

Current Issues and Future Trends in Health Care

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INTRODUCTION

It is a pleasure to bring greetings to our Indonesian colleagues from the 21 members of the Council of Management of the International Hospital Federation, which in turn represents 21 nations. The federation has members in all five continents and in 90 nations. I, therefore, have the great privilege of seeing and hearing of health services developments around the world. Today, I will review some of the important trends and ideas I see emerging in health services delivery. I have identified 8 trends which I wish to describe. While I will identify them as trends 1 to 8, I don't wish to imply that one is any more significant than the other.

TREND 1 — CONTROLLED COMPETITION

Throughout the history of health care organisation, there has been a debate about the role of government versus private initiative in health care provision. Until recently the United States and the United Kingdom have been at opposite ends of this spectrum. Britain has had a government dominated health service whilst in the United States private initiative has been the driving force. It may be of interest then to reflect on one of the outcomes of these approaches. The United States spends presently 13% of its Gross National Product on health care. In the United Kingdom that figure is only half of that, 6.5%. If one considers the difference in the per capita income of citizens of the United States and the United Kingdom, you can see what a dramatic difference there is. However, in both countries there is major change under way. The United States has found that competition which is promoted by a system based on private initiative has resulted in, inter alia

a) Service duplication

- b) Over supply of high technology
- c) Poor community health systems and status and
- d) Denial of access based on ability to pay of 37 million Americans.

In the last few weeks I have been in the United States discussing the US President's proposed reforms with my American colleagues. It is too early to say what will be the ultimate outcome of the reform movement in health care in the US but some elements of the President's package will clearly remain intact. **Firstly**, for the first time 100% of the American population will have access to health care irrespective of their ability to pay. **Secondly**, employers both in large industries and in small businesses will be forced to carry health insurance for their staff and families and **thirdly**, that health care financing will be organised on a state level through insurance alliances in each state. The final essential of President Clinton's programme is that there be community-wide managed care systems at the local level. This will in turn lead to a system of controlled competition of purchasing and providing care.

The United Kingdom has already moved to controlled competition through its internal market approach. This involves hospitals and other health care facilities competing for government funds to provide local services. The system has now been in operation for some two years and the impact of the reforms are becoming evident.

Firstly, there has been improved productivity in hospital and health services. This has had the impact of reducing usage of big city teaching hospitals. This is likely to result in the near future in the closure of some of London's great, world famous hospitals. Another hoped for impact of the government was that there would be a reduction in waiting lists for elective surgery. The

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results in fact have been mixed. The overall analysis suggests that there has been no real benefit in this context. The other unexpected outcome has been that increase in productivity has brought with it rapid patient throughput which has meant that hospitals have often spent their elective surgery budgets within the first half of the year and have no funds remaining to continue their elective surgery for the remainder of the year.

It is of concern to me that many countries are beginning to copy the UK model. New Zealand has completely moved to this model and Sweden is in the midst of its implementation and many countries are about to adopt the system. My concern is that all the evidence on the system is not yet in. Governments should be more cautious about adopting such radical reforms.

TREND 2 – RE-DEFINING QUALITY

Quality has become a central focus for nations in organising their health services. This is because poor quality health care is a waste of resources. Our communities are also becoming better educated and so demand a better quality of health care. It used to be that health service providers thought of quality as a lesser priority but now it is one of the major driving forces of health care delivery.

We can see this move focusing on quality in the expansion of accreditation systems throughout many countries. Existing accreditation systems are also becoming more sophisticated. In the United States the Joint Commission on Accreditation of Hospitals and Health Facilities has spent many millions of dollars on identifying patient care outcomes as a means of measuring standards of health care.

Around the world we see hospitals adopting continuous quality improvement and Total Quality Management Systems as apart of the central core of their management. That is, their total organisational structure and their information systems are being re-designed to focus on quality.

One of the interesting developments in this regard is the increasing use by American hospitals of what have been called **Standard Treatment Protocols**. These protocols set out what is necessary to be done for each diagnosis at each phase of care and identifying what diagnostic and treatment services are required and how the patient's treatment should be scheduled.

The British approach has been different; they have focused their standards on attempting to determine the patient's perspective on quality and service. We can see from the listing which follows that the British definition of quality is quite different to that of the United States (see **attachment 1**). This concept of the patient's charter of rights is a personal initiative of the British prime minister, Mr. Major. This charter of rights has been distributed widely through hospitals and the community and each patient has access to the patient's charter booklet which sets out what they may expect of the health service provider. The listings which follow provide more detail of the patient's charter in Britain (see **attachments 2 & 3**).

Another approach that governments are using to define quality in health services is to look at the health status of the community. In particular they are setting targets for preventable

diseases and health promotional activities. So for example, governments or regions are setting targets for reductions in infectious diseases of various kinds and in coronary disease etc.

In some way it can be seen that there is a re-definition of quality which expands the focus from the clinical level to the patient level and to the community level.

TREND 3 – MANAGING WITH DATA

Some years ago I visited Cuba to examine their health system. They have a very advanced system of community health mapping. That is, that they are able to identify morbidity not only in every community but in every house in their cities. They then use this information to get a basis for the organisation of their health services and for developing priorities.

In the United States there are sophisticated community-oriented information systems being developed with the use of

Attachment 1

British Patient's Charter Rights National Standards

1. Respect for privacy, dignity and religious and cultural beliefs.
2. Arrangements to ensure everyone, including people with special needs, can use services.
3. Information to relatives and friends.
4. Waiting time for an ambulance service.
5. Waiting time for initial assessment in accident and emergency departments.
6. Waiting time in outpatient clinics
7. Cancellation of operations.
8. A named qualified nurse, midwife or health visitor responsible for each patient.
9. Discharge of patients from hospital.

Attachment 2

British Patient's Charter Rights Existing

1. To receive health care on the basis of clinical needs regardless of ability to pay.
2. To be registered with a GP.
3. To receive emergency medical care at any time, through your GP or the emergency ambulance service and hospital accident and emergency departments.
4. To be referred to a consultant, acceptable to you, when your GP thinks it necessary, and to be referred for a second opinion if you and your GP agree this is desirable.
5. To be given a clear explanation of any treatment proposed, including any risks and any alternatives, before you decide whether you will agree to the treatment.
6. To have access to your health records, and to know that those working for the NHS are under a legal duty to keep their contents confidential.
7. To choose whether or not you wish to take part in medical research or medical student training.

Attachment 3

British Patient's Charter Rights New

1. To be given detailed information on local health services, including quality standards and maximum waiting times.
2. To be guaranteed admission for treatment by a specific date no later than two years from the day when your consultant places you on a waiting list.
3. To have any complaint about NHS services — whoever provides them — investigated and to receive a full and prompt written reply from the chief executive or general manager.

Attachment 4

Appendix A. Sample Surgical Clinical Path-DRG 104: Valve Procedure with Catheterization

Critical Occurrences	Preadmit: Tele Unit	Tele Unit/ Cath	OR Day	POD 1	POD 2	POD 3	POD 4	POD 5	POD 6	POD 7
	LOS Day 0	LOS Day 1	LOS Day 2	LOS Day 3	LOS Day 4	LOS Day 5	LOS Day 6	LOS Day 7	LOS Day 8	LOS Day 9
Consults	SS Home nursing Dietician			Respiratory Therapy	Cardiac rehab CNS					
Tests	ECG. CXR. Labs.	Pre-op Labs	Post-op ECG, CXR, labs, VS, Neuro checks		DC ECG	DC CXR	D/C labs except PT continue		GXT scheduled	Done prior 9a
Treatments (includes needs)	Client lists home needs Old records to unit	IV Sheath removal	Monitor Ventilator Artline/CVP NG T. pacer Chest tubes IV Foley Skin Care/ incision I & O/wt Analgesics	D/C 2-4L 02 NC D/C D/C	02 pm 1.5./C&D8 D/C box D/C HL (Change site) DC Central Lines	D/C 02 D/C wires	D/C	D/C		
Activity	UP	BR —> UP	Turn q 4 hr. ROM	Dangie X 2	Ambulate tid		tid and ad lib			
Diet	NPO 6 hrs before procedure	NPO p MN	NPO	Liquid diet	Cardiac Diet or diet as at home-fluid restriction (DC when at pre-op wt)					
Discharge	Assess home support health habits coping ability							Physician order on chart for DC mg needs	Predischarge orders, scripts, med sheet on chart	D/C before 12 Noon
Teaching	Cath Booklet	Tcaching and tour		Begin post-op tcaching				Transfer record Discuss D/C plans	Complete	Review meds, activity level, S&S to report, diet, labs, appts.

Pre-op

computers these link hospitals to community health services, to local GPs; One example is in San Diego where half the population is covered through this network of information.

The most obvious example, of course, of managing health services through the use of data is that of "DRGS" (Diagnosis Related Groups). This system means that hospitals are reimbursed on the basis of the average cost of dealing with a particular diagnosis. This system which began in the United States about a decade ago has now reached Australia, Spain, Sweden and I understand parts of Asia. However, DRGS have now been extended, as indicated early, to standard protocols but further to the concept of developing patient critical paths for dealing with a particular diagnosis. The attached appendix (i.e. **attachments 4 & 5**) gives an indication of what is involved. You can see not only what will occur in each phase of care but when each phase of care will take place. You can see, from the chart setting out the "cardiac path" for the treatment of three types of surgery, the potential cost saving implications of using these systems. I think we will hear much more of this new concept.

TREND 4 – COMMUNITY ORIENTATION

Australia has been a leader for many years in orienting its health services to the community. Many of its hospitals have been carrying out community outreach programmes for more than a decade. Many European countries also have a regional basis for their health service delivery which puts an emphasis on care at the community level. Sometimes this extends beyond health care workers, for example in Sweden that postmen have been given a responsibility to ensure that the house-bound elderly in the community are "okay".

Concepts of health promotion have also been with us for at least two decades. It must be reported, however, that the results of these programmes have been, in large part, disappointing. Hospitals are still filled with the problems associated with lifestyle. Research I think is beginning to show us that what we must do in regard to influencing of lifestyles is to start with health promotion programmes for our children. In this context I have been delighted to find out Mickey Mouse is coming to our aid in that the Disney Corporation is beginning to produce health promotion materials for children around the world.

Another aspects of community orientation of health services is our growing research base on health care screening economics. It has now been clearly shown that cervical cancer, colon cancer, breast cancer, hypertension and hypercholesterolemia are all targets for cost beneficial national screening programmes.

The World Health Organisation has long recognised that the health of a country is not primarily related to the nation's health services. The health of the citizens of a country of course relates to the standard, or the environment, transport, education, welfare and housing. This can all be distilled into one word – "poverty". I think we in health services often forget the need to coordinate with our colleagues in other sectors to help to improve the health status of our peoples.

TREND 5 – RATIONING

The Paris-based organisation – OECD, the Organisation for Economic Cooperation and Development, estimates that hospital cost inflation is primarily caused by medical technology developments. The study which demonstrated this is now a few years old but it can be said that it is known that investment in bio-medical research has increased to 4 billion dollars a year. It is estimated that through new bio-genetic techniques that some four thousand previously unmanageable diseases will become treatable. Health care economists around the world are recognising the likely impact of these great leaps of medical science and putting them into the context of an already cash-starved health systems. Are we then heading into a period of rationing of health care?

Let's examine the situation a little more deeply. We can see that while bio-genetics has as potential for increasing costs it is likely that new vaccines will become available through this technology and therefore reduce infectious disease. Presently pharmaceutical products account for some 40% of a reduction of mobility in our communities and therefore there is the increased potential for further reduction as medical research proceeds also in terms of techniques, we already know that day surgery and diagnostic approaches have reduced costs.

Further we can see that most nations are now setting up national programmes of technology assessments to ensure the appropriate introduction of high technology on a rational basis.

Attachment 5

Figure 4. CardiacPath""—Patient and Financial Outcomes Comparison

Procedure	Pre-CardiacPath			Post-CardiacPath		
	Average Total Charges *	Average LOS	% Mortality	Average Total Charges *	Average LOS	% Mortality
Valve Surgery (DRG 104-105)	\$54,017	13.4	10.2	\$40,122	10.6	4.3
CABG Surgery (DRG 106-107)	\$37,648	11.1	2.7	\$33,913	9.9	2.7
PTCA (DRG 112)	\$17,566	3.8	0.9	\$15,738	2.4	0.7

* Includes anesthesia fees

.Source : Borgess Medical Center , Kalamazoo , Michigan

Another interesting dimension of this question is that of appropriate utilization of resources; we can see from the attached data (**attachment 6**), emanating from the Rand Corporation in Los Angeles, that we have far to go in eliminating waste. Rand have also identified the impact of the health financing system on the utilization of services. You can see from their data on caesarian sections what this impact is. The following chart demonstrates the phenomenon (**attachment 7**).

In summary I think we can say that much can be done to reduce costs and pressures on services in health care but it is my personal view that rationing will have to come. The British research on "qualities" has clearly demonstrated that health services can be delivered on a more rational basis by allocating resources relating to the quality of life expected following particular medical procedures. That is, for example, any rational health system would lower the priority of fund allocation to bypass surgery because of its rather doubtful long-term benefits yet it would increase resources allocated to say, hip replacement because of the profound improvement of the quality of life of the recipient of this particular procedure. You will be aware, I'm sure that the State of Oregon in the United States has developed this "quality" system into an operational programme which has just cleared the courts and is to be put in place in that state for Medicare patients. It would seem to me that it is a model which we must all examine in a future where health care rationing seems imminent.

**Attachment 6
Hospital Wastage (Rand Corporation Studies)**

- 1 in 4 hospital days unnecessary.
- 1 in 4 clinical procedures unnecessary.
- 2 out of 5 medications unnecessary.

**Attachment 7
Financial Disincentives
Caesarian Sections US Data**

	Rate
In government hospitals	21%
In voluntary not-for-profit hospitals	23%
In for-profit hospitals	31%

TREND 6- FOCUSING ON PATIENTS

We in hospitals and health care have always put emphasis on patient care but experiments are going on in health service delivery facing a renewed examination of a health service from a patient's point of view. For example in the United States there are several hospitals which have been restructured to become what are called "patient-focused hospitals". This involves the decentralisation of many of the allied health professional services so that they actually operate at ward level. That is in each ward there will be a physiotherapist, a laboratory technologist, a pharmacist, a social worker etc. This means that a true patient care team is developed at ward level.

The result of this restructuring has been shown to, not only improve the patient's perspective of care, in that they truly obtain the sense of being cared for by a small team of professionals, but

also cost savings have been demonstrated, ranging to as much as 5% of operating costs.

There are also developments concerning staff training. That is there is a belief that a multi-skilled staff a more effective way of dealing with patients. That is, there is a new level of professional which can carry out many of the basic professional functions. This multi-skilling has also occurred at the low level of employee, whereby for example the ward cleaner takes on a broader function of food delivery to the patients and messages around the hospital as well as providing a patient comforting role.

There is also a world wide trend to educate the patient concerning their condition and their health in general; there is also a trend to sharing information with the patient particularly the patient's records. In many countries it is now the law that the record belongs to the patient and they have access to it at all times.

The other dimension of patient focusing is in regard to medical ethics where it is now recognised that questions concerning the patient's fate or that of their family must be discussed with them and that the patient and his family take a major role in the decision-making concerning further medical procedures. The most obvious example of this is Euthanasia in the Netherlands.

Another new patient-directed development is that of the non-smoking hospital. Many us hospitals are now totally non-smoking, that is neither patients nor staff may smoke in the buildings or in the immediate surroundings of the hospital. This idea is also spreading internationally and is evident now in parts of Australia and in Britain and is gaining hold as a concept everywhere.

TREND 7- DEPRIVATION AND DISASTER

Among all of the exciting developments in health care there is also a dark side and that of course is so evident in Africa and in the former Yugoslavia. In Africa of course the problem is deprivation. I was staggered to read recently that the health budget for some African countries is as little as 50 American cents per person per annum. This means that they have no possibility of importing drugs or equipment and as a result their pharmacies remain empty and their professionals helpless.

In Yugoslavia we have seen the grotesque sight of hospitals being targeted as military objectives. Many hospitals have been destroyed and health service professionals have been killed and tortured. The Geneva Convention whereby hospitals are sanctuaries of peace, has not held up in this horrible civil war.

TREND 8- HEALTH SERVICE RESEARCH BASE POLICY

One of the truly hopeful signs of health services development around the world in the establishment of National Health Service Research Institutes. These research institutes can provide information on the health of the country and the impact of its health service systems through their research activities. That is for the first time countries are obtaining facts to base their health policy on rather than what has been in the past purely ideology or supposition.

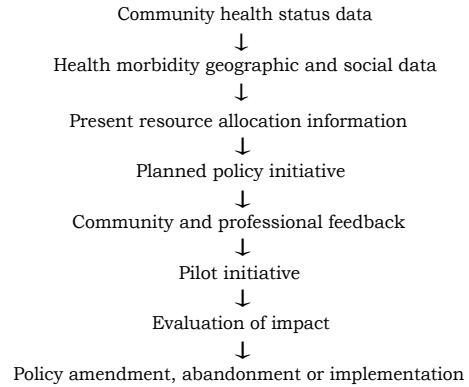
This development is long overdue particularly when we make comparisons with industry where they spend very substantial proportions of their budget on research and development; in some industries this is as high as 30% of their input whereas in health care we tend to spend nothing or very little. The establishment of these Health Service Research Institutes and the use of data can result in rational health policy development. This means that health policy can be developed based on the following flow chart (attachment 8).

CONTEMPLATIONS

Indonesia has been one of the success stories of health status improvement over recent years. Indeed it is true to say that you have much to show the world in regard to how to rapidly improve the health status of a nation. Can I then say that whilst all of the trends I've outlined today are of great interest, all countries need to carefully assess new trends before they take action to implement them. My advice would be to keep in touch with the world through reading and attendance at conferences but to digest the information carefully. Ask yourself whether what you've just read or heard relates to a problem in your country and whether the

Attachment 8

Rational Health Policy Development



problem is one which requires a priority solution. In short to develop Indonesian solutions to Indonesian problems.

Thank you for the honour of being invited to speak at your conference and may I wish the rest of your deliberations well.

