MAPPING THE INCENTIVES FOR PCTs

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The alternative scenarios

- Fuller use of all UK capacity private and public.
- Shifting of cases within NHS and from private to public.

Outlook for PCTs

- Little real growth after generic cost increases.
- Pressure from local acute providers.
- Unfunded forward commitments.
- Welcome for DTCs as a free good – *but what happens as they become a substantial programme?*

Number of NHS Day Cases

	1996/7	2000/1	% of all FCEs.
Acute Surgical	1,899	1,848	42
Ophthalmology	207	339	68
Urology	272	338	57
Trauma & Orthopaedics	178	212	26

Audit Commission

- Concealed in-house capacity.
- 120,000 places.

In addition, many day places used for minor procedures that could be shifted into primary care

New GP Contract

Already shift of 600,000 procedure

Key variables : DEMAND

- Shift from self-pay in private sector. 50,000+
- Rise in referral rates
- Wanless : Procedure rates could double to match best International practice

Number of operations 2001/2

		& over 75
Hip replacement	30,674	34
Knee replacement	29,099	36

Pressures on staffing resources

- Competition for experienced staff.
- Pressure on costs.
- Realism and engineering.

PCTs have limited funding

- Unlikely to fund beyond waiting list targets.
- Impact of national tariffs / money following the patient.
- Concerns about responsibility / care pathways.

Making a success of DTCs

- Concerns about over-expansion.
- Need for co-operation with DGHs – shared information base.

Battering Ram or Lever ?

- DTCs need to build partnerships with GPs & local hospitals.
- Rethinking of DGH concept.