行政院及所屬各機關因公出國人員出國報告書
（出國類別：開會）

參加「第 23 屆國際健康照護品質協會(ISQua)年會」會議

服務機關：中央健康保險局
出 國 人 職　　稱：科長
姓　　名：王復中

出國地區：英國倫敦
出國期間：九十五年十月二十一日至十月二十七日
報告日期：九十六年一月

摘　　要

會議目的：瞭解健康照護品質相關議題目前在國際間最新的發展趨勢。

研討主題：本次大會主題爲「改善健康照護—不斷改變的挑戰」，在大會的精心安排下，分別在三天的專題演講中，觸及人力、組織、品質內容、使用資訊科技與評估系統建立等廣泛的議題。

心得：就大會演講及研討主題整理成「論質計酬」、「健康資訊科技改善醫療照護品質與安全」、「E-health」、「績效與評鑑的連結」、「台灣英國經驗交流」等五個部分的重點，以供讀者參考。

結論與建議：

一、 台灣在採用論質計酬前應進行系統化評估。

二、 加強健保局與醫策會等不同衛生單位的跨組織合作交流。

三、 鼓勵健保局員工自行研究投稿國際學術研討會。

四、 衛生主管機關可考慮贊助國際學會以加強影響力。

五、 增加資訊科技應用誘因以改善醫療品質。

目　　次

壹、目的

爲持續追蹤與瞭解有關健康照護品質議題的最新發展，奉派前往英國倫敦參加國際健康照護品質協會「International Society for Quality in Health Care (ISQua)」 於 2006 年所舉行的第二十三屆年會。

國際健康照護品質協會係於 1985 年在義大利北部城市伍汀內(Udine)成立，原爲一以歐洲國家爲主體的組織。自 1995 年起，總部秘書處常設於澳洲東墨爾本，主要贊助人爲澳洲國家衛生部及澳洲維多利亞省衛生部。目前團體會員超過 70 餘國、遍及世界各地，參與者包括醫師、醫療人員、醫院、保險機構、決策人員疾病人。國際健康照護品質協會大會於每年十月間舉行，下屆(2007)年會將於美國波士頓召開。

參與本次會議，除了被賦予收集相關資訊，建立交流管道的責任，也希望能對此一會議進行評估，藉以瞭解本局未來透過此會議加強健保業務交流與擴大國際合作的可能性。

貳、過程

一、議程說明

本屆年會開會時間爲九十五年十月二十二日起至十月二十五日止，爲期四天，來自世界各國的與會代表超過 500 人，其中來自台灣的代表就有 26 人。大會主要議程集中於二十三日至二十五日，地點選

在倫敦市中心的伊麗莎白女王國際會議中心(QEII Center)，就在西敏寺旁離國會大廈步行百尺內。本次大會主題爲「改善健康照護—不斷改變的挑戰」，在大會的精心安排下，分別在三天的專題演講中，觸及人力、組織、品質內容、使用資訊科技與評估系統建立等廣泛的議題。而此次年會的論文中，則有 Orals 75 篇、Presentation Posters 95 篇以及其他 Display Only Posters 159 篇，除了分散在過去所重視的病人安全等健康照護品質問題外，E-Health 等資訊科技議題也日益受到重視，這也將是明年的大會主題。

觀察本次會議中每位報告者準備充分、資料詳盡，惟在場地上由於分散在各樓層，人氣似乎因而受到影響。特別是 Poster 主要集中的 2、5 樓，儘管大會費心特別安排了一些 Sessions 在旁邊可以讓人經過瀏覽，整體而言人潮還是很少，這個經驗值得想要舉辦類似會議者參考。

二、每日議程相關資訊

本屆年會議程可參考附錄一，其中較爲重要之內容說明如下：

十月二十二日，Pre-conference Workshops

此會前會於歷史悠久的英國皇家外科學院舉行，共分績效衡量與評鑑兩場同時舉行，本人參加的是有關績效衡量的議程，會議主題爲 Controversies in Performance Measures: Are We Ready for International Consensus? 共有四個 Sessions。

十月二十三日，Plenary Sessions

分上下午各有一場，其中上午第一場大會邀請到現任英國衛生部長 Patricia Hewitt 女士蒞會演講。

Poster Sessions

除了連續三天的展示外，每天下午 13:30~14:00 均有半個小時的時間，針對 Presentation Posters 分七個不同主題在各會議室場地同時舉行，海報作者可以和與會者直接進行交流。

Track Sessions

上午下午各有一個時段，共十七場次，討論包括政策、病人安全、臨床照護、績效衡量、系統面等議題，除了被邀請的學者專家外，自行投稿獲接受的文章也被組織在這個時段中報告。

十月二十四日，Plenary Session

同十月二十三日分上下午各一場。

Poster Session

同十月二十三日。

Track Sessions

同十月二十三日，共十七場次。

十月二十五日，Plenary Session

同十月二十三日分上下午各一場，除了屆紹明年的大會規劃外，也對健康照護的未來提出了期許。

Poster Session

同十月二十三日。

Track Sessions

同十月二十三日，共十七場次。

本屆年會議程結束後，本人與醫策會與臺大醫院等部份國內與會者，利用十月二十六日待機時間，把握機會順道訪問了英國 NICE 與 NHS 轄下的 Litigation Authority 部門，並進行討論，讓這次的行程增加了額外的附加價值。

參、心得

一、論質計酬(Pay for Performance, P4P)

照護品質越好，對病人而言當然是一件好事，但對於醫療院所呢？可能的風險或許是成本，或許是其他病人的抱怨。論質計酬被視爲一個有助於改善醫療品質並降低成本的支付方法，是不是真的如此？與會的專家指出，在美國最近的研究確實支持這個論點，但研究所找的對象是比較嚴重的病人，是否在不同族群間有很大的差異則需要進一步研究。同時由於美國屬多元保險，此方法的實施會有許多執行問題需要克服，例如不同醫院的比較不公平的問題、病人看不同醫師的績效應如何衡量的問題，在國內的環境下同樣會發生。然而，對健保局最重要的是，論質計酬的策略是要獎勵還是處罰醫療提供者？經費是由總額還是另外一筆錢來？報酬的單位？目標達成是看績效還是看進步？這些涉及 Incentives 的議題必須好好思考，並將自己國情考慮進去，推動時一步一步來不能太急，隨時監控與評估，才能在最後獲得成功。

與美國一個有趣的對比是英國，其英格蘭所採用 Star Rating，由於公醫制度缺乏 Incentives，使得此方法能否改善品質不無疑問，同時在 Rating 時需要的指標，雖然遵循易測、正確、重要性等原則訂定，但指標一旦訂出來後就有被操弄得可能性，例如 Emergency Call < 8 mins，就被發現有醫療服務提供者在分子與分母上動手腳，這種情形在國內健保過去所訂的指標中亦不乏例子，論質計酬恐怕會加大這種情形的嚴重性。

荷蘭的經驗則提供了另一問題的參考。當論質計酬實施時，我們到底是站在信任醫療服務提供者還是控制醫療服務提供者的哪一邊？當所訂的指標如果不在原來健保資料庫收載範圍內，收集時需要醫師的配合，則這是一種控制的意圖將會更強烈，荷蘭的經驗告訴我們這些指標不論怎麼訂都會遭受很大的批評，所以在執行上必須考慮到醫師的配合意願，並在控制與自我規範間取得平衡。

如果這些指標將會公開成爲報告，那麼，一些新衍生的議題也必須加以注意。在澳洲的觀點下，很少將指標做不同醫院間的比較，即使這類的比較在英、美等國相當流行。這是因爲澳洲政府認爲在醫院內本身的差異可能遠比不同醫院間更大，使得這樣的比較失去意義，同樣的情形會不會發生在台灣，值得我們注意。台灣若要將論質計酬或其他品質相關的指標建立成一個系統化的公開資訊時，法國的 PATH Project、英國的 NICE 經驗，都提供我們在發展、建置與使用上很好的借鏡。最後，基於指標的可比較性，建議在使用上應該列入國際間常作爲比較的相關指標，例如本次大會獲頒貢獻獎的 Commonwealth Fund 所使用的跨國比較品質指標(目前健保局已委託哈佛學者協助建立台灣部分的指標)，或是 OECD 最近進行的 HCQI

Project(可參考本大會官方刊物 *International Journal for Quality in Health Care* 2006 年 9 月號之 OECD HCQI 專刊有詳細介紹)以便能將台灣的健康照護成果國際化。

二、健康資訊科技改善醫療照護品質與安全

在今年的大會中，許多場次提到要透過健康資訊科技來改善醫療照護品質與病人安全的問題，其中亦包括了第二天下午討論使用健康資訊科技衡量與改善品質與安全的 Plenary Session。儘管資訊科技有助於提升照護品質與病人安全的觀念早已普遍爲人所接受，但對醫療服務提供者而言，往往較不願投資在改善病人安全的資訊科技上，而寧願投資在提升醫療照護品質的資訊科技上，主要是因爲醫療資訊科技與品質多數會給人一種正向關係的印象。儘管品質與安全這兩者在某些情況下是有關連的，但使用這些醫療資訊科技往往在品質與安全上引發爭辯，若再加上衡量與改善的不同目的，將會使得問題更爲複雜。例如實施電子化病歷，到底是爲了幫助管理者得到一個更好的品質衡量方法還是爲了提升病人安全呢？某些人認爲電子化病歷根本不能提升病人安全，解決之道，或許需要的是心態上的改變。

對健康照護而言，使用健康資訊科技的重要性與日俱增，其所能提供的不只是個別個案的改善，還有整體系統的監控與評估，對健保局等醫療保險人而言，透過資料收載、分析、回饋，可以提供醫療服務提供者參考，這些品質資訊將成爲改善的誘因，例如去年南區分局針對牙醫與西醫基層所進行的管理策略就是基於這個觀點下

發展，其結果並已獲得本局該年度同仁自行研究優等獎。

三、E-health

現今的健康照護服務正面臨重大轉變。藉由資訊科技的發展健康照護服務正面臨一個典範的轉移過程(Paradigm Shifts)，資訊科技分別由自動化、資訊化而至現今無所不在的網路環境，影響所及的不只是醫療照護人員，病患、醫療設備供應商以及政府部門，無不在這個新的轉移過程中受惠。這個過程，簡言之，就是一個以整合、跨領域，以及資訊通訊科技爲基礎的面貌，進行在個人、組織、社區乃至國家中健康與醫療照護的擴散。這個擴散爲的核心價值在於爲更多人打開一扇窗，獲得更多更易更好的照護服務。

爲了讓這個照護服務的新觀念落實，策略性的健康系統規劃與電子商務的觀念必須被引入，而在這個電子商務的運作環境中，電子交易紀錄的重要性自不言可喻。透過各種型式的網路，連結醫療提供者、個人與保險人後，公眾健康的管理與核心價值才能進一步被確認。在這個整合型電子健康照護服務的核心價值就是藉由建立一個可以永續經營的健康服務模式(Business Model)來幫助降低服務成本與增加效率。同時，這些服務將不限於直接面對病患的照護，不只改善醫療照護的溝通與成本，還能增加使用者滿意度、生活品質、安全性以及更有效率與效能的健康照護服務。

在本次大會中，除了每天都有一場關於 E-health 的 Session 外，在第三天的大會還舉辦一場早餐會，專門討論資訊科技如何在醫療上扮演輔助模擬的角色。這些資訊科技除了幫助醫師 Easy to do right thing,

have to do wrong thing! 之外，也讓醫療專業人員的學習曲線縮短，特別在外科手術等複雜環境下的模擬，更讓病人安全同時得到顯著的提升，例如這次大會中所介紹的脊椎手術模擬器，就可以幫助醫師減低以往只能看書憑感覺一弄錯就讓人下肢癱瘓的風險；亦或可以追蹤醫師檢視 X 光片的眼球追蹤系統在訓練與評估醫師專業能力上的輔助，都是提升醫療服務品質很好的工具。國內醫療服務提供者投入在使用模擬病人真實反應的胃鏡模擬器來幫助醫師更了解病人的感覺這類資訊科技的金額，遠不及因醫療糾紛所賠償的金額，最大的問題在於，目前的環境下沒有經濟上的誘因去鼓勵醫療服務提供者投資這些資訊科技，或許在評鑑中加入將這些設備列入充分條件後，再由健保依據評鑑結果給付，可以建立一個較具有誘因的新環境。

四、績效與評鑑的連結

評鑑不應獨立存在，美國在醫院實地評鑑與績效衡量指標的結合上，有一系列系統性的方法值得借鏡。於 2002 年開始的 3800 家醫院的評鑑結果，最後刊登在 2005 年新英格蘭期刊上，其所發表的報告，亦可於www.qualitycheck.org網站上查閱，其中有許多更詳細的資料，美國在評鑑上的做法提供我們許多有用的資訊來了解如何有效與醫院績效緊密結合。美國將於 2007 年完成的Strategic Surveillances System，則是評鑑的最新成果，請拭目以待。

基於成本考量，醫院實地評鑑的頻率不可能很高，對健保局而言，目前所使用的品質或績效監控指標，在及時性上當然較實地評鑑

高，但在深度與廣度上卻有所不同，特別是過程面指標的缺乏，單獨使用這些短期指標可能會對醫院的績效衡量產生很大的偏差。當然，一個完美的評鑑制度並不存在，但透過兩者的結合，例如目前各分局進行的呼吸照護評鑑方式，雖然尚未盡完美，但卻已走在正確的方向上。

五、台灣英國經驗交流

由於醫策會受委託辦理國內醫院評鑑事宜，每年的 ISQua 年會都會規劃相關行程，組織國內對此會議有興趣的同好一同參加。由於該會爲 ISQua 會員，透過醫策會報名可享優惠，同時每年也會視情況規劃一些參訪行程，例如這次的所參訪 NICE 與 NHS 轄下的 Litigation Authority。NICE 應該是國內比較熟悉的一個組織，經費來自於英國 NHS，其相關資料請參考附錄二。這次參訪的另一個機構，NHS 轄下的 Litigation Authority(NHILA)，主要業務在承辦英格蘭地區的公立醫院的無過失醫療。NHILA 是依據英國 2002 年通過的 Human Rights Act 所成立的風險管理機構，雖然不是保險公司，但卻有點像保險公司的運作方式，其基金來自醫院，NHSLA 依據各醫院規模，病床與病人數訂定保費收費標準，每年再依據各醫院的無過失醫療個案發生情形重新計算並調整其保費。目前平均每個死亡個案給付約在 10,000 英鎊左右，但一般的個案則差異很大，會依據個案身分不同而有所不同，最有名的一個案例是一位在倫敦的舞蹈家，NHSLA 共計需付給其約 4,000,000 英鎊的高額賠償。儘管如此，NHSLA 並沒有因爲調高醫院保費而收不到錢，因爲這些醫院除了 NHSLA 之外

也沒有別的選擇，目前並沒有任何私人保險公司願意承接這個業務，同時對醫院而言，透過 NHSLA 可以避免與當事人直接接觸，減低包括訴訟等許多不確定的風險，以台灣目前還是各醫院自行向醫師籌措費用成立一個基金的方式，這實在是一個很值得參考的制度。惟 NHSLA 目前只有承作醫院，對開業醫並沒有包括在內。

本次大會中，各國的學者專家共聚一堂，充分達到國際交流，其中來自台灣的研究也有十餘篇發表於其中，透過這次會議，也讓許多國際人士了解到台灣在醫療照護品質上努力的成果，醫策會同時也在這次大會中取得的學會的評鑑認證。

肆、結論與建議

第一次參加 ISQua 年會，除了幫助自己對病人應如何得到最佳照護品質、獲致最佳的治療結果有更多的體會與瞭解之外，也明白改善健康照護的工作是要被不斷的檢討才能符合多變環境的需要，這個改變的過程必須從不同的面向來思考。無論如何，這些不同照護品質的觀點，與健保局關注民眾健康的目的殊無二至，值得我們的學習與借鏡。

透過參與本次年會，也得到了一個與世界各國交流的好機會，尤其是對健康照護品質這樣具有多元面貌的主題，更可以學習到世界各國在方法及系統發展上的差異。綜合本次所見，謹提出以下幾點建議供參：

一、台灣在採用論質計酬前應進行系統化評估

本次大會在不同主題的會議中多次觸及論值計酬這個議題，甚至會前會中也有一個 Session 在討論這個方法。在會議中，多數學者專家的看法並不那麼樂觀，大多強調採用時需要小心謹慎，台灣在推動論質計酬前實應參考其他各國的經驗，並根據國情加以適當修正，以免良法美意成空。

二、加強健保局與醫策會等不同衛生單位的跨組織合作交流

在醫院評鑑與醫療品質上，其實與許多不同的衛生單位有關，惟有透過跨組織間的合作，才能讓整個醫療服務品質不論在結構、過程與結果上均能被緊密的監控與管理，健保局的功能需要與其他單位互補，方能在保險人身分上發揮其最大的效益。

三、鼓勵健保局員工自行研究投稿國際學術研討會

從本次大會的投稿資料中顯示，整體接受率約爲 75%，可以說是非常高。雖然要列入 Oral Presentation 的機會較低(佔入選之 23%)，但由於本次會議中將 Poster 分爲兩部分，其中一部份亦有 Presentation 的 Session，對於參與者來說，反而得到更多的曝光機會(三天的海報展示加上一場正式的 Presentation)，若以健保局歷年同仁自行研究的水準來看，只要加強英文能力，能夠以英文清楚表達研究內容後投稿，被接受的可能性並不小，由於每年本局均會選派同仁參加

此項會議，建議未來可以由投稿被接受者獲得這個機會，一方面符合實質參，一方面幫助台灣將健康照護品質的成果國際化。

本項會議過去國內其他單位多有投稿，惟獲得接受之比例起伏很大，經洽詢過去幾年參與者的經驗顯示，應多注意每年大會所訂定之主題，如非其所規劃議程內的主題，較不容易入選，2007 大會的主題爲「Transforming Healthcare in the Electronic Age」，本局有關 IC 卡之建置成果或可爲一個值得努力的方向。

四、衛生主管機關可考慮贊助國際學會以加強影響力

除了投稿參與外，澳洲衛生部的做法亦值得借鏡。在 ISQua 這個學會中，澳洲政府透過贊助，事實上已取得對此學會的實質影響力，我國欲從事衛生外交工作，透過這種間接方式與國際社群建立聯繫管道不失爲一種變通的做法，亦可降低大陸方面的打壓。對國內衛生主管機關而言，透過贊助學會除了名義上的參與外，若能透過執行理事規劃於本國有利之議程，例如舉辦一個討論總額制度對品質影響的 Session，將有助於我們的成果在國際發聲。

五、增加資訊科技應用誘因以改善醫療品質

政府透過資訊交流與服務來滿足醫療提供者與民眾。這個模式中再度突顯發展一個有效率的整合健康照護資訊基礎建設的重要性。未來，至少有以下幾個方向值得各界一同努力：(1)整合型電子健康照護服務是一種新的經驗，需要新的知識來協助；(2)這個新典範需要更多電子商務與電子化企業的觀念應用在健康照護上；(3)透過壓力

與需求來傳達資訊科技在健康照護服務上的重要性；(4)整合型電子健康照護應用潛在好處的發掘。

然而在努力建立這個環境的同時，也需要注意對醫療服務提供者設計誘因，鼓勵其進入增加資訊科技應用的行動中，以發揮醫療資訊科技的最大綜效（Synthesis）

PROGRAM OVERVIEW

SUNDAY 22 OCTOBER

0930: Workshops at RCS

1800: Welcome Reception at QEII

MONDAY 23 OCTOBER

0930: Welcome from ISQua's President: *John Helfrick* and Conference Chair, *Sir Ian Kennedy*

Introduction to the Program: *David Haslam,* Program Chair

A1: PLENARY PRESENTATION

- The challenge of continuous change
  Patricia Hewitt

1030: BREAK

1100 - 1230: Workshops and Brief Papers

1230 - 1400: LUNCH

Nurses & Midwives meeting

1330 - 1400: Track Poster Sessions

1400 - 1530: Workshops and Brief Papers

1530: BREAK

1600 - 1700: PLENARY PRESENTATIONS

- Responsive regulation in health care
  John Braithwaite
- Supporting doctor-patient relationships alongside the regulators
  Sir Liam Donaldson

1715 Poster Presenters Wine and Cheese Reception

TUESDAY 24 OCTOBER

0730: Breakfast - Leadership

0900: PLENARY PRESENTATIONS

- Global Nursing Shortages: Scope and Potential Solutions
  Linda Aiken
- The Influence of Medical Migration on Health Care Quality: A Physician's Perspective
  Richard Cooper

1030: BREAK

1100 - 1230: Workshops and Brief Papers

1230 - 1400: LUNCH

Educators meeting – by invitation

1330 - 1400: Track Poster Sessions

1400 - 1530: Workshops and Brief Papers

1530: BREAK

1600 - 1700: PLENARY PRESENTATIONS

- Using health information technology to measure & improve healthcare quality & safety
  David Bates, Sir Brian Jarman, with Mike Pringle

1715 ISQua Annual General Meeting

1900 Gala Reception, Hunterian Museum, RCS

WEDNESDAY 25 OCTOBER

0730: Breakfast - Simulation

0900: PLENARY PRESENTATION

- The Danish experience of implementing a national reporting system - the challenges and the incentives
  Beth Lilja Pedersen
- Panel: Perspectives on reporting with
  Laurent Degos, Philip Hassen, Bruce Barraclough

CELEBRATING QUALITY

1030: BREAK

1100 - 1230: Workshops and Brief Papers

1230 - 1400: LUNCH

1330 - 1400: Track Poster Sessions

1400 - 1500: Workshops and Brief Papers

1500: CLOSING PLENARY PRESENTATION

What if?
Sir John Oldham

Farewells

1600: CLOSE

PRE CONFERENCE PROGRAMS:

SUNDAY 22 OCTOBER 0930 to 1700 hrs

Venue: Royal College of Surgeons,
35 – 43 Lincolns Inn Fields, London WC2A 3PE

- **Controversies in Performance Measures: Are we ready for consensus?**

ISQua's 2006 London Indicators/Measures Summit program has been designed to explore a variety of cutting edge, controversial issues associated with the use of Indicators/ Measures. Program leaders will focus on the use of performance data in one context or another.

- **Accreditation for quality improvement: Making it happen!**

Across the world, accreditation is the longest established and most widely known formal process for the external evaluation of healthcare services and systems, for community-based through to tertiary-level care. New national accreditation programs are constantly emerging.

ISQua's London Accreditation Symposium program is being compiled around issues such as reproducibility of results, patient safety, setting and assessing standards and will give leaders from both new or emerging accreditation programs and more mature or longer established programs, opportunities to learn from their peers and exchange ideas.

- **Above programs are being interfaced for a joint session for delegates to come together to exchange on the use of performance data in relation to accreditation.**

Check ISQua's website for details of the full day programs and speakers for each workshop.

Controversies in Performance Measures: Are We Ready for International Consensus?

ISQua's 2006 London Indicators/Measures Summit program has been designed to explore a variety of cutting edge, controversial issues associated with the use of Indicators/Measures. Program topics will focus on the practical use of performance measure data in a variety of contemporary contexts.

Sunday 22 October, 2006 at the Royal College of Surgeons, Lincolns Inn Fields

Registration details: See Conference registration forms

09.30 hours:	**WELCOME:**	John Helfrick, ISQua President,
		Setting the scene: Jerod M. Loeb, Program Chair
	SESSION 1:	**Pay for Performance – Reward vs. Punishment**
		Chair: John Helfrick, ISQua President,
		How incentive payments affect performance improvement, gaming of the system, and appropriateness of care
		Presenters: Heather Palmer, USA, Gwyn Bevan, UK; Richard Grol, Netherlands
11.00hrs: *BREAK*		
11.30 – 12.30:	**SESSION 2**	**Linking Performance Data and Accreditation: Are We There Yet?** *This session will combine with the Accreditation Symposium*
		Chair: Jan Mainz, DK
		Presenters: Jerod Loeb, USA, Lone de Neergaard, DK, Brian Johnston, Australia
12.30 hrs: *LUNCH*		
13.30 – 15.00	**SESSION 3**	**Public Reporting of Data:** **The Good, the Bad, and the Ugly**
		Chair: Brian Johnston, Australia
		Presenters: Bob Gibberd, Australia; Charles Bruneau, France; Bruce Keough, UK.
15.00 hrs: *BREAK*		
15.20 – 17.00	**SESSION 4**	**It's Tough to Make Predictions, Especially About the Future - What's Next?**
		Recent developments from projects of the OECD (comparing across countries), the AQA in the US (comparing at the physician level), and panel discussion on likely future trends in performance measurement.
		Chair: Jerod Loeb, USA Presenters: **Ed Kelley OECD/AHRQ, to provide overview** Panel to include some of the speakers through the day
FAREWELLS		

NHS
National Institute for
Health and Clinical Excellence

An Introduction to NICE and how the Institute fits into the NHS

NHS
National Institute for
Health and Clinical Excellence

Setting the scene – How NICE fits into the National Health Service

National Institute for Health and Clinical Excellence

The NHS before NICE

- NHS funded through taxation
- Devolution of resources locally
- Decisions taken locally on funding treatments
- Variations in practice were common (‘post-code’ prescribing)
- Uncertainty over best treatments
- No agreement on how to assess cost effectiveness.

Roadmap of the NHS

Department of Health (DH)

NHS National Institute for Health and Clinical Excellence

Special Health Authorities

- *NICE*
- *Healthcare Commission*
- *National Patient Safety Agency*
- *NHS Direct*
- *NHS Appointments Commission*

10 Strategic Health Authorities (SHAs)

Local NHS performance management

Primary Care

152 Primary Care Trusts (PCTs)

- *Doctors*
- *Dentists*
- *Opticians*
- *Pharmacists*
- *Walk-in Centres*
- *NHS Direct*

Planning/Agreement of Secondary Care

Care Trusts	Mental Health Trusts	NHS Trusts	Ambulance Trusts
Health/ Social Care Services	*Mental Health Services*	*NHS Hospitals*	*Ambulance Services / Patient Transport*

NICE public health guidance also applies to local government, whose responsibilities include:

- *social services (i.e. care of the elderly)*
- *planning applications (i.e. sports centres / cycle tracks)*
- *licensing applications (i.e. to serve alcohol)*
- *environmental health (i.e. safe housing)*

Provision of all local health and care services

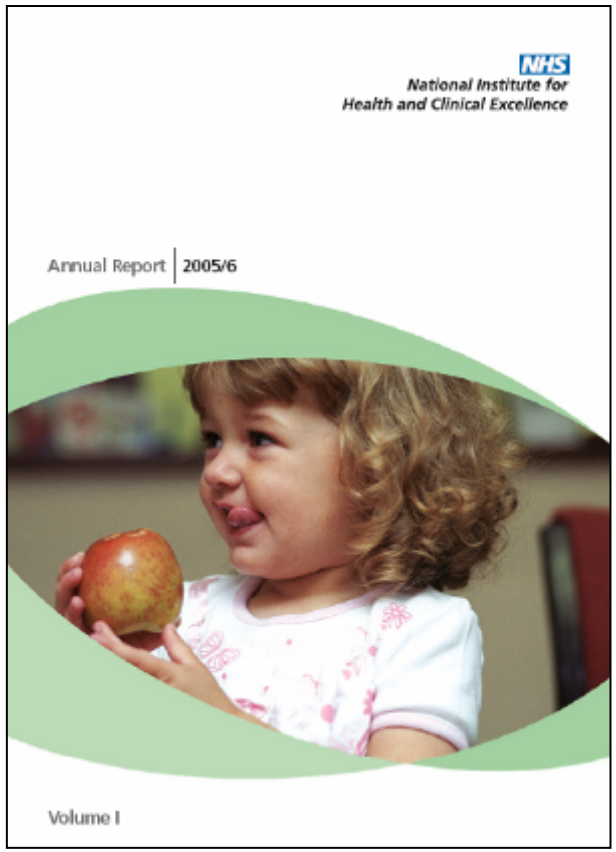
NHS
National Institute for
Health and Clinical Excellence

How NICE fits in to the NHS

- NICE provides national guidance on the promotion of good health and the prevention and treatment of ill health
- NICE guidance reduces variation in the availability and quality of treatments and care (the so called ‘postcode lottery’)
- NICE guidance helps resolve uncertainty about which medicines and treatments work best and which represent best value for money for the NHS
- NICE sets national standards for the NHS on how people with certain conditions should be treated.

NHS
National Institute for
Health and Clinical Excellence

How NICE is set up

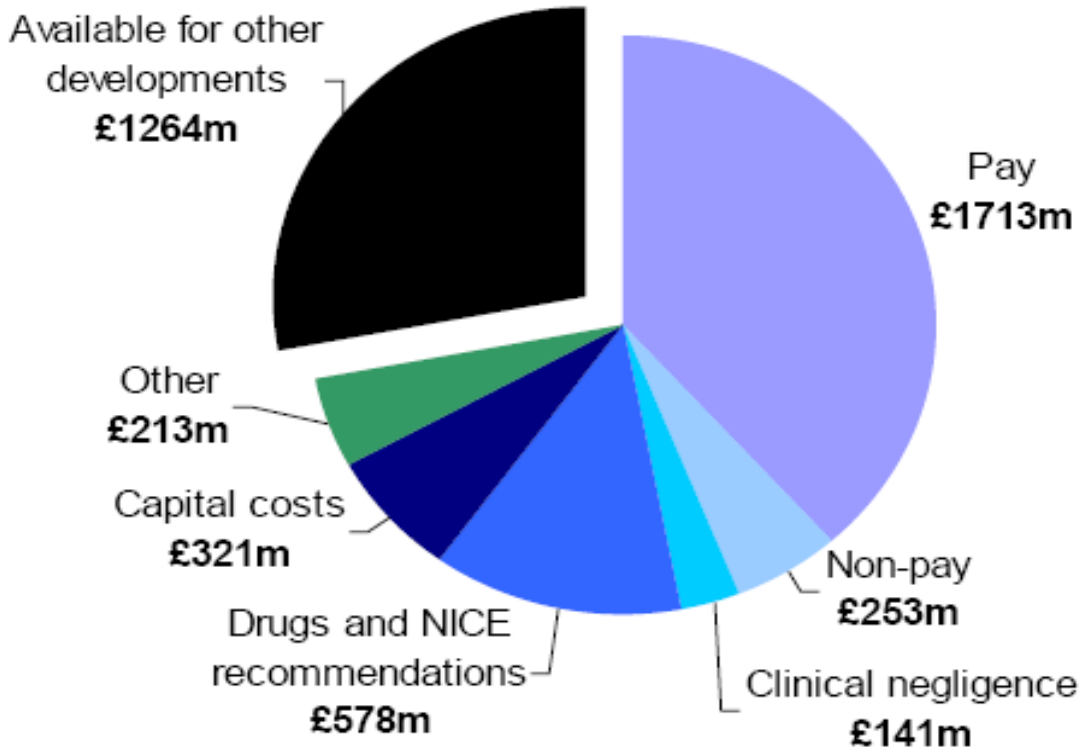


- Established as a Special Health Authority in 1999
- Funded by Department of Health
- Staff of around 200
- Many more people are involved part time in developing our guidance (around 1000)
- Current budget – around £30 million
- Money to implement NICE recommendations comes out of local budgets.

NHS
National Institute for
Health and Clinical Excellence

The impact of NICE on NHS budgets

Of the £4.5 billion cash increase in 2006/07 for hospital and community health services in England, it is estimated that drugs and NICE recommendations will account for 13% of the total (£578m)[1]



[1] *"Where's the money going?", King's Fund, London 2006*

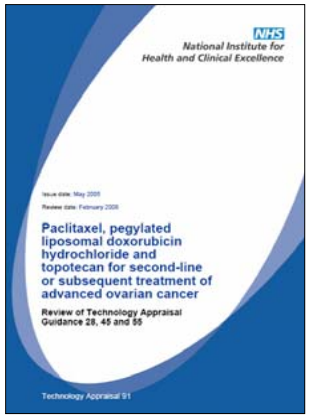
NHS
National Institute for
Health and Clinical Excellence

How NICE fits in with the regulators

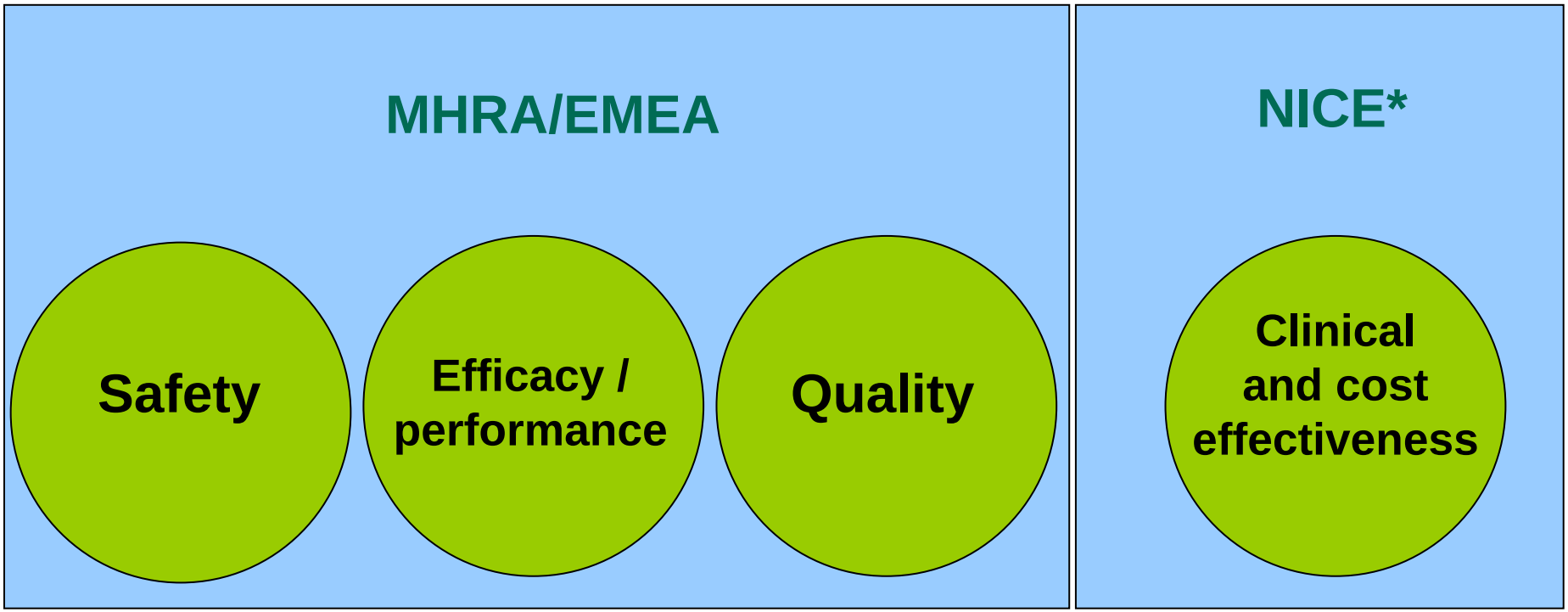
NHS
National Institute for
Health and Clinical Excellence

How NICE fits with the regulators

1. Technology is developed
2. Technology is licensed / approved
3. Technology ***can*** be prescribed
4. NICE guidance
5. Technology ***should*** be prescribed.



NHS
National Institute for
Health and Clinical Excellence



** Or local decision makers where no NICE guidance is available*

NHS
National Institute for
Health and Clinical Excellence

Developing guidance – How NICE works

NHS
National Institute for
Health and Clinical Excellence

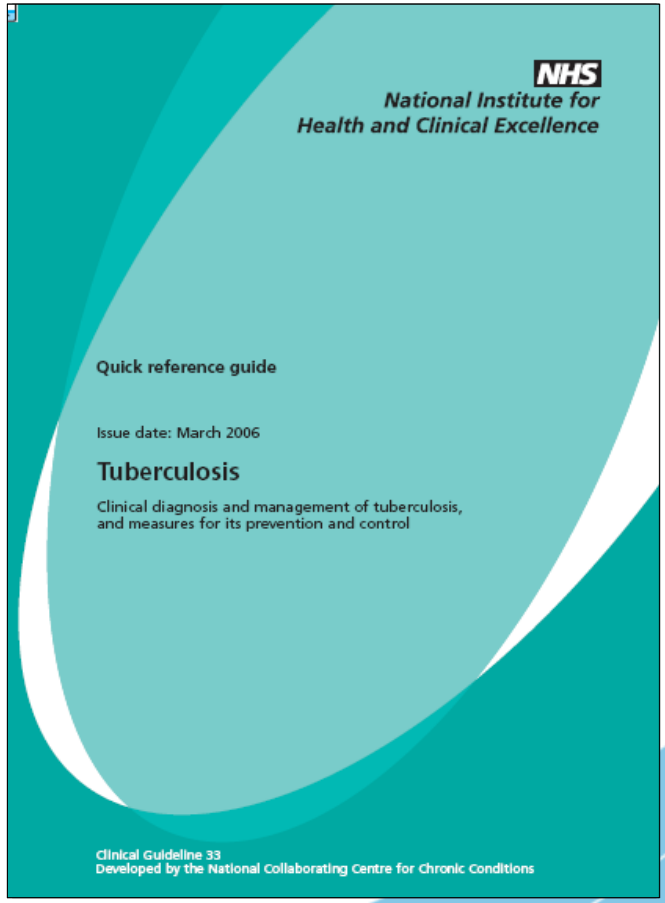
Core principles of all NICE guidance

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

NHS
National Institute for
Health and Clinical Excellence

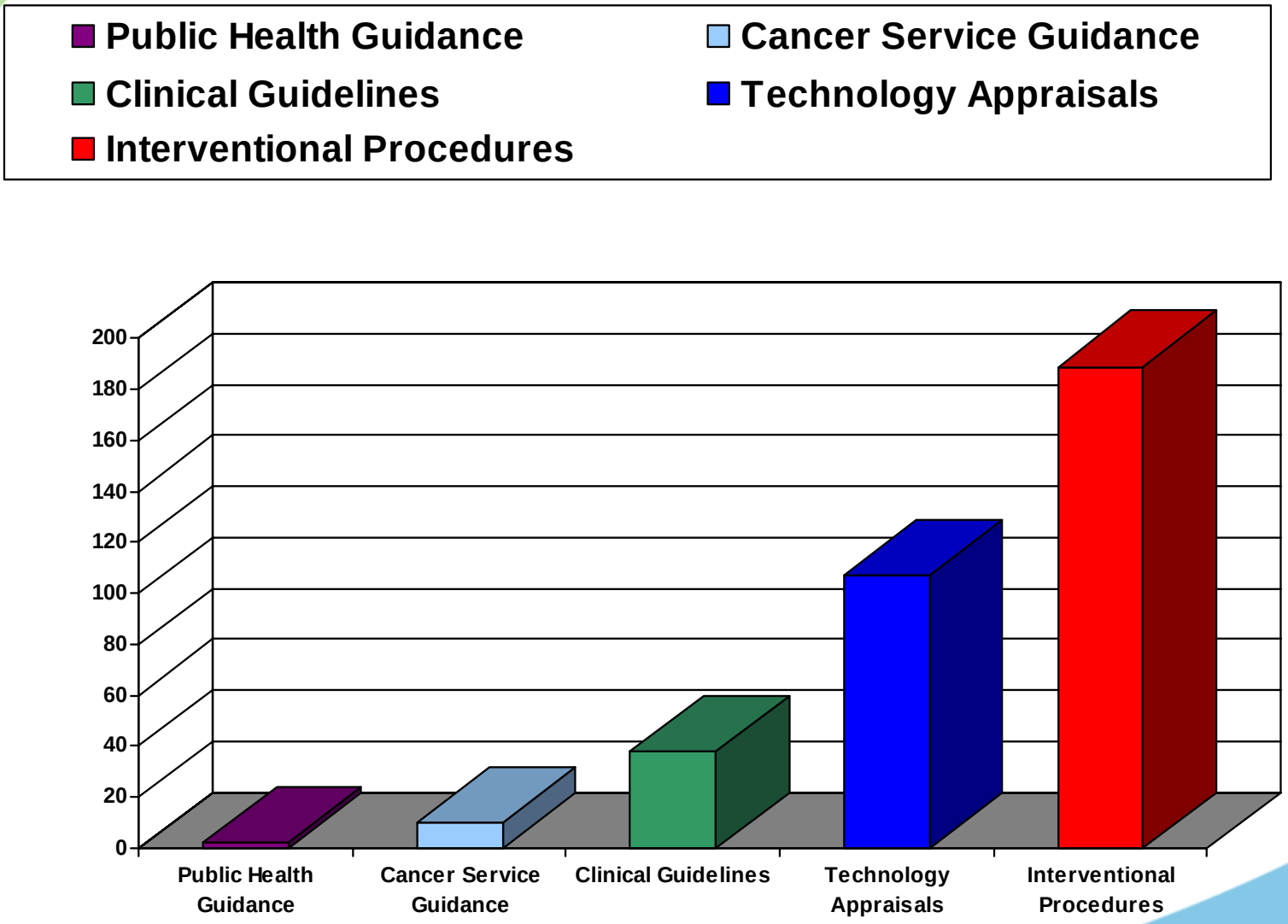
We produce guidance in three areas

- **Public health** – guidance on the promotion of good health and the prevention of ill health for those working in the NHS, local authorities and the wider public and voluntary sector
- **Health technologies** – guidance on the use of new and existing medicines, treatments and procedures within the NHS
- **Clinical practice** – guidance on the appropriate treatment and care of people with specific diseases and conditions within the NHS.



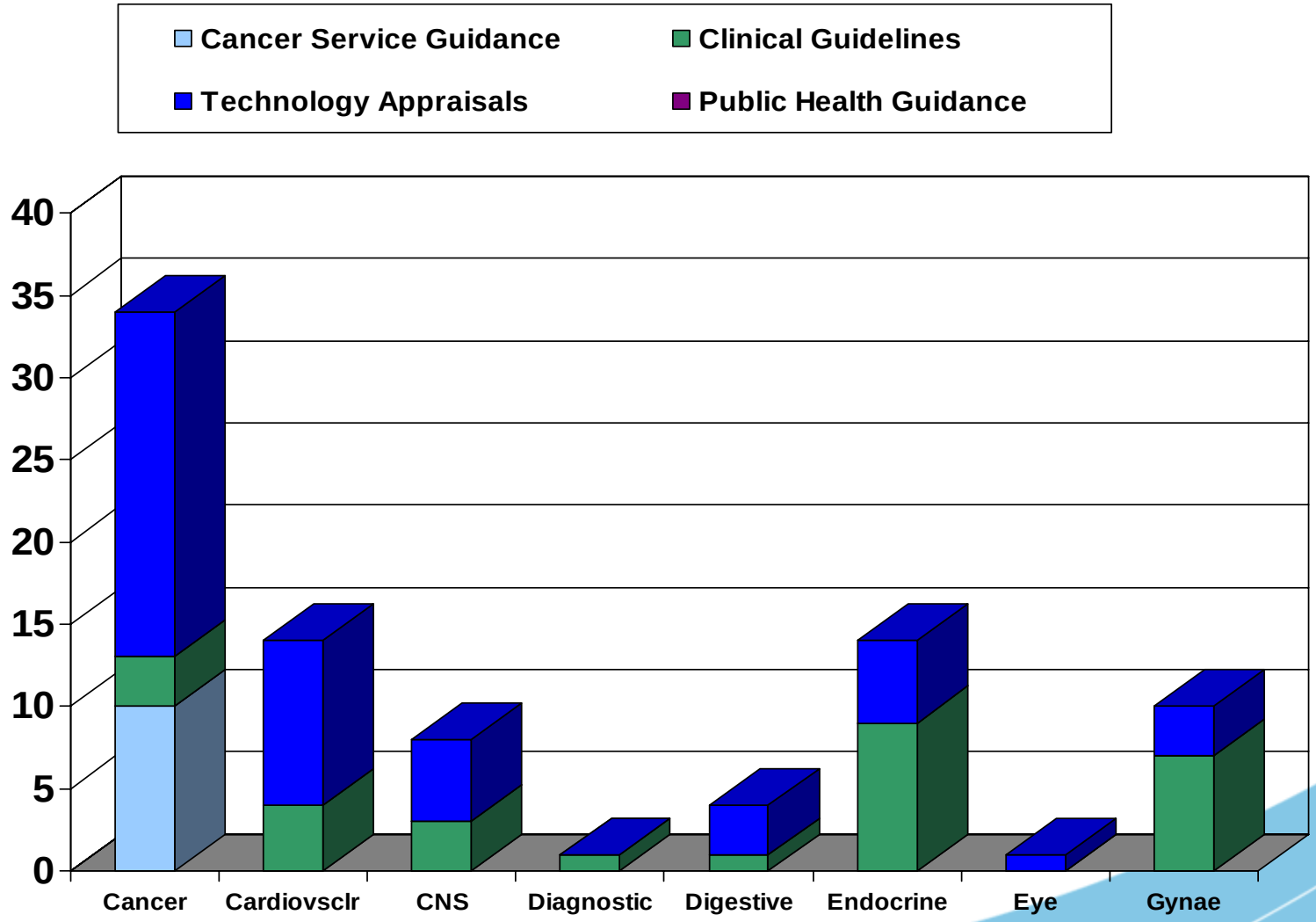
Total Volume of guidance

NHS
National Institute for
Health and Clinical Excellence



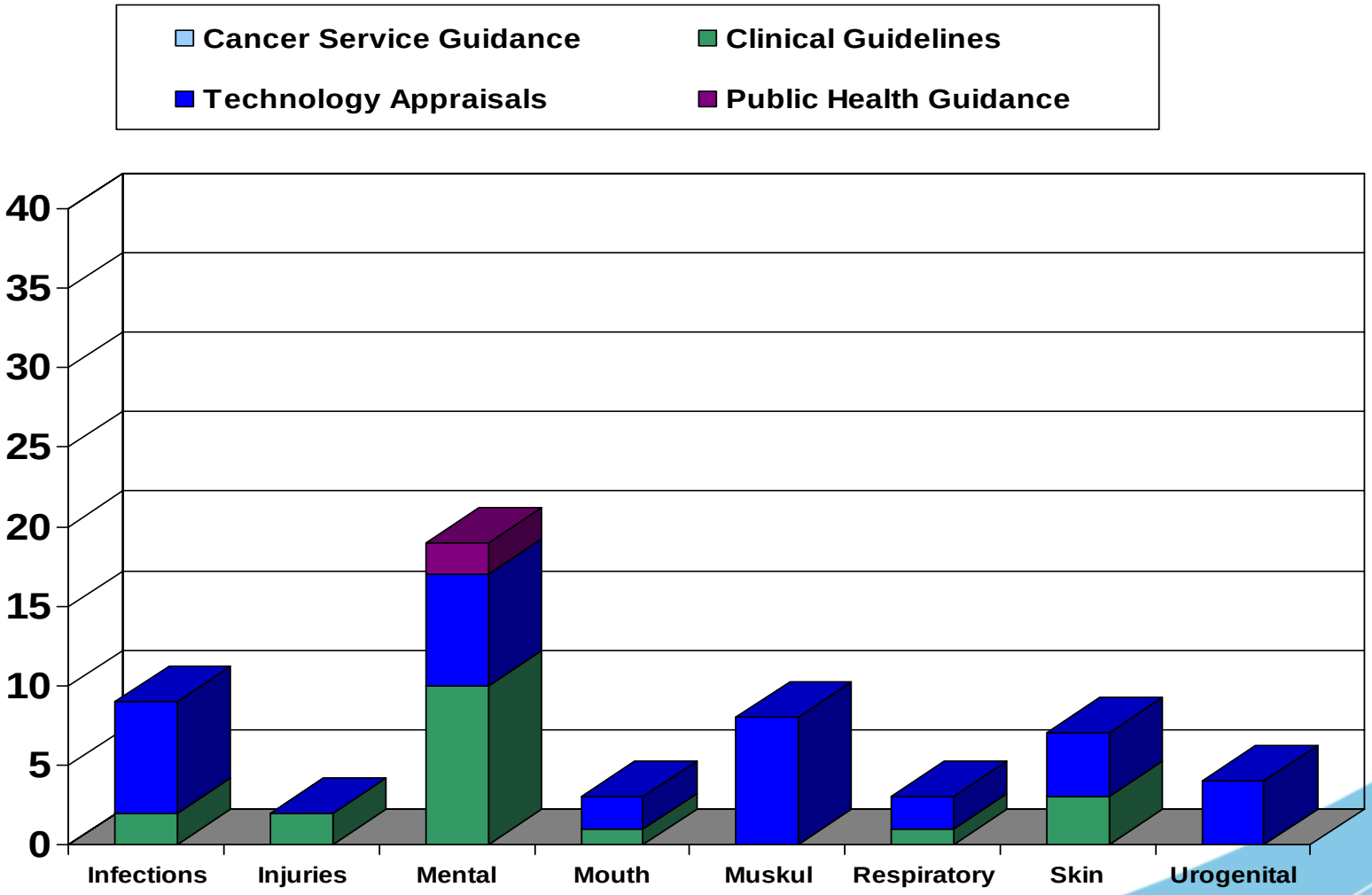
Volume of guidance by disease area

NHS
National Institute for Health and Clinical Excellence



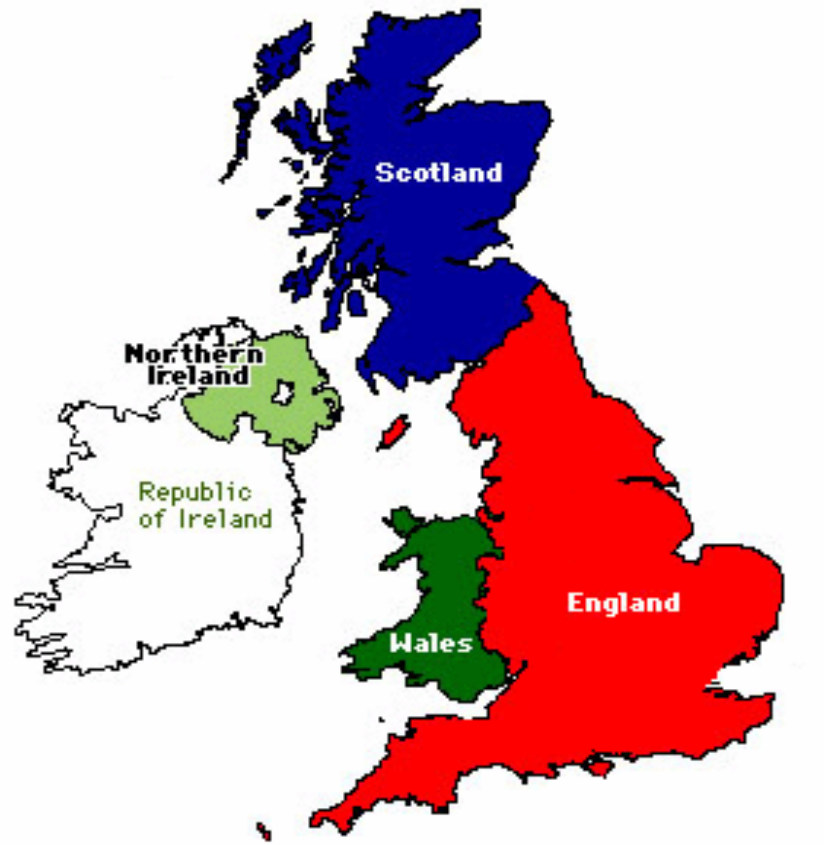
Volume of guidance by disease area

NHS
National Institute for Health and Clinical Excellence



NHS
National Institute for
Health and Clinical Excellence

Where does NICE guidance apply?

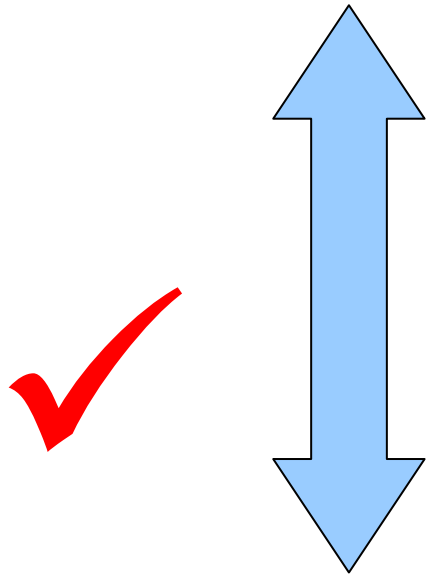


- Clinical guidelines and technology appraisal guidance apply to England, Wales and Northern Ireland
- Interventional procedures guidance applies to England, Wales, Scotland and Northern Ireland
- Public health guidance applies to England only.

NHS
National Institute for
Health and Clinical Excellence

The process NICE follows

- Topic selection
- Referral to NICE
- Scope
- Draft guidance
- Consultation
- Final guidance
- Opportunity for appeal
- Review, usually every 2 – 4 years.



6 – 18 months

NHS
National Institute for
Health and Clinical Excellence

Technology appraisals look at …

- **Pharmaceuticals** (for example, beta-interferon for MS)
- **Devices** (for example, insulin pumps)
- **Diagnostics** (for example, liquid based cytology)
- **Procedures** (for example, surgery for morbid obesity)
- **Health promotion tools** (for example, patient education models for diabetes).

NHS
National Institute for
Health and Clinical Excellence

NICE appraisal guidance by type and recommendation

	Routine use	Selective use	Research use only
Pharmaceutical	21	43	2
Device	5	10	2
Diagnostic	1	1	1
Procedure		7	3
Health promotion	1		
Totals	28	61	8

Our estimate of total annual cost to the NHS of technology appraisal guidance if implemented fully = £1,005.8 million

NHS
National Institute for
Health and Clinical Excellence

The impact and status of NICE guidance

NHS
National Institute for
Health and Clinical Excellence

The impact on health professionals

- Health professionals must take NICE guidance into account when deciding what treatments to give people
- However, NICE guidance does not replace their knowledge and skills; it is still up to health professionals to make decisions about a particular patient in consultation with the patient and/or their guardian or carer when appropriate.

NHS
National Institute for
Health and Clinical Excellence

The impact on funders

- The NHS must usually make funding and resources available within 3 months of the issue of NICE technology appraisal guidance.
- For other guidance – local health organisations should review their management of clinical conditions against the NICE guidelines.

NHS
National Institute for
Health and Clinical Excellence

The impact on patients

- Patients denied treatments recommended by NICE can use the NHS complaints system
- Patient groups increasingly vocal over implementation of NICE guidance
- Healthcare Commission inspects Trusts to ensure compliance with NICE guidance – patient experience can feed into this.

NHS
National Institute for
Health and Clinical Excellence

Managing technologies not yet approved by NICE – avoiding "NICE blight"

- New STA process should help reduce gap between licensing and NICE guidance
- In the meantime - NHS organisations must not use the lack of NICE guidance as an excuse for withholding funding for treatments and should assess treatments locally
- Health Service Circular 1999/176 - http://www.nice.org.uk/page.aspx?o=294355.

NHS
National Institute for
Health and Clinical Excellence

Topic selection – keeping it relevant

NHS
National Institute for
Health and Clinical Excellence

How are topics selected?

- NICE commissioned by Department of Health for:
  - Technology appraisals
  - Clinical guidelines
  - Public health guidance
- Interventional procedures referred by clinical community
- Anyone can suggest a topic via our website
- Clinical topics are usually: NHS priorities, major diseases, controversial (or potentially so)
- Once topic is referred Government has no undue influence on what our guidance says.

NHS
National Institute for
Health and Clinical Excellence

New process announced Sept 06

- NICE responsible for the administration of the early stages of topic selection
- NICE's new extended role means that it is the principal point of contact for individuals and organisations who want to suggest topics
- NICE also responsible for performing an initial 'sifting' of suggestions
- Aims to ensure that NICE's stakeholders have clear opportunities to make an input into the selection of topics
- Help ensure that NICE's work programme addresses topics of importance to patients and professionals and makes the best use of NHS resources
- Integrate the selection of public health topics into the selection process
- Improve the timescale for referral of topics to NICE.

NHS
National Institute for
Health and Clinical Excellence

Helping reduce ineffective practice

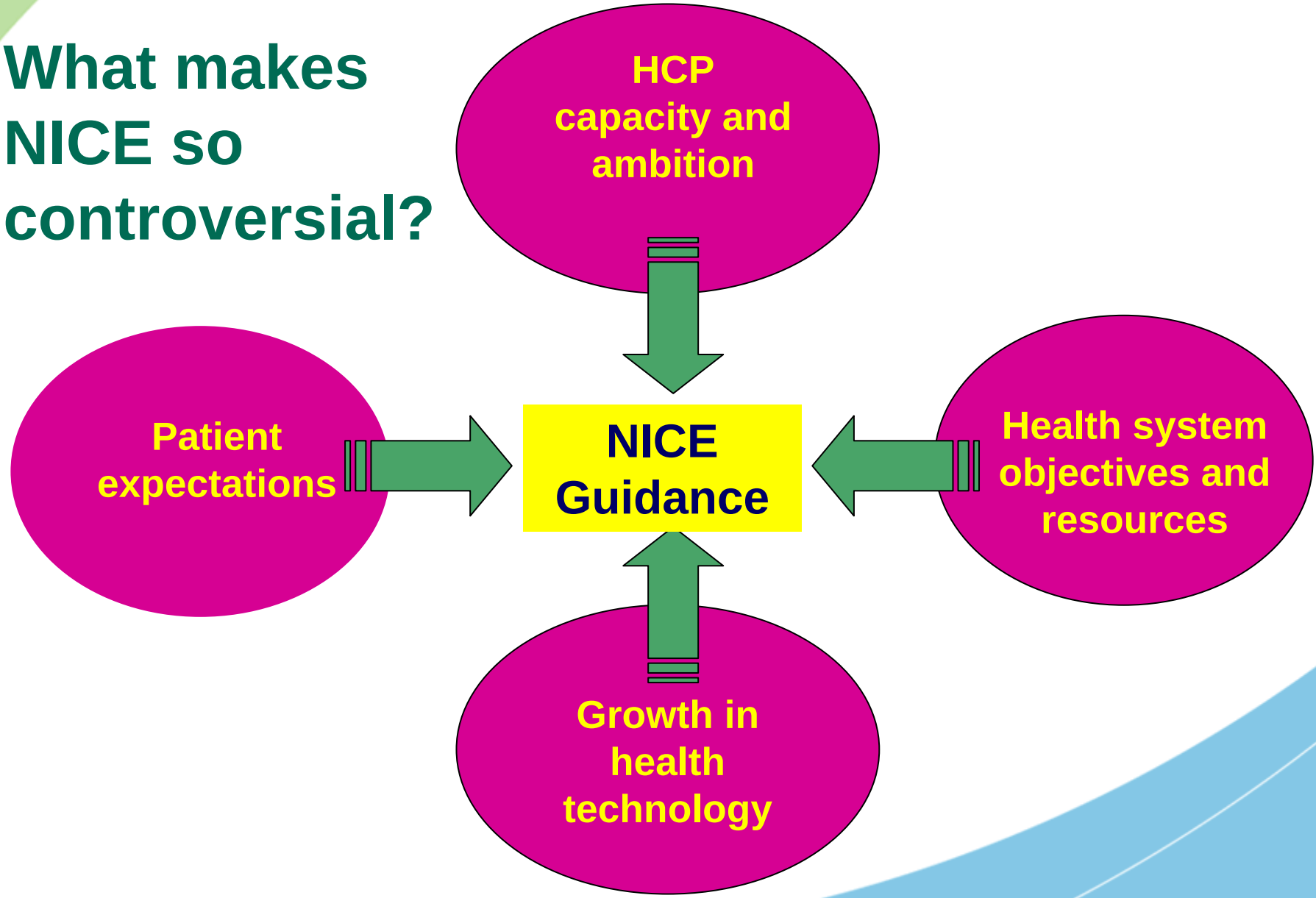
- New programme of work launched Sept 06
- A range of products to help the NHS make better use of its resources
- NICE will help the NHS to reduce spending on ineffective practice, that is, practice that does not improve patient care
- Reducing spending on ineffective practice will save money that the NHS can invest in drugs and approaches that do improve patient care
- Suggestions welcome using usual process.

NHS
National Institute for
Health and Clinical Excellence

Why is NICE so controversial?

NHS
National Institute for
Health and Clinical Excellence

What makes NICE so controversial?



NHS
National Institute for Health and Clinical Excellence

DYING – FOR THE SAKE OF £70 PER DAY

LUNG cancer victim Tony Harper has only weeks to live.

Victims of the IVF postcode lottery

Give us the sight-saver

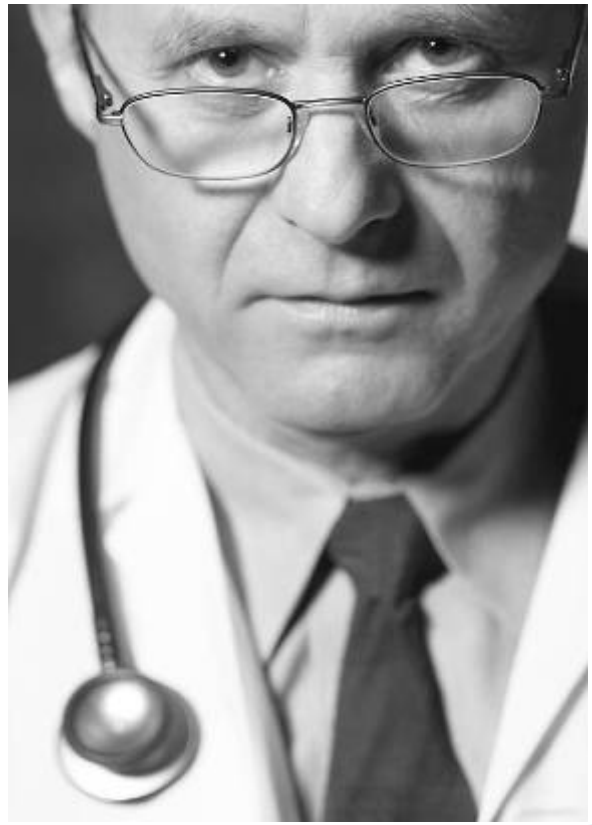
New drug that can prevent blindness 'is being denied'

By **Ben Quinn**

NHS
National Institute for
Health and Clinical Excellence

Not everyone agrees with us …

- Our recommendations are sometimes controversial …
- Differences between NICE and BHS guidance on hypertension
- Herceptin – timeliness of producing NICE guidance
- Alzheimer's disease – searching for the real responders.



NHS
National Institute for
Health and Clinical Excellence

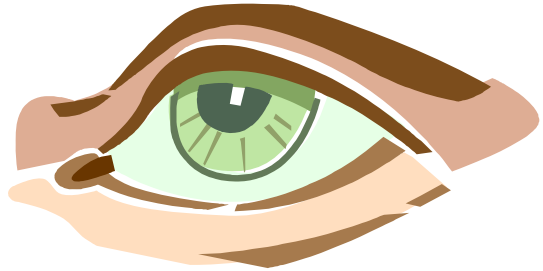
Can NICE ever be truly independent?

NHS
National Institute for
Health and Clinical Excellence

Assessing Cost Effectiveness – How do we do it

NHS
National Institute for
Health and Clinical Excellence

How do you compare the costs and benefits of two very different treatments?



National Institute for Health and Clinical Excellence

Assessing Cost Effectiveness

- How well does this course of action work compared to standard practice in the NHS

+

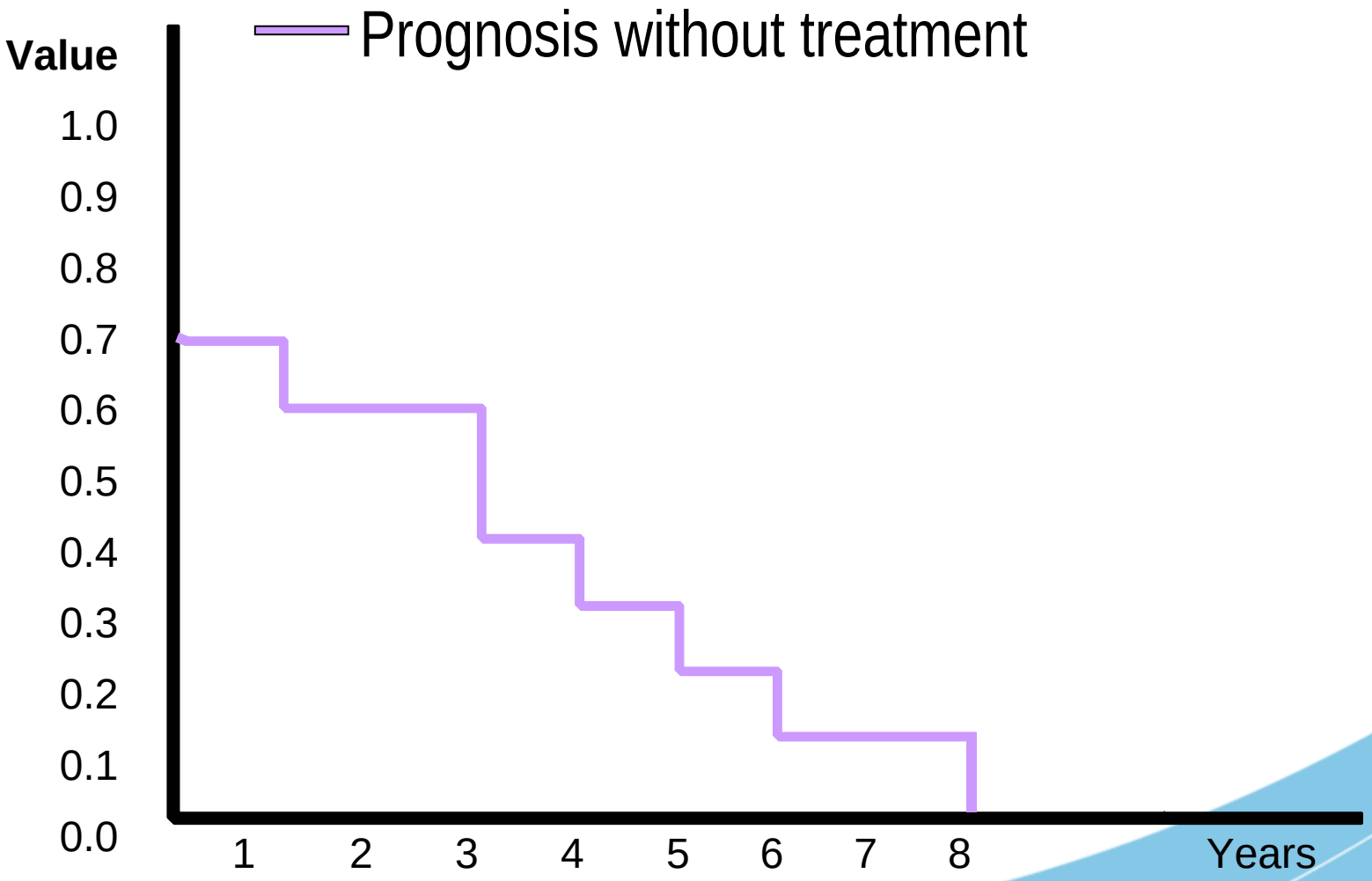
- How much does this course of action cost compared to standard practice in the NHS.

Quality adjusted life years (QALYS)

- simple concept:
  - Health care should improve the quality of your life and/or increased your life expectancy
  - Therefore an index which combined quality of life with life expectancy could be used to compare the benefit of all health care interventions.

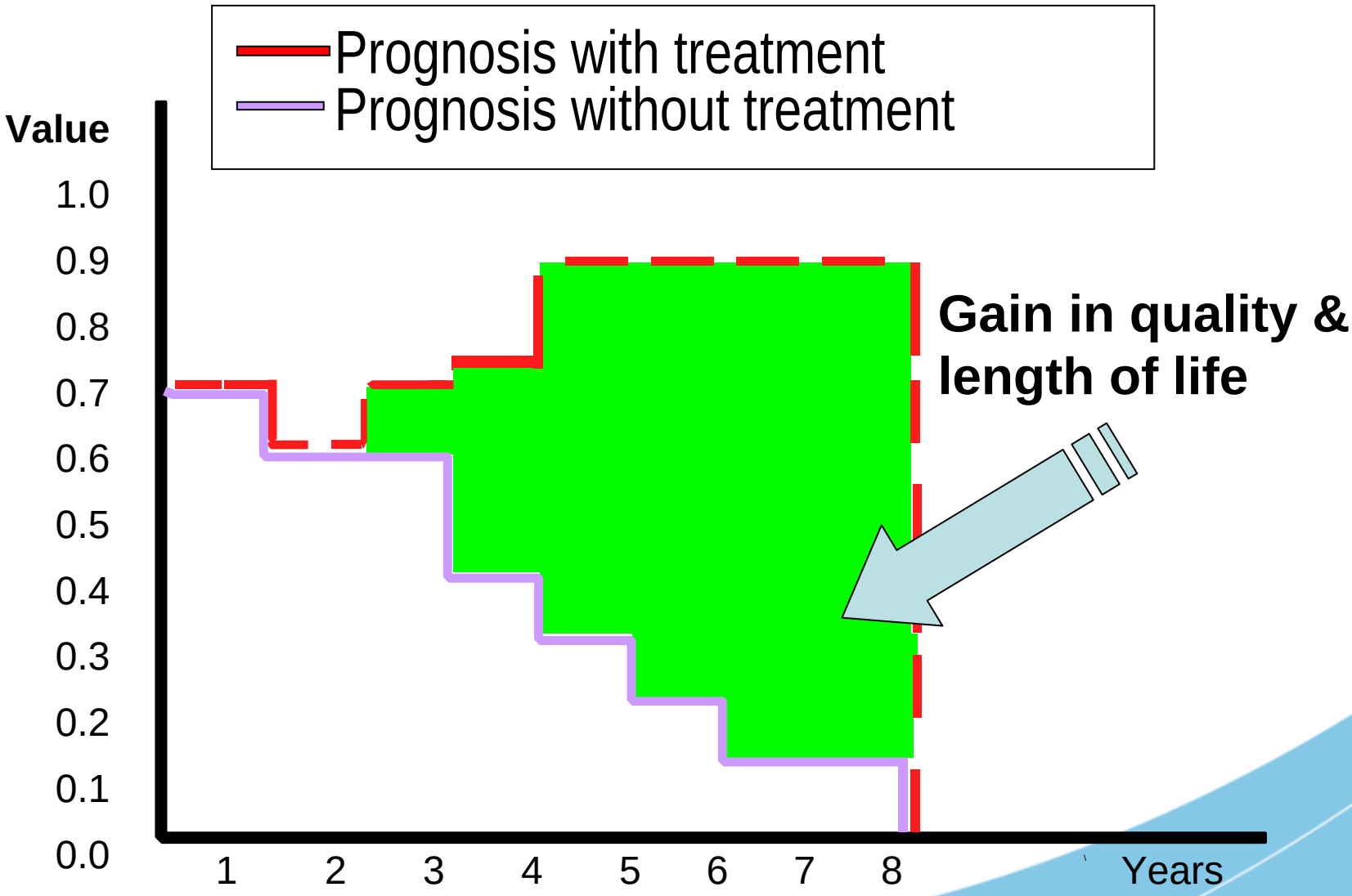
NHS
National Institute for
Health and Clinical Excellence

The QALY



NHS
National Institute for
Health and Clinical Excellence

The QALY



NHS
National Institute for
Health and Clinical Excellence

The incremental cost-effectiveness ratio (ICER)

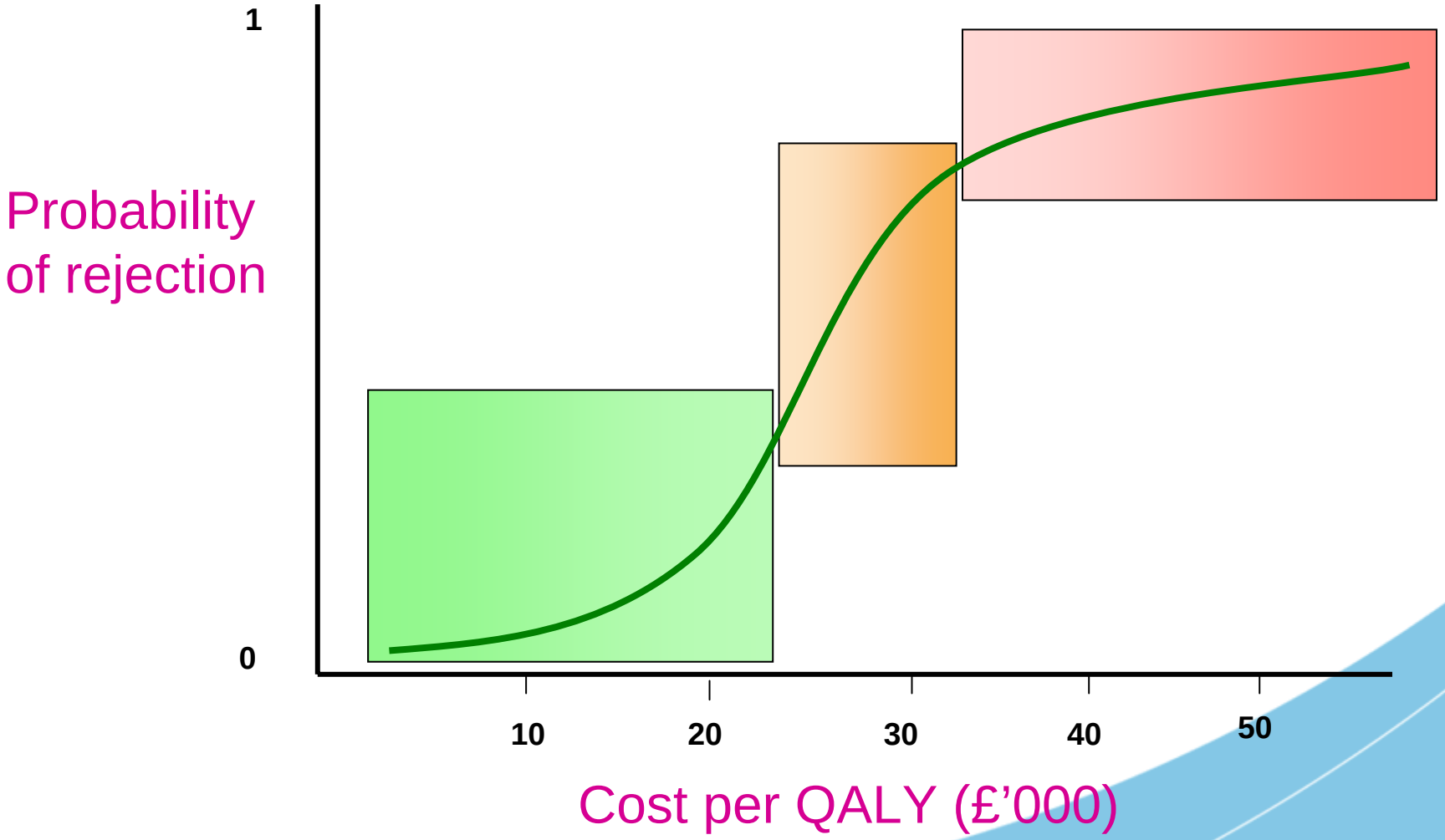
- The (main) statistic of interest
- Used to determine cost-effectiveness

  = $(Cost_B – Cost_A)$ / $(Effect_B – Effect_A)$

- Where A is the standard treatment and B is new treatment.
- Assume a new treatment cost £40,000 a year compared with an existing treatment of £10,000. The benefit of the new treatment is 4 quality adjusted life years rather than 2 years if they received the standard treatment
- **The ICER is £15,000 [(40,000 – 10,000) / (4 – 2)].**

National Institute for Health and Clinical Excellence

Assessing Cost Effectiveness



NHS
National Institute for
Health and Clinical Excellence

So is it worth it?

NHS
National Institute for
Health and Clinical Excellence

There are still many challenges…

- Explaining why, when we say no – eg alzheimers
- Implementation of NICE guidance – not as widespread as we would have like
- The process – producing guidance well takes time
- Topic selection – need to make sure we are referred the right topics.

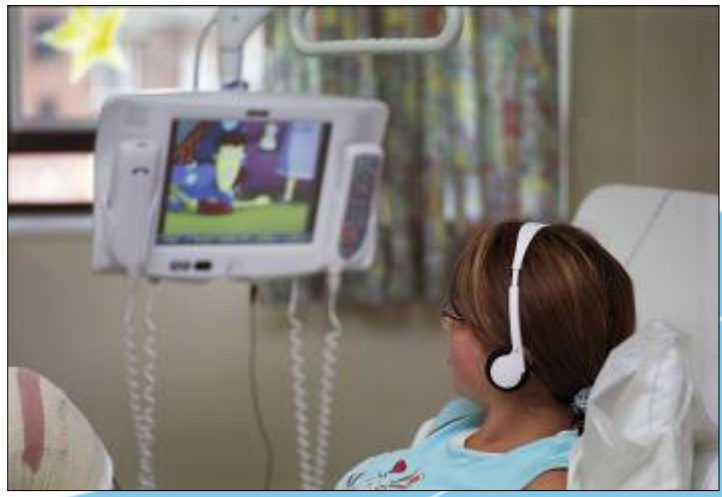
NHS
National Institute for
Health and Clinical Excellence

…but NICE is evolving to meet them

- Tools to support implementation – eg “How to” guide, slide sets and costing templates
- New faster Single Technology Appraisal process and guidelines processes
- Faster and more streamlined topic selection process and more involvement of NHS
- Working with Healthcare Commission to ensure implementation of NICE guidance is high on their agenda
- Addition of public health remit provides opportunities to broaden the reach and impact of NICE guidance beyond the NHS.

NHS
National Institute for
Health and Clinical Excellence

The patients …



NHS
National Institute for
Health and Clinical Excellence

The reviewers …

"In only four years, NICE has developed a well deserved reputation for innovation and methodological development that represent an important model for technology appraisal internationally"

WHO Review – Summer 2003

NHS
National Institute for
Health and Clinical Excellence

The feedback…

"I like NICE guidance. At night, down in A&E, it's a bit lonely and it's good to be able to say, when you need a scan for a head injury, 'it's recommended in the NICE guidance' It works!"

Liz, A&E Senior House Officer, St Thomas' Hospital, London

NHS
National Institute for
Health and Clinical Excellence

Getting Involved and finding out more

NHS
National Institute for
Health and Clinical Excellence

Ways to get involved

- Suggest topics for the NICE work programmes
- Submit evidence and research
- Respond to consultations (through a registered stakeholder)
- Nominate members of Guideline Development Groups
- Adapt NICE guidance for local use
- Implement recommendations in day to day practice
- Come and visit us or invite us to speak
- ***Most importantly – keep up to date …***

NHS
National Institute for
Health and Clinical Excellence

Where can you find out more?

- Sign up for the E-newsletter
- Log on to the website and register your details at www.nice.org.uk.
- Contact us – nice@nice.org.uk