28·6 to 94·6. Of 195 geographies, 167 had statistically significant increases in HAQ Index levels since 1990, with South Korea, Turkey, Peru, China, and the Maldives recording among the largest gains by 2015. Performance on the HAQ Index and individual causes showed distinct patterns by region and level of development, yet substantial heterogeneities emerged for several causes, including cancers in highest-SDI countries; chronic kidney disease, diabetes, diarrhoeal diseases, and lower respiratory infections among middle-SDI countries; and measles and tetanus among lowest-SDI countries. While the global HAQ Index average rose from 40·7 (95% uncertainty interval, 39·0–42·8) in 1990 to 53·7 (52·2–55·4) in 2015, far less progress occurred in narrowing the gap between observed HAQ Index values and maximum levels achieved; at the global level, the difference between the observed and frontier HAQ Index only decreased from 21·2 in 1990 to 20·1 in 2015. If every country and territory had achieved the highest observed HAQ Index by their corresponding level of SDI, the global average would have been 73·8 in 2015. Several countries, particularly in eastern and western sub-Saharan Africa, reached HAQ Index values similar to or beyond their development levels, whereas others, namely in southern sub-Saharan Africa, the Middle East, and south Asia, lagged behind what geographies of similar development attained between 1990 and 2015.

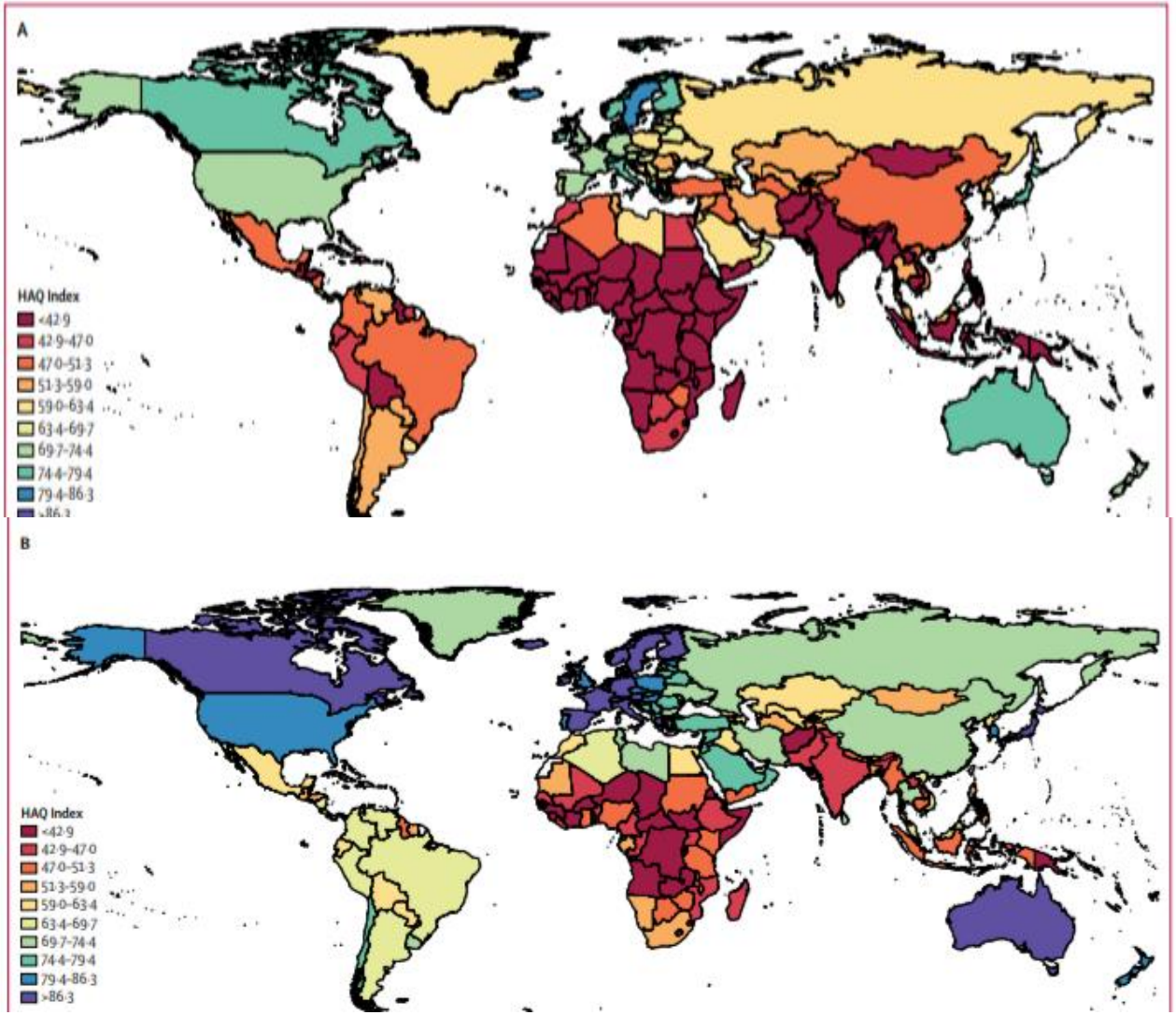
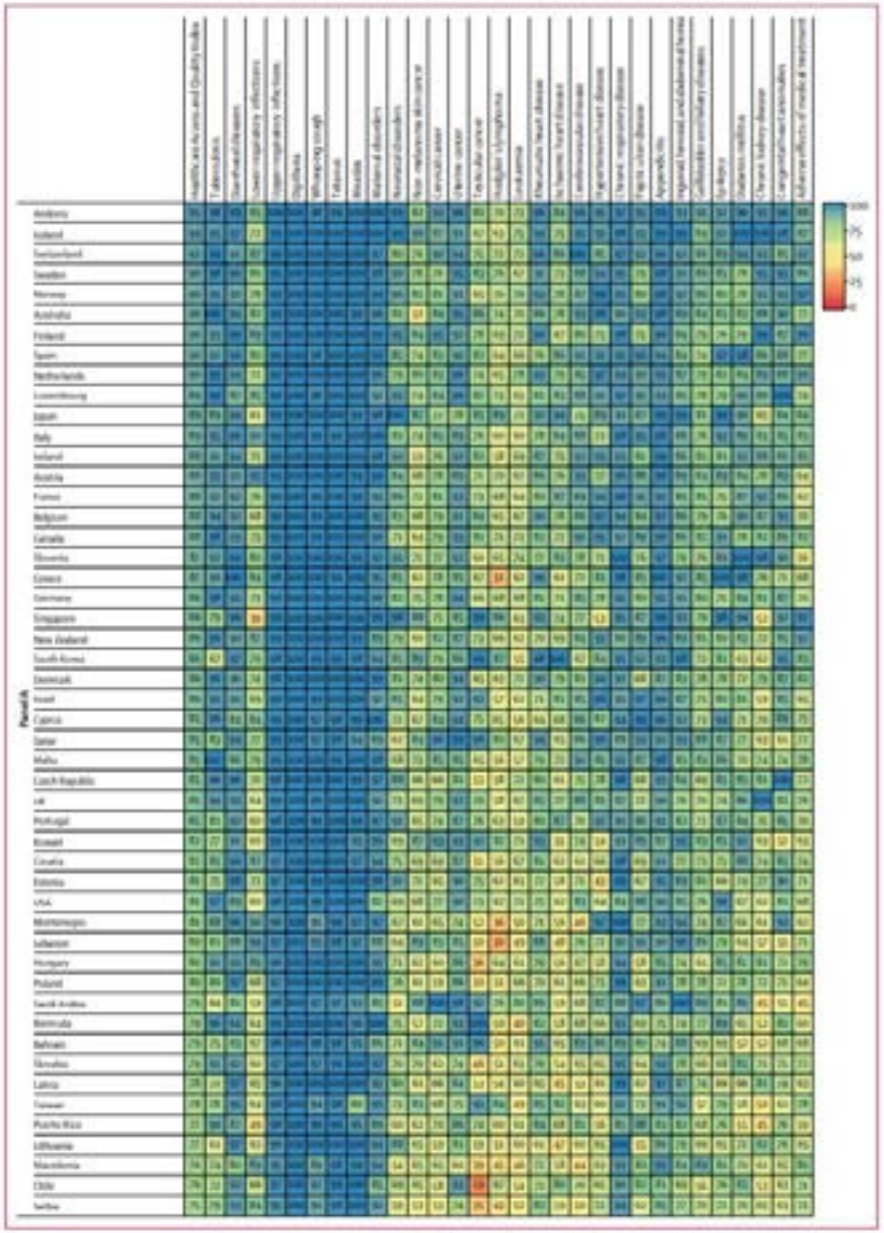


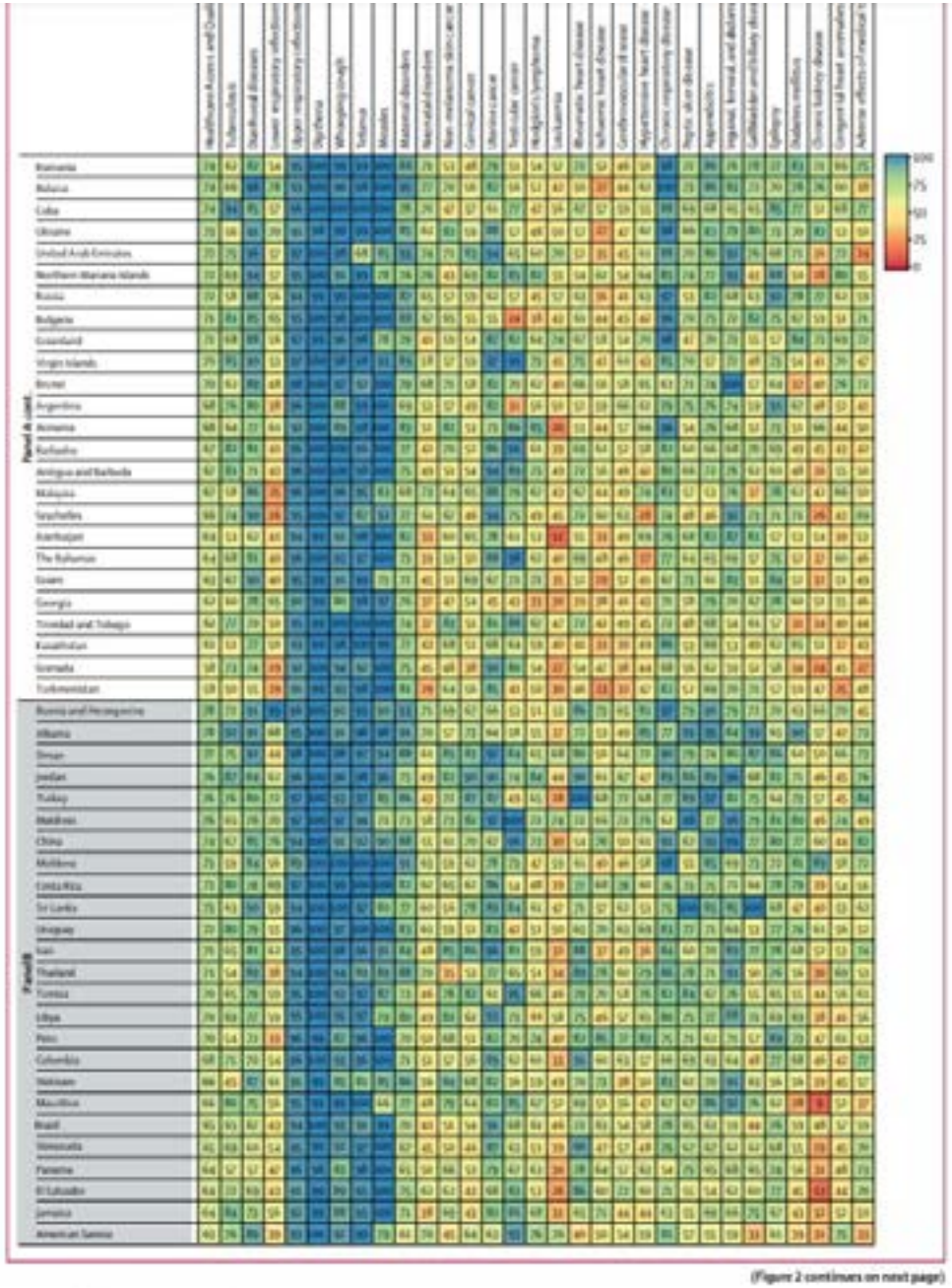
Figure 1: Map of HAQ Index values, by decile, in 1990 (A) and 2015 (B)

Deciles were based on the distribution of HAQ Index values in 2015 and then were applied for 1990. HAQ Index = Healthcare Access and Quality Index. ATG=Antigua and Barbuda. VCT=Saint Vincent and the Grenadines. LCA=Saint Lucia. TTO=Trinidad and Tobago. TLS=Timor-Leste. FSM=Federated States of Micronesia.



(Figure 2 continues on next page)

<-----UK

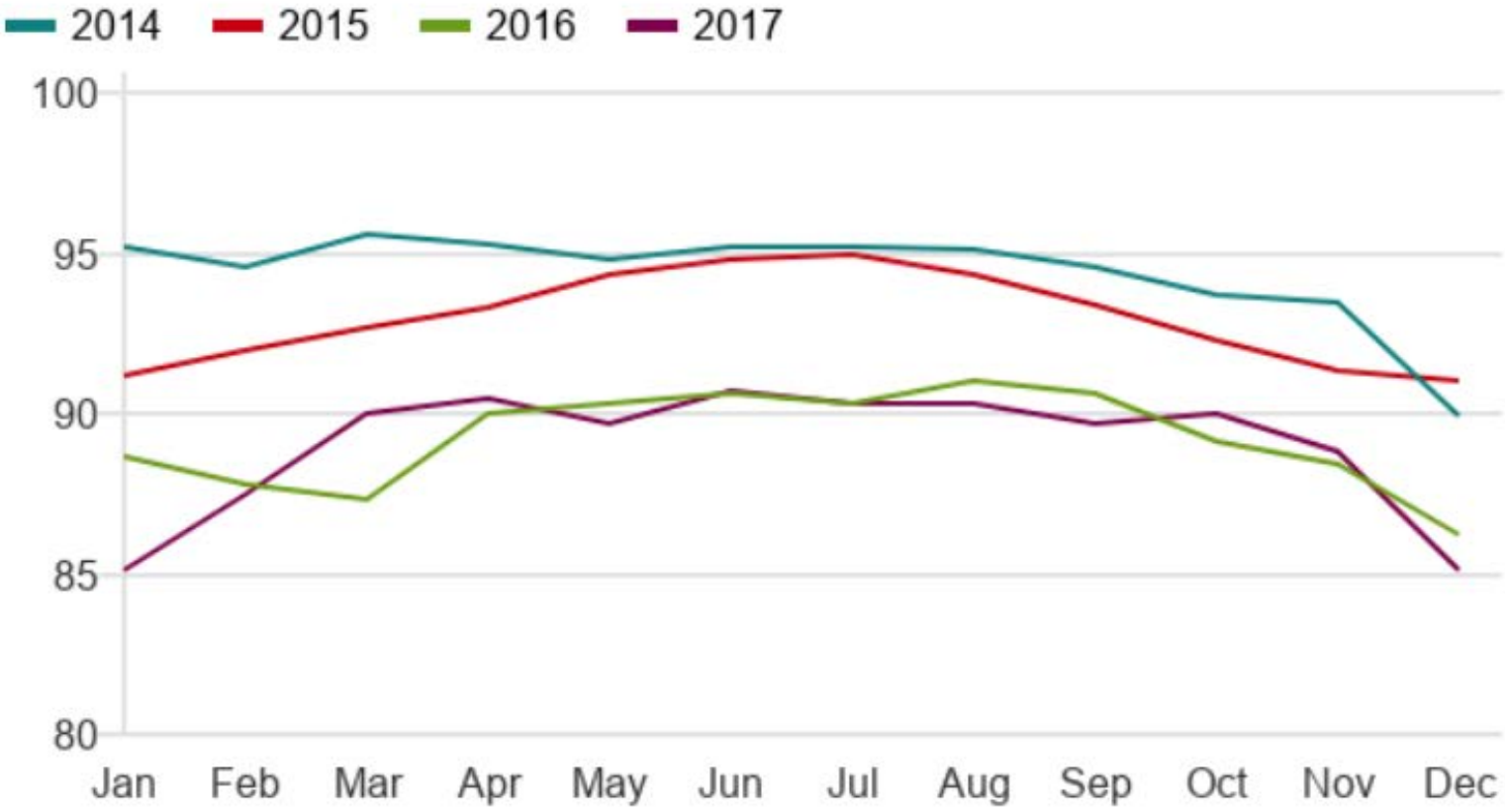


(Figure 2 continues on next page)

<----- Brazil

A&E performance in England

Percentage of patients dealt with at A&E within four hours



Source: NHS England

BBC

Overview

Governance (politics, structures and finance)

Clinical workforce, clinical practice and innovation

Patient and public expectations and involvement

Outcomes and equity

Pondering the future

Based on my 40 years experience of the NHS in UK concentrating on the last 20 years. A personal (political science) perspective based on a series of case studies.

Rationing health care: a logical solution to an inconsistent triad

Albert Weale, Professor of Political Theory and Public Policy at University College London

BMJ 1998;316:410

The basic principle of the NHS is simply that comprehensive, high quality medical care should be available to all citizens on the basis of professionally judged medical need without financial barriers to access. In seeking to enact this principle, the NHS is not alone..... Yet, in the face of increasing healthcare costs this basic principle threatens to become what logicians call an inconsistent triad; a collection of propositions, any two of which are compatible with each another but which, when viewed together in a threesome, form a contradiction.

The Health Service Ideal : High Quality, Comprehensive, Universal

High Quality, Comprehensive, Universal

High Quality, Comprehensive, Universal

High Quality, Comprehensive, Universal

The future

Market forces (purchaser/provider split, commissioning, PFI) have not delivered their promise.

More “connectedness” of local services (health and social care - integrated care systems)

But no clear direction on central versus local balance – how to achieve universality through local entrepreneurship ?

There will always be a need to prioritise health services fairly

The role of evidence is key – but need to be more imaginative on what form it takes

Thank you for listening

Professor Peter Littlejohns
Faculty of Life Sciences and Medicine, King's College London

THANK YOU TO MY FUNDER

Collaboration for Leadership in Applied Health Research and Care South London
(CLAHRC South London)

This research was supported by the National Institute for Health Research (NIHR) Collaboration for Leadership in Applied Health Research and Care South London (NIHR CLAHRC South London) at King's College Hospital NHS Foundation Trust. The views expressed in this presentation are those of the authors and not necessarily those of the NHS, the NIHR, or the Department of Health and Social Care.

http://www.clahrc-southlondon.nihr.ac.uk/
http://www.priorities4health.com/