How to keep beds free

Helping people with chronic diseases to manage their condition keeps them healthy and out of hospital. **Paul Robinson** reports

There is a long-held conviction among policy makers that people with long-term conditions are the most intensive users of the most expensive healthcare services. The Department of Health estimates that the treatment and care of those with long-term conditions accounts for 69% of total health and social care expenditure in England – the equivalent of almost £7 of every £10 spent.

Making sure that people with diseases such as chronic obstructive pulmonary disease (COPD) and heart disease do not have repeated emergency admissions to hospital is therefore central to government health policy. Since 2004, ministers have embarked on a series of initiatives to shift treatment and care away from expensive emergency hospital services (secondary care) by encouraging GPs, community matrons and nurses, and other health and social care staff to play a greater role in managing people who live with these chronic diseases.

The thinking is straightforward enough. If you can identify people who either have, or are at risk of developing, these diseases, then with the right support you can help them to manage their condition. This means telling them about the warning signs that indicate their condition is worsening and giving them the appropriate treatment away from a hospital bed.

But has the policy had any impact? It looks as if it may have done. At CHKS, an independent healthcare information provider, we have carried out research revealing a marked reduction in hospital admissions for two long-term conditions, COPD and chest pain (an indicator of heart disease), between January 2003 and December 2005.

We adopted a tightly defined category for our study: anyone who had four or more admissions within two years of their first – hence the 2005 cut-off for the data. We analysed all emergency hospital admissions in England against a list of 49 conditions identified by the NHS Institute for Innovation and Improvement as those for which primary care professionals could have an impact. By numbers of first admissions, the top four of the 49 conditions were chest pain, COPD, acute abdominal pain not requiring intervention, and deliberate self-harm (mainly drug overdoses).

Taking these four conditions, the findings of our research suggest that the policy made a significant impact on COPD and heart disease: the number of first admissions for COPD fell 43% over the period and the number for chest pain fell 27%.

The effect was less pronounced for the other two conditions. The reduction in first admissions for acute abdominal pain was 6% and that for deliberate self-harm was 8%. However, this all needs to be seen in the context of an overall 12% rise in emergency admissions in England between 2003 and 2005.

To get some idea of how much the NHS may save by reducing admissions in this way, we used the NHS tariff – the agreed, service-wide list of prices for treatment. We established that the total cost of admissions for the patients we studied (those having four admissions within two years) was £148.6m for those with COPD and £97.4m for those with chest pain.

On this basis, the reduction we traced in admissions for people with COPD saved the NHS £30.2m between 2003 and 2005. The cost-saving for chest pain admissions was £12m, making the total saving £42.2m over three years (although chest pain accounted for more first admissions than COPD, there were more total admissions for COPD and they were more expensive).

While these figures may appear small relative to overall NHS spending, and indeed relative to spending on long-term conditions, it should be emphasised that the study was drawn very tightly and that the estimated savings are therefore extremely conservative.

Questions remain about the impact of greater primary care involvement in other areas

Further research by CHKS on overall admissions for people with COPD in England, Wales and Northern Ireland indicates a continuing downward trend: there was an 8% fall in admissions in England between 2005 and 2007 and a 4% drop in for Wales and Northern Ireland.

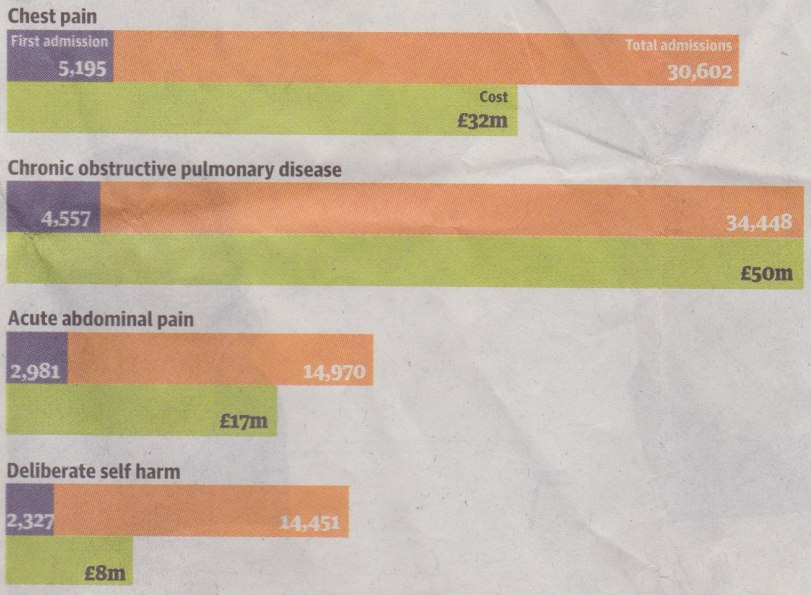
Identifying the impact of elements of policy on emergency admissions is a complex area. Previous research we have done has identified that the implementation of the A&E four-hour target (no patient should spend more than four hours in A&E, and if they need more time for treatment or observation they have to be admitted) has been a factor in the trend of rising admissions. Comparison with the other countries in the UK show that there has been no increase across Scotland and Northern Ireland for the past five years. "Payment by results" has given a strong financial imperative to the English NHS to find ways to reduce the number of admissions and rebalance spending across the system.

So the findings are good news for the government, as it gives the first indication of a countrywide impact for the policy shift, but questions remain about the impact of greater primary care involvement in other areas that have been identified as having some potential. Our findings for acute abdominal pain and deliberate self-harm were less encouraging – though still positive – and there are 45 other conditions outside our analysis.

Paul Robinson is head of market intelligence at benchmarking consultants CHKS

Top four long-term conditions

Admissions and cost, annual average



Multiple hospital admissions by condition

Patients with four admissions within two years of the first, England