The implications of the discovery that Care in the Community does not save hospitals money

This week the HSJ issued a report of a high-powered commission on hospital care for frail older people[i]. It didn't mince words, as follows:

- "There is a myth that providing more and better care for frail older people in the community, increasing integration between health and social care services and pooling health and social care budgets will lead to significant, cashable financial savings in the acute hospital sector and across health economies. The commission found no evidence that these assumptions are true.
- The commonly made assertion that better community and social care will lead to less need for acute hospital beds is probably wrong.
- The pursuit of current NHS funding policies looks likely to lead to a funding gap. No major political party's current health policy commitment will meet this funding gap.
- The commission was concerned about the prevalence of magical thinking in current policy and politics, which regards providing more integrated care for older people with frailty closer to home as being a "silver bullet" to slay the demon of poor care. We described this as a Messiah concept. The commission concluded that the track record of success for previous Messiah concepts in the NHS (lean, Toyota, community matrons, the case management pyramid) should urge us towards caution, pragmatism and realism."

There will be many people looking to respond to this report but for us it is just a statement of the obvious, but inconvenient truth[1]. Care in the community, care closer to home, care anywhere but in an acute hospital has been the mantra of choice for those in the NHS tasked to save money without a clue how to do it.

There already is a funding gap which is likely to become worse as funding is withdrawn year on year. That said where does it leave Monitor continuing to promote "significant change"[ii]; the "transformation industry" and all those promoting "radical reconfiguration" based on heroic assumptions about the ability of health economies to reduce demand by shifting care into the community and saving money by cutting back acute care?

Taking recent SW London plans as an example, where we advised local authorities on NHS proposals, 50% reductions in A&E attendances were projected enabling the closure of a fully functioning A&E department. Investments of around £200m were planned to facilitate this. These plans were eventually shelved but equally ambitious plans in West London and elsewhere are being implemented, at who knows what cost to the health and wellbeing of local populations.

We can anticipate three likely responses:

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[1] Seán Boyle's response in the Guardian http://www.theguardian.com/society/2012/sep/09/community-healthcare-no-panacea?newsfeed=true

1. It may be claimed that evidence of no evidence for savings in the past is not the same as evidence that savings will not be available in the future. This qualifies as the "insanity response". Insanity being defined as the belief that continuing to do the same thing will eventually produce a different result[iii].
2. In the absence of evidence "theoretical proof" can be claimed as good enough to justify action to resolve problems. This is the McKinsey view of the world. Theory you will recall justified sub-prime mortgages and use of mathematics-based derivatives to rule over financial common sense within the financial world. Theory has its place but needs to be thoroughly tested before risking the lives of the UK population.
3. The third response is likely to be to refer to the Veterans Association of America. The recurrent claim is that it has proved possible to extract savings from a system which spends over twice what is spent in the UK by shifting care into the community. But looking at health services in Oregon, whence much of the evidence emanates, confirms there are considerably more emergency beds and hospital beds than for comparable populations in the UK. It may be a faraway country about which we know little but surely we all know that comparing like with like is necessary before emulation is regarded as safe as a driver of our healthcare provision.

In the end though we are not in a rational debating chamber but in a time, pre-election, where the Chancellor's figures are not looking good and many people and organisations are seeking to "help".

The NHS is said to need "world class management" (code for multinationals taking over chunks of the NHS); "transformation " and "significant change" (code for more work for world-class management consultancies) and is presented to the public as "in deficit" (when it isn't overall), unaffordable (when it is cheaper than comparable countries), unproductive (when it actually has fewer beds and doctors) and unsustainable (when the population continues to give its support and reacts badly to plans to reduce capacity).

All the major political parties look set to continue the squeeze on NHS resources in future years with scarcely a billion or two between them. Perversely those people most discontented with the NHS are most likely to vote for UKIP despite its half-baked contradictory NHS policies.

Thus although the Commission report may seem like a significant landmark in the ongoing battle for the NHS it may be that those that think that way are falling into the "rationality trap". It isn't a matter of evidence or reason but of which side you are on. The results of the recent bye-elections would appear to suggest that politicians have misjudged the public mood. Expect some recalibration of NHS policies in coming weeks.

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[i] http://www.hsj.co.uk/Journals/2014/11/18/l/q/r/HSJ141121_FRAILOLDERPEOPLE_LO-RES.pdf

[ii] Chief executive of Monitor, David Bennett, called for trusts to make "greater efficiencies" and to plan for "significant change" over the next few years.

He said: "This is proving to be a tough year for many foundation trusts. Funding is rising, but not as quickly as costs are increasing. These are driven by higher demand for healthcare, reflecting an ageing population and more people suffering complex conditions, and also higher staffing levels.

"Nevertheless, trusts can and need to deliver greater efficiencies while also planning for more significant change over the next two to five years, so that they can continue providing the quality services that patients value."
http://www.hsj.co.uk/5077100.article?WT.tsrc=Email&WT.mc_id=EditEmailStory&referrer=e20#.VHXe2Wdya70

[iii] Attributed to Einstein in 1925