ERS
ENTIDADE REGULADORA DA SAÚDE

THE PORTUGUESE HEALTH REGULATION AUTHORITY

Title: The performance of NHS Local Health Units (ULS)

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Executive summary

The Portuguese Health Regulation Authority (ERS), in fulfilling the request of the Ministry of Health, conducted a study in which the performance of NHS Local Health Units (ULS) is assessed in terms of access to healthcare, service quality, production efficiency and economic and financial performance.

The first part of the study provides a description of the historical and legislative background that led to the creation of ULS within the Portuguese National Health Service (SNS), as organizations that integrate primary health care and hospital care. The process of vertical integration was initiated with the creation of ULS Matosinhos in 1999 and only almost a decade later, in 2007, continued with the creation of ULS Norte Alentejano. The following year saw the birth of ULS Alto Minho, ULS Baixo Alentejo and ULS Guarda, and in 2009 the sixth ULS was created in Castelo Branco; two years later ULS Nordeste was born and finally, in 2012, ULS Litoral Alentejano was created. Thus, presently there are eight ULS functioning.

Along the years, some aspects arising from the concrete functioning model of ULS have been under the regulatory intervention of ERS, aimed at issues related to the timely provision of diagnostic tests, specialty consultations and surgeries.

In this study, access to care provided by ULS is analysed on a geographical axis, which comprises the dimensions of proximity and capacity, and also a temporal axis. The dimension of proximity considers the adequacy of the geographic distribution of establishments to the distribution of the population in terms of distance or travel time. A comparative approach reveals that the degree of proximity to the network of primary

points of provision is similar in areas of ULS and not ULS; in both cases the percentage of the population that resides within 15 minutes of travel time to a point of provision is above 90%. The dimension of capacity assesses the coverage of service networks in terms of volume of resources in hospital and primary care. In hospital care, according to ratios of doctors and nurses to population, it appears that areas covered by ULS exhibit a concentration of health professionals a lower than in areas not covered by ULS. In primary health care the situation is reversed, with ULS revealing an allocation of health professionals in relation to population above areas not covered by ULS.

From a temporal perspective, we analysed indicators such as the average waiting time for surgery and the percentage of surgeries performed beyond maximum waiting times set in the legislation. On average, there are no significant differences between hospitals integrated and not integrated in ULS. Nonetheless, in both cases the percentage of surgeries performed beyond maximum waiting times has been increasing over the years.

In the section dedicated to quality, we analysed the results of hospitals enrolled in the National System of Health Quality Assessment (SINAS) of ERS, under four dimensions of quality of care, namely “Clinical Excellence”, “Patient Safety”, “Comfort and Adequacy of Facilities” and “Patient Focus”. The results published in December 2014 evidence that significant differences between ULS and non-ULS hospitals can only be found in the dimension of “Patient Safety”, with the latter exhibiting, on average, better results. In the other quality dimensions the differences are not statistically significant.

Given the role of ERS in handling health care users’ complaints, an additional analysis focused the main constraints reported in such complaints, with a comparative view of ULS and non-ULS providers. Such analysis shows that the main concerns of users are similar in ULS and not ULS, with the exception of “waiting times longer than an hour”, which between 2006 and 2014 was the fourth most targeted theme in complaints from users of ULS, but ranked has unimportant in non-ULS.

The productive efficiency of ULS, at the level of primary health care and hospital care, is also compared to the performance of non-ULS providers. In terms of skill-mix in primary care providers, ULS favours a greater number of nurses per doctor than in areas not covered by ULS, in the same region, with the exception of ULS Alto Minho, Matosinhos and Guarda. In hospital care, the analysis of the ratio of ambulatory surgeries to total surgeries performed by establishments, between 2010 and 2013,

reveals a growth trend in both groups of hospitals, although non-ULS hospitals have an average ratio of ambulatory surgery systematically above ULS hospitals.

Also as part of the productive efficiency analysis, the average length of stay (ALOS) in hospitals was compared. On average, ALOS is higher in ULS hospitals, having increased in such hospitals between 2011 and 2013 faster than in non-ULS hospitals. An econometric procedure that examines length of stay taking into account the ULS and non-ULS status of hospitals together with patient characteristics and nature of the inpatient episode, does not alter the conclusion that ULS have longer stays.

In turn, the efficiency of network operation between primary and hospital care was studied with the incidence of hospitalizations for ambulatory care sensitive conditions (ACSC), which are interpreted as avoidable hospitalizations. The analysis of the proportion of ACSC hospitalizations in total admissions reveals that with the exception of ULS Alentejo, avoidable hospitalizations are more frequent in ULS than in non-ULS hospitals of the same region. This suggests that eventual gains in terms of coordination between primary and hospital care allowed by the creation of ULS are not driving a reduction in avoidable hospitalizations.

Finally, economic and financial performance was analysed with the indicator of average Days Payable Outstanding, concluding that delays are large both in ULS and non-ULS hospitals, despite measures announced by the Government to eliminate NHS arrears.