Wealthy Natíon
Healthy Natíon

A plan to revitalise NHS Scotland

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Financial, structural and cultural change

Healthcare outcomes in Scotland are deteriorating relative to many other countries that spend a similar amount or less on healthcare. This should persuade us that the current model of healthcare in NHS Scotland (NHSS) is outdated and unable to quickly adopt changes that benefit the population it is there to serve.

There is an urgent need for politicians to publicly accept that additional spending cannot and does not serve as a cure-all, and that without truly significant reform NHSS will remain unable to meet the challenges it faces.

Whilst the initiatives outlined in the Scottish Government's Operational Improvement Plan are welcome, the plan does not properly address the financial, structural and cultural changes that are needed to preserve the NHS in Scotland. Therefore, unless significant reform occurs that improves the efficiency and productivity currently delivered by NHSS, it seems very unlikely that we will benefit from greater spending on healthcare.

The Scottish Government should acknowledge that NHSS is currently unable to deal with many of the challenges it faces and that an honest debate with the public about urgent reorganisation and reform of finances, structure and culture is necessary.

> "No society can legitimately call itself civilised if a sick person is denied medical aid because of lack of means."
>
> Aneurin Bevan

Prevention

There is a need to improve the general health of the population to reduce demand on a stretched healthcare system.

We face an ageing population burdened by increasing chronic diseases such as obesity, diabetes, certain cancers, cardiovascular disease and dementia. Most of these diseases are overwhelmingly associated with diet, lifestyle and poverty.

Addressing these issues must be an intermediate and long-term goal that goes hand in hand with improving the economic outlook and education of the population of Scotland.

Conclusion

All of these changes could be implemented within the term of the next Scottish Parliament if the political will is there to do so. We believe they will substantially improve the performance of NHSS, allowing us to preserve a high quality easily accessed NHS, which is now a matter of urgency.

As well as looking at how these immediate changes to the NHSS are implemented, a great advantage of the Scottish Government setting up the Independent Commission, as we recommend is that it can look at further reform. Our health system needs to strive for constant improvement and the further lessons we can learn from other healthcare models such as those in Sweden and Germany. Such reform may well be more long-term and seem radical, but it is important that new ideas are given due consideration if we are to make NHSS the best healthcare system in the world, which must be our aim.

RECOMMENDATIONS

To protect the future of NHSS from the short-termism of the political cycle, the Scottish Government needs to convene a commission of independent senior experts and business leaders, without political affiliation, that can consider:

The modernisation of healthcare provision, through:

- A focus on patient outcomes and experience, which must be the priority for everyone in healthcare and involves extending patient choice as essential to ensuring high standards
- Decentralisation of funding and control to local bodies
- Transparency of funding, with money following the patient more directly
- Re-establishment of a medical hierarchical system that is based on experience and ability, with a Head of Department setting standards, nurturing, developing, and supporting younger colleagues. Managers focussed entirely on the delivery of excellent patient outcomes
- A new constitution for the NHS in Scotland so that patients know what they can expect from the service.

Recruitment into healthcare and measures to ensure retention of staff up to the state retirement age.

A capital fund dedicated to ensuring the estate and infrastructure in the Scottish Health Service underpins the objectives set out in the Constitution.

What do other countries do differently?

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Case studies

Two European countries that have healthcare systems with better outcomes than Scotland and the UK are Germany and Sweden, which spend a similar proportion of their GDP on healthcare (Germany - 12.8% of GDP; Sweden - 11.5%; UK - 12%).

We have chosen these countries for comparison partly as they spend a similar proportion of GDP on healthcare, but primarily because they achieve better outcomes across many areas and have different models of how healthcare is funded.

SWEDEN

Structure: Healthcare in Sweden is decentralised – responsibility lies with the regional councils and, in some cases, local councils or municipal governments. The role of central government is to establish principles and guidelines, to set the political agenda for health and medical care, and overall regulation.

Funding: The bulk of health and medical costs in Sweden are paid through regional and municipal taxes. Contributions from the national government provide an additional source of funding, while patient fees cover only a small percentage of costs. The proportion of people with Voluntary Health Insurance has increased over the last decade; about 10% of the population aged 16-64 years now has access to private insurance, often financed by their employer. The publicly financed health system covers public health and preventive services, primary care, inpatient and outpatient specialised care, emergency care, rehabilitation services, patient transport services, social services, and long-term care.

Patient choice: Freedom of choice with respect to both primary and secondary care providers has been mandatory since 2010, and patients may have direct access to specialist care depending on which region they are in. There are both public and private providers of healthcare, and the same regulations apply to both.

GERMANY

Structure: Governance of healthcare delivery is decentralised with the federal government having responsibility for setting the overall legal framework. State Governments are responsible for hospital planning and public health, whilst most decision-making power is delegated to corporatist bodies e.g. associations of providers and sickness funds.

Funding: Healthcare insurance is compulsory for citizens in Germany either under the Statutory Health Insurance (SHI) scheme, which makes special provision for low-income groups to ensure everyone is covered, or through substitutive Private Health Insurance (PHI).

Patient choice: Primary and ambulatory care is separated from inpatient care delivered in hospitals. Primary and ambulatory care are provided entirely by private providers paid via a on-contact capitation fee and a fee-for-service basis. The fee to the insured patient for consulting a GP or office-based specialist is 10-15€, which includes any follow up visits within 3 months, with insurance covering the rest of the cost. Hospitals are remunerated directly by the insurer for their activity mainly through fee-per-case payments which are fixed by a national tariff system called Diagnostic Related Groups – DRGs. The patient does not pay for healthcare in hospitals, but the hospital can also charge inpatients a 10€ per day fee as a contribution to meals and accommodation that the patient is responsible for paying.

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