Regionalized specialized services

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Lesson 1

• Weigh up the evidence carefully
• Understand the context and how this affects how the evidence is applied
Strong trends to regionalization

- Many countries are regionalizing hospital services
- Reasons for regionalization:
  - Increased specialisation
  - Workforce shortages
  - Quality and outcome relationship
    - Complex multidisciplinary care
    - Complex procedures
    - But the evidence cannot be generalized
    - Few studies in medical specialties
- Evidence for cost savings & economies of scale is poor

Most significant opportunities
- Stroke
- Acute coronary syndrome
- Cancer
- Vascular surgery
Opportunities for decentralization

• But there are also opportunities to decentralize:
  • Improved primary care
  • New technology

Examples

• Routine monitoring
• Local tests & investigation
• Minor procedures
• Specialist consultation
Lesson 2

• Choose the model to fit the problem – is what is being provided knowledge and information or hands on care and procedures?
• There are other options than centralizing all services
• Many services that are specialized can be brought closer to where patients live
Different approaches 1

• Very specialist center – taking all referrals. Very limited role for local hospitals. Examples:
  • Cardiac surgery
  • Lysosomal storage disorders
  • Rare cancers e.g. retinoblastoma
Different approaches 2

Hub and spoke / tiered network
- Shared pathways of care
- Division of labour
Different approaches 3

Non-hierarchical network

e.g. Parkinson Net
Lesson 3

• Managing these changes requires skill and well organized processes
Planning and executing change

- Hospitals need to be planned as part of a wider system including primary care
- Markets have limitations as mechanisms for determining the shape of hospital systems
- Successful change has been based on
  - Planned based on patient need
  - Planning with expert input – based on regions
  - Criteria based on standards – not normative input targets
- Dialogue with public and stakeholders: starts early & requires skill
- Support from doctors
- Financial frameworks to manage the impact on hospitals
- Capital investment
- On some occasions mergers to create larger units to support closure
High-level regional meeting
Health systems respond to NCDs
16-18 April, Sitges, Spain

Practical experience
Panel Session
Lesson 4

• Making the models work requires new ways of working for hospitals, specialists and primary care
Making new models work 1

• Hospital – Hospital relationships
• Defining levels of care
• Transfer, escalation and step-down arrangements
• Shared pathways
• Challenges to make smaller hospitals viable and attractive places to work
Making new models work 2

- New roles for some specialists in supporting primary care
  - Co-producer of pathways and guidelines with patients and primary care professionals
  - Educator and advisor - keeping the system up to date with the science
  - Support to specialist nurses and care coordinators
  - Dealing with the most complex and difficult patients
  - Taking a population health view:
    - Developing and running registries
    - Identifying the highest risk patients
    - Developing population health interventions
    - Understanding the context & social environment
Making new models work 3

• Outreach to:
  • Support for end of life care
  • Support care homes
  • Provide ambulatory diagnosis and treatment for emergencies

• Other changes
  • Shared record systems
  • Regulation
  • Payment models
What are the leap frog opportunities in this area?

• Possible ideas
  • Using technology
  • Rethinking the role of the chronic disease specialist
  • Redesigning specialist consultations – outpatients / ambulatory care
  • The initial reception and management of emergencies
  • Other support to primary care services in managing NCDs
  • More centralization or more decentralization?

• What do you think?