



Health policy reading from 2018

Nigel Edwards

This is a selection of interesting material I came across in the health policy literature, news and podcasts in 2018 plus a few suggestions from people on Twitter.

Mortality

Trends in life expectancy are heading in the wrong direction in the USA and UK. In the USA CDC [reported](#):

- Life expectancy at birth decreased for the first time since 1993 by 0.2 years between 2014 and 2015, and then decreased another 0.1 years between 2015 and 2016.
- Between 2000 and 2016, death rates for five of the 12 leading causes of death increased: unintentional injuries, Alzheimer's disease, suicide, chronic liver disease, and septicaemia.
- The age-adjusted death rate for drug overdose in the U.S. increased 72 percent between 2006 and 2016 to 19.8 deaths per 100,000 population in 2016.

The ONS reported further slowing in the growth of [life expectancy in the UK](#) echoing concerns raised by Sir Michael Marmot and others. Veena Raleigh provides a good [summary](#) of the evidence and some international comparisons. She reports a widening gap between life expectancy and healthy life expectancy and that socio-economic inequalities in life expectancy are also widening in both sexes, as a result of greater gains in life expectancy in less deprived populations. Between 2011–13 and 2014–16, the difference in life expectancy

between the most and least deprived widened by 0.3 years among males and 0.4 years among females, and [life expectancy among the most deprived females fell over this period](#).

Unsurprisingly, there are significant [regional variations](#) and a worrying [north-south divide in deaths](#) from cardiovascular reasons, alcohol misuse and drug misuse. The authors suggest that this gap might be due to exacerbation of existing social and health inequalities and might suggest increasing psychological distress, despair, and risk taking among young and middle-aged adults, particularly outside of London. This echoed some of the controversy in 2017 when [Dorling](#) and others highlighted austerity as a culprit. The UK's record of this at a national level was the subject of [harsh criticism](#) of the government's treatment of the poor by the UN and has been a source of comment even in the [USA](#). Being poor is definitely a risk [factor](#). A fascinating article in [AJPH](#) highlighted to me by @EmilieCourtin suggests that despair is a US problem too and runs much deeper than the opioid crisis – including a failure of politics and political institutions.

In 2017 a drop in life expectancy in the 75+ group might be related to the growth in multi-morbidity which was definitely a key theme in 2018.

Perinatal and infant mortality

The problem of terrible outcomes in the USA for black woman and babies has been known about for a long time but has recently received a lot more attention. There is an excellent programme on the [BBC World Service](#) and reporting by Priska Neely who [has been writing about the rates of black infant mortality](#) for some time and is interviewed here on [The Gist podcast](#). Prematurity is the main culprit. They are not alone: there is a problem for [Latinas](#) too. Cash benefits can [help](#). The question is, why is there a high rate of prematurity? [Racism](#) and resulting long-term stress may be an important underlying factor – a fascinating finding is that while there is some link to premature birth and coming from west or central Africa the real problem seems to be being black in the USA. Newly arrived migrants seem to have fewer problems than their children and grandchildren, which suggests the problem is being in the USA rather than being from Africa.

But there is also a [problem in the UK](#) for woman of African/Caribbean origin as well. There are also high rates in the Pakistani/Bangladesh communities although congenital abnormality (related to consanguineous marriage) rather than prematurity is more likely to be the problem for this group.

As well as poor infant mortality, we also found more evidence that child health outcomes in the UK are not very good more generally. This was highlighted in a report [we published](#) in

March; in a very interesting and concerning [book](#) by Al Aynsley-Green; and in [this](#) study which looked at why child mortality is almost twice as high in England compared with Sweden. The latter found that ‘Policies ... could have most impact by reducing adverse birth characteristics through improving the health of women before and during pregnancy and reducing socioeconomic disadvantage.’ That child [poverty](#) is growing and services are [shrinking](#) are further causes for concern and are leading to [more use of healthcare as well as long-term problems](#). Russell Viner points out the long-term adverse consequences of this and the need to prioritise in the [BMJ](#).

Multi-morbidity

Multi-morbidity is at least as, if not more important than ageing as a driver of [demand for healthcare](#) and the major culprit in the failure of healthy life expectancy to grow. The Richmond Group’s view of the [issues can be found here](#).

Kingston and others used modelling to project ‘that between 2015 and 2035, multi-morbidity prevalence is estimated to increase, the proportion with 4+ diseases almost doubling (2015: 9.8%; 2035: 17.0%) and two-thirds of those with 4+ diseases will have mental ill-health (dementia, depression, cognitive impairment no dementia). Multi-morbidity prevalence in incoming cohorts aged 65–74 years will rise (2015: 45.7%; 2035: 52.8%). Life expectancy gains (men: 3.6 years, women: 2.9 years) will be spent mostly with 4+ diseases (men: 2.4 years, 65.9%; women: 2.5 years, 85.2%), resulting from increased prevalence of rather than longer survival with multi-morbidity.’ Thanks to @mancunianmedic for highlighting this. [Age and Aging](#) and the [Lancet](#) both have material covering this work. The results of Cassell and others study of the epidemiology of multi-morbidity in primary care is in the section on primary care.

The growth in multi-morbidity may partly be the result of increased survival – this seems to be an important driver of increased emergency admission. [Laudicella et al](#) found that the improvement in hospital survival rates that occurred between 2000 and 2009 explains 37.3 percent of the total increase in unplanned admissions observed over the same period. One extra patient surviving increases the expected number of subsequent admissions occurring within 1 year from discharge by 1.9 admissions.

Research by the Health Foundation [reported](#) that ‘one in three patients admitted to hospital in England as an emergency in 2015/16 had five or more health conditions, such as heart disease, stroke, type 2 diabetes, dehydration, hip fracture or dementia. This is up from one in ten in 2006/07.’ I suspect this is contaminated by the increased emphasis on coding and coding depth over this period but nevertheless broadly reflects reality.

The Health Foundation also [reported research that found](#) that people in deprived areas develop multiple conditions 10 years earlier than those in the least deprived areas. The Guy's and St Thomas' Charity's [analysis and narrative](#) tells the story of how people progress to having multiple conditions in an interesting and engaging way.

Integration: interventions to deal with multimorbidity

[David Oliver](#) proposes a manifesto for how the system needs to change to respond. The Lancet published the Sharing Evidence Routine for a Person-Centred Plan for Action ([SHERPA](#)) framework to guide clinicians in the management of multi-morbid patients allowing for the fact that individual guidelines do not work well for them. This is based on discussion between the clinicians and the patients, the development of a plan and an understanding of the patient's priorities.



Trisha Greenhalgh #PeoplesVote 
@trishgreenhalgh

Following 

My PhD student has found 175 different definitions of integrated care....

7:36 pm - 3 Jun 2018

At the Nuffield Trust we have done a lot of evaluations of various interventions to try and manage care through integrated models designed to reduce hospital use. In common with quite a lot of other research in this area the results are often mixed or negative, in a surprising way. We are holding a seminar on 27 March to investigate this.

A large cluster [RCT of the 3D approach to multi-morbidity management](#) found no difference between trial groups in the primary outcome of quality of life. One large study found that the introduction of [risk stratification in primary care](#) actually led to an increase in emergency admissions and use of other NHS services without evidence of benefits to patients or the NHS. The evaluation of the care home scheme in [Sutton](#) identified fewer benefits than expected. These are not uncommon findings.

On the other hand, some of the Vanguards, particularly those in care homes in [Rushcliffe](#), did better and there was a notable success of a GP based complex intervention in [Frome](#). There was a progressive reduction, by 7.9 cases per quarter in unplanned hospital admissions across the whole population of Frome during the study period from April 2013 to December 2017 – a decrease of 14%. At the same time, there was a 28.5% increase in admissions per quarter within Somerset. Patients were identified using broad criteria, including anyone giving cause for concern. Patient-centred goal setting and care planning combined with a compassionate community social approach was implemented broadly across the population of Frome.

Even in the USA ACOs have taken time to develop sophisticated approaches. Only a third have adopted approaches to reduce [low value care](#).

ICs and devolution

One common theme in many approaches is that there has been a lot of focus on governance and structures – a typical case is reported by the team evaluating [Salford's work](#) in this area. The [King's Fund's review of ICs](#) found it was still early days with progress being made in developing their capabilities to work as systems and work more collaboratively to manage finances and performance. They found some early signs of progress in delivering service changes, particularly in relation to strengthening primary care, developing integrated care teams and reviewing how specialist services are delivered. There were similar findings from [the very extensive evaluation of devolution experiment in Manchester](#):

Since the launch of devolution, much effort has been expended in establishing relationships, setting up governance arrangements, and producing and agreeing strategies and plans, and the focus has only more recently shifted toward implementation and changes that service users and the public would notice.

The GM Partnership has invested heavily in building relationships among those health and care organisations which make up its membership and developing shared governance arrangements and decision-making processes which are intended to promote and sustain a collective narrative of managed consensus. However, it is difficult to tell how secure those arrangements are and they have not yet really been severely stress tested.

Health in the wider community

2018 was the 10th anniversary of the WHO Tallinn Charter which made the connection between health and wealth a central policy concern. It also had the great tag line of [leaving no one behind](#). Unfortunately, I learned from Peter Smith's Office for Health Economics Annual Lecture, which contained material prepared for Tallinn, that the UK Treasury is unusual, if not unique, in not having the job of promoting social welfare as part of its mission. This explains a lot about the UK approach to public policy over the last 100 years. The whole [lecture](#) on the economic case for NHS investment is worth a look.

The work done in [Wigan](#) to [reshape the relationship between local government, other public services and the public](#) in response to huge cuts caught my eye. There is an interesting blog that pulls together ideas on ways to improve population health by [Dr Greg Fell DPH at Sheffield here](#) and a number by [Paul Corrigan here](#).

All of this is somewhat undermined by continued cuts to local authority spending on [public health](#) and the state of local government finances was commented on Richard Vize, who identified a serious problem with [government policy](#) in this area – as did [IFS](#).

Health Affairs carried interesting material [on how integrating health care with other services offers significant potential benefits](#). A second [paper](#) found that a 10 percent increase in non-hospital health spending was associated with a 0.006 percent decrease in all-cause mortality one year after the initial spending. This effect was larger and significant in countries with greater proportions of racial/ethnic minorities. Interesting but only to a country with a more forgiving approach to valuing future benefits.

2018 was also the 40th anniversary of the Alma-Ata Declaration, and there was some interesting discussion of [repositioning primary care](#) in promoting wider health and addressing social determinants – rather than the debates about networks and scale. This approach in [Oldham](#) and the one in Frome mentioned above seemed to capture the spirit of this.

Dave Buck at The King's Fund pointed out an article on how upgrading housing can reduce [hospital admission](#), although we don't know how cost effective this is. 2018 seemed to be the year where social prescribing got much more mainstream attention – like many of the ideas here, the speed of adoption is not very fast and there has been some suspicion that [politicians](#) have become interested just at the point where they [don't want to spend on mainstream services](#). There is also more to do to [develop](#) the [evidence base](#). Interestingly there was also this concern about the hazards of [medicalising loneliness](#).

Workforce

2018 was the year that the workforce got real attention at last. Strangely, given its importance, this is not an area where there tends to be a lot of good policy research.

While looking at skill mix does offer a lot of opportunities in a number of areas it is becoming increasingly clear that diluting nursing skill mix in inpatient settings is a bad idea. A [poster](#) in advance of publication found a link between specialist nurse assessment and reduced mortality. A large [NIHR study](#) finds that more registered nurses reduces the risk of death, adverse events and length of stay. This very much supports the findings of the [RN4Cast research](#) and while it's not from 2018 it is worth looking at the short blog on this [here](#).

“The contention of some leaders in health care that fewer highly skilled professional nurses in hospitals supported by lower skilled, lower waged workers is safe and cost effective is not supported by this study,” says lead author [Linda Aiken, PhD, RN](#), Director of Penn Nursing’s Center for Health Outcomes and Policy Research. “This research is consistent with a growing body of research showing that sufficient numbers of professional nurses providing direct care to hospitalized patients produces the best outcomes and avoids costly adverse care outcomes.”

Our work on [acute medicine in smaller and remote](#) hospitals has some useful pointers for rethinking some aspects of the medical workforce more generally and reinforces ideas in the [RCP Future Hospital Programme](#).

With the Health Foundation and The King’s Fund we published a [short report](#) detailing the scale of the problem, to be followed this year by one focused on solutions.

Other interesting articles in this area:

- [Jeffrey Braithwaite](#) on whether ‘acute care workplaces operating at slow speeds are associated with factors such as increased wait lists, poor performance and costly care; those that are too fast risk staff exhaustion, burnout, missed care and patient dissatisfaction. We hypothesise that hospitals are best positioned by being in the Goldilocks zone, the sweet spot of optimal pace.’
- Is burnout partly related to the inability of medicine to deal with deep social causes of the ill health that doctors see in their practice or the stress of working in a broken system? The idea of

[moral injury](#) is an interesting one in this context.

- Mayo Clinic launch a campaign against [burnout](#) which includes staff eating together – an evidence based intervention
- Time and motion for [A&E doctors](#) – mostly engaged in fact to face work
- A review of [pay for performance](#) at the individual clinician level. This goes beyond the usual explanations that relate to 1) structural obstacles outside the control of individual providers 2) problems with metrics 3) gaming 4) the crowding out of intrinsic motivation by extrinsic incentives. The article looks the theory of Pierre Bourdieu who laid out the theories of habitus (a system of dispositions shared by those of the same social group) and capital. These are used to explain why P4P schemes have tended to disappoint due to their failure to engage with social, symbolical and cultural capital created in doctors' roles and only focusing on the economic capital component.

Migration

The [Financial Times](#) had some good facts about migrants from the MAC – for as much as facts matter in this area:

Eastern European migrants have a higher employment rate than those born in Britain, while non-European Economic Area migrants had a lower employment rate. There is some evidence that higher rates of immigration from the EU depressed wages for the lowest paid and enhanced them for the most highly paid. For the lowest paid, EU migration is estimated to have reduced pay by 5 per cent in real terms between 1992 and 2017, but it raised pay by 3.5 per cent for those in the top tenth of the wage scale over the same period. But pay still increased dramatically for those born in the UK which compensated for this. European migrants paid substantially more in taxes than they took in benefits or public services in 2016-17. The report estimated that European migrants made a total contribution of £4.7bn to the public finances in 2016-17. All migrants — including those from outside the EU — who entered the UK in 2016 are likely to help lower UK public debt by £27bn over their lifetimes. The evidence on crime is more mixed as the young men are more likely to commit crime – people from Eastern Europe were more likely to commit theft but less likely to be convicted of violent or drug related crime.

The [Lancet Commission](#) on migration and health put the 40 people crossing the channel that required the Home Secretary to return from South Africa in some context. They report that “international migration has increased to 258 million, and the numbers of refugees and people displaced by conflict, natural disasters, and climate change are at their highest levels:

22 and 40 million, respectively. Despite negative political narratives, migration is not overwhelming high-income countries”.

AI and digital

Quite a lot of breathless prognostication on one hand – such as this review of the top applications in health in [HBR](#). On the other, some of the shine seems to have worn off IBM’s Watson with [concern about its recommendations](#), and there seems to be some suspicion that the [marketing has run ahead of the product](#) so that partners have been re-evaluating their involvement. Prediction in this sort of area is full of the opportunity for error and this article from [MIT](#) discussed a few of these including:

- Amara’s Law – we tend to overestimate the effect of a technology in the short run and underestimate the effect in the long run
- Arguments based on magical thinking
- The fact that much AI tends to be very narrow in its application and has no way to generalising this
- Loose application of the term ‘learning’
- Moore’s law doesn’t apply to everything or translate from processor to product.

Ben Bray wrote an interesting blog which reviewed some of his thinking about the application of AI in [radiology](#) which suggested a lot more than just interpreting images, this echoed by [HBR](#) who argue that AI will not replace radiologists. The RCGP issued a report on [AI in primary care](#) and the potential impact on GPs – initially mostly in administration but growing.

The [dark side of algorithms](#) received more attention – for example in the exclusion of people from [benefits](#), hidden [bias in recruitment and elsewhere](#).

[US research](#) found EHR implementation reduced hospital 30 day mortality but that there were often significant teething problems (including temporary increases in mortality) and others of the sort that led Atul Gawande to write on ‘why doctors hate their computers ‘in the [New Yorker](#). “I’ve come to feel that a system that promised to increase my mastery over my work has, instead, increased my work’s mastery over me.” He also looks at some possible future scenarios of how this plays out and is somewhat equivocal about whether some of the coming innovations will help. Health Affairs has a thoughtful article on this theme and looks at how AI might help with [physician burnout](#). They think seeing AI as a way to “augment”

physicians may be more realistic and broader reaching than ideas about replacing doctors and ‘with the right support from policy makers, physicians, patients, and the technology community’, they see opportunities for AI to be ‘a solution for—rather than a contributor to—burnout’. They also have a good review of the policy issues [here](#). This is their taxonomy:

While there are complex technical and methodological details that underlie specific AI applications, there are [three basic types](#) of AI solutions: simple task automation (Type 1), pattern recognition (Type 2), and contextual reasoning (Type 3). The maturity and proven impact of solutions ranges from those widely available and proven (Type 1), to those being piloted and nearing readiness for implementation (Type 2), to those being tested in “laboratory settings” and still likely more than 12 months away from wide-scale implementation (Type 3). All AI solution types can offer significant improvements across multiple use cases in health, including clinical support, population/public health, patient/consumer experience, and administrative/business processes.

Enrico Coiera (@EnricoCoiera), who writes insightfully on this topic, posted some [rules to help interpret AI papers](#).

Health apps seem to be useful for making organisational aspects of healthcare work better as in this example for [emergency care](#), this one for [outpatients](#). The evidence for impact on health from monitoring apps was more limited, as shown in this [systematic review](#). There was [some evidence](#) they might work when combined with insurance based incentives. There are some tricky regulatory [issues](#).

DHSC published their [strategy](#) ‘*The future of healthcare: our vision for digital, data and technology in health and care*’, which was well received.

I seem to have heard less of the Internet of Things in 2018. Perhaps because it is quite challenging to implement and incorporate into work processes. This interesting article from [Deloitte](#) gives some clues about what needs to be done and why it may be hard.

Primary care

The King's Fund's [report](#) on new models of primary care has a survey of new models (also in [BMJ](#)).

We and others had reports on continuity (see below).

The proportion of GP practices providing online consultations has doubled in the past 12 months, a [survey suggests](#), but [1/4 weekend GP appointments were not used](#). This perhaps is not so surprising given [this report](#) that showed patient experience of making appointments and satisfaction with opening hours were only modestly associated with overall experience. But [JSRM](#) reported research the UK compares quite well to other European countries on 7 day access to primary care. [RAND](#) found that direct to consumer primary care consultation will improve access but can evoke new demand and therefore may not save money.

Multi-morbidity in general practice is a significant issue. An [interesting study](#) by Cassell and others found 27.2% of the 404,000 patients in their study had multimorbidity. The most prevalent conditions were hypertension (18.2%), depression or anxiety (10.3%), and chronic pain (10.1%). The prevalence of multimorbidity was higher in females than males (30.0% versus 24.4% respectively) and among those with lower socioeconomic status (30.0% in the quintile with the greatest levels of deprivation versus 25.8% in that with the lowest). Physical–mental comorbidity constituted a much greater proportion of overall morbidity in both younger patients (18–44 years) and those patients with a lower socioeconomic status. Multimorbidity was strongly associated with health service utilisation. Patients with multimorbidity accounted for 52.9% of GP consultations, 78.7% of prescriptions, and 56.1% of hospital admissions.

There has been a big [increase in tests](#) ordered by GPs – patients in 2015/16 had on average five tests per year, compared with 1.5 in 2000/1. This is perhaps a good proxy for increased workload.

[Removing QoF points](#) was associated with an immediate decline in performance on quality measures. In part, this probably reflected changes in EMR documentation, but declines on measures involving laboratory testing suggest that incentive removal also changed the care delivered. This adds to Martin Roland's previous useful [synthesis](#).

[Ben Gowland](#) has an interesting series of podcasts on primary care that are worth a listen.

Continuity matters

In mental health, there was this study in [British Journal of Psychiatry](#):

Debate exists as to whether functional care, in which different psychiatrists are responsible for in- and out-patient care, leads to better in-patient treatment as compared with sectorised care, in which the same psychiatrist is responsible for care across settings. This is the first robust evidence that patient satisfaction with in-patient treatment is higher in sectorised care, whereas findings for length of stay are less conclusive. If patient satisfaction is seen as a key criterion, sectorised care seems preferable.

Continuity is also important in general practice where access has often been the policy priority. [Pereira Gray et al in BMJ Open](#) report the first systematic review of the area, which reveals that increased continuity of care by doctors is associated with lower mortality rates. Although all the evidence is observational, patients across cultural boundaries appear to benefit from continuity of care with both generalist and specialist doctors. Many of these articles called for continuity to be given a higher priority in healthcare planning. Despite substantial, successive, technical advances in medicine, interpersonal factors remain important. This is supported by work by colleagues at the [Nuffield Trust](#). The Health Foundation also published [analysis](#) that continuity with a known GP may reduce emergency admission for ambulatory care sensitive conditions.

This [report](#) suggested significantly improved outcomes from continuity in maternity care by midwives.

Management and organisation

Research [suggests](#) that NHS management is not a bureaucratic burden. Steve Black used the [Battle of Britain](#) to make the argument that well organised services and good management of resources rather than some of the myths of the NHS is the key to success. This echoes a number of points made in Dixon-Woods et al's excellent study of NHS [culture](#) back in 2013. A more [general study](#) by John van Reenan at MIT on the contribution of management to productivity found it does make a difference and the UK could improve.

[Research](#) (which many have questioned but confirms many people's suspicions) also suggested that management consultancy in the NHS can do more harm than good.

Bad news for the idea of replacing the CEO as the main strategy for organisational turnaround. A study by [Janke, Propper and Sadun](#) found that "...CEOs of large public hospitals such as those included in the NHS do not bring about changes in hospital performance, a result that stands in stark contrast with earlier findings relating to the private sector and to smaller public sector organizations." Warning – econometrics.

There is not enough study of organisational failure so this systematic review of qualitative studies that evaluated [organisational characteristics of healthcare organisations that were struggling](#) in terms of patient outcomes was a useful contribution. Five domains characterised struggling healthcare organisations: poor organisational culture (limited ownership, not collaborative, hierarchical, with disconnected leadership), inadequate infrastructure (limited quality improvement, staffing, information technology or resources), lack of a cohesive mission (mission conflicts with other missions, is externally motivated, poorly defined or promotes mediocrity), system shocks (ie, events such as leadership turnover, new electronic health record system or organisational scandals that detract from daily operations), and dysfunctional external relations with other hospitals, stakeholders, or governing bodies.

[This review](#) in HBR brings together recent evidence on financial incentives and nudges as methods for getting change in behaviour and points out that the link between culture and outcomes is increasingly clear – in particular citing Jeffrey Braithwaite's [systematic review](#). The extent to which there is a more egalitarian approach that creates psychological safety is an interesting factor in creating these cultures. There is a good overview of the area [here](#) referencing this study of culture and mortality in [BMJ Quality and Safety](#). Highly competent [boards](#) do create an environment in which staff have positive attitude about the handling and reporting of safety issues, but there is no direct effect on safety outcomes. This [article](#) by Huw Davies and Russell Mannion has an overview of the idea of culture in healthcare more generally.

There was a lot of interest in [complexity](#) theory as an approach and in terms of its implications for [system](#) change and [improvement](#): 'we might adopt a new mental model that appreciates the complexity of care systems and understands that change is always unpredictable, hard won, and takes time, it is often tortuous, and always needs to be tailored to the setting.' This was also appearing in discussions of [public management more generally](#). And in this interesting [article](#) suggested by @mellojonny the argument is that inequalities need to be understood through a more complex lens than the usual more dominant discourses.

Finally, in this [international review](#), Greer and others look at the experience of strategic commissioning in Europe. They found that “strategic” has definitional characteristics that are difficult to attain, none of the ten health care systems purchased strategically by any definition.

Hospitals

[The WSJ](#) wrote on the future of hospitals, with similar messages from Ezekiel Emmanuel in [NYT](#), Eric [Topol](#) and [Robert Pearl](#). Some of this is similar to things I was reading 30 years ago.

Mergers may create [economies of scale](#) but these may disappear below 200 beds and above 600 – using DEA methodology. A study of mergers in [Denmark](#) found some mergers do not seem to lower costs. This finding indicates that some merged hospitals become too large and therefore experience diseconomies of scale. Other mergers lead to considerable cost reductions; they found potential gains resulting from learning better practices and the exploitation of economies of scope.

Outpatients – I have been saying for some time this area deserved more attention. The RCP published a good [report](#) on new models which echoed themes in our workshop [report](#). Interesting [research](#) on implementing video consultations in outpatients found them to be safe and slightly shorter than conventional consultations. They are, however, relatively complex to build into practice. BMJ are also critical of the current [model](#) as was [David Oliver](#).

Closing A&Es did not affect population level outcomes – see this [interrupted time series study](#).

Mary Dixon-Woods highlighted a [systematic review](#) on reducing adverse events in hospitals. This found that the evidence for patient-safety interventions implemented in hospitals worldwide is weak. Interventions to prevent delirium, cardiopulmonary arrest and mortality, adverse drug events, infections and falls are most effective and should therefore be prioritised. The [Grattan](#) Institute showed that safer care would have money and that the accreditation system in Australia has failed.

[Post ICU syndrome](#) – not often discussed. Here is Daniel Freeman’s [Radio 4 show](#) about it. Previous research on post-hospital syndrome also reached the mainstream in this [NYT](#) article referencing [this](#), the latest in a number of articles on this in the last few years. This might also help to explain why US [policies to prevent readmission can cause harm](#), particularly for patients with heart failure and pneumonia (but not for AMI).

Do private hospitals outperform public hospitals in efficiency, accessibility, and quality of care in the European Union? [A literature review](#) suggests it's hard to tell, but probably not.

Economics of palliative care: a [meta-analysis](#) of US data by @PaCE_TCD shows hospital palliative care changes patterns of care for those with the highest illness burden in a positive way. But in a thoughtful [blog](#) by Ashish Jha points out that end-of-life spending often gets confused with spending money on people who are sick because some of them ultimately die and that some caution is required on our thinking on this issue.

Mental health

This is not an area I monitor greatly, but a few things caught my eye. The BBC had a good feature – [10 charts about the scale of the mental health problem](#). There is a good short read on the 2017 Green Paper on children and young people [here](#). ‘The green paper sets out actions that will be put in place across the education sector to strengthen the focus on children and young people’s mental health.’

This interesting [blog](#) summarised key evidence on prevention in mental health, referencing a study in [Lancet Psychiatry](#) on this topic.

Innovation

There is a long standing concern about how to get better spread of innovation and there have been several government and independent reviews, including this by [David Albury](#), [this](#) from The King’s Fund, and our own [report](#). The latter led me to this [comparative study](#) of innovation in eight countries which describes the front-line cultural dynamics that must be fostered to achieve cost-effective and high-impact transformation of health care. It argues for more focus on vital, yet currently underused, organizational action to support the adoption of innovation.

Nesta published a report called the [Biomedical Bubble](#) – this argued that ‘continuing to prioritise the biomedical, in a period when government aims to boost research and development spending to 2.4% of GDP, risks unbalancing our innovation system, and is unlikely to deliver the economic benefits or improvements to health outcomes that society expects.’ This is partly due to the slowdown in R&D productivity. They argue that ‘greater emphasis needs to be given to the social, environmental, digital and behavioural determinants of health, and decisions about research priorities need to involve a greater diversity of perspectives, drawn from across the country.’

There is also interest in frugal (reverse) innovation in which developments in low- and middle-income countries are deployed in high-income settings – see The Commonwealth Fund case [studies](#) and Matthew Harris on this in [JSRM](#).

Miscellaneous

- [A year of reverses in commonly held beliefs in medical treatment – science still works though](#)
Interesting blog by Derek Lowe.
- Long-term funding projections for health and social care by [IFS](#). Very good [Radio 4 programme](#) on fairness and social care by Paul Johnson of IFS
- Dr Partha Kar nominated our [report](#) with the King's Fund and Health Foundation comparing the NHS to other health systems. There is another good overview of international comparisons [here](#).
- Tim Harford's [guide](#) to using stats and FullFact on [how to spot a dodgy image](#).
- Public sector performance tracker from the [Institute for Government](#)
- The [poor state of regulation](#) of medical devices and implants around the world and their potential for harm should have perhaps got more attention than it did.
- NHS history in [charts](#)
- Lessons from [Germany's social care system](#)
- Robotic surgery – not much [better](#)
- Task errors by emergency physicians are associated with interruptions, multitasking, fatigue and working memory capacity: a prospective, [direct observation study](#)
- Interesting [overview](#) on the question of whether prevention actually saves money
- PFI costs more - [BMJ](#) – no more [PFI or PF2](#)
- [Cardiac mortality falls](#) when US cardiologists go to their big annual conference
- Has 111 been a [success](#) – up to a point
- Theresa May and [Windrush](#) and the [Go Home](#) van
- Alan Maynard [RIP](#)
- [Cheese played a surprisingly important role in human evolution](#)
- Civilisation on the brink of [collapse](#)

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