

FROM FEAST TO FAMINE

Reforming the NHS for an age of austerity

by David Furness and Barney Gough

The SMF Health Project Final Report

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EXECUTIVE SUMMARY

Britain is in the midst of a severe economic recession which has ripped a deep hole in the public finances. A significant and sustained public spending squeeze is inevitable and will hit the NHS hard. Even if the NHS budget is maintained in real terms over the next decade, rising workforce costs will mean that frontline services will feel the pinch. Meanwhile, demographic changes over the next ten years will see an ageing population stretch the services the NHS provides as never before.

This presents a massive challenge to health policymakers and begs the question that underpins this report: how best can a quality health service be maintained over the next decade in the context of a severe funding squeeze?

The task facing the health service in England is huge. Failure to achieve greater efficiency and productivity may mean that the entire post-war settlement of healthcare funding and provision will be undone. To maintain support for the current system, the public must be convinced that what is offered by state services is of a high quality. And healthcare providers face a stiff task in achieving continuing quality improvements at a time of rising government debt, rising taxes and falling investment in public services.

Confronted with the dual dilemma of reduced funding and increased demand, it may be tempting to look to the experience of other countries and suggest that the NHS should be overhauled and rebuilt as a system of social insurance, based on the perception that such systems deliver better performance and increased efficiency. But however appealing this may seem it is neither plausible nor sensible. First, there is little evidence that social health insurance performs much better than tax-funded systems. Indeed, many European countries, including France and Germany, spend a greater proportion of their GDP on healthcare than the UK does. Second,

attempting such a transformation would be an enormous policy gamble. While some systems have moved from an insurance-based model to one that is predominantly tax-funded, there has never been an example of a change in the opposite direction.¹

Introducing a system of social insurance would require a total structural overhaul, which must be avoided. Structural upheaval has characterised healthcare reform in England over the last ten years and more of the same is not the way to a stable, efficient and quality service. Instead, the task of achieving good value for money and equipping the health system to deal with the substantial challenges it faces must be met without throwing out the structures that already exist.

So, with large scale structural change ruled out, what options remain to safeguard quality provision within the NHS in the next decade? Two strategies will be key to success: improving efficiency and introducing a mechanism to constrain the inexorable growth in demand.

A local health service

If the necessary efficiency savings and cuts in services are to be achieved then power must be devolved away from central government to local commissioners. Difficult decisions about healthcare services must be removed from the national level if rational decisions are to be made and explained to service users and understood and accepted by them. Without such depoliticisation, populist demands risk skewing the priorities of the NHS. Responsibility for decommissioning services must therefore be placed in the hands of local commissioners, who will be able to allocate resources with the best possible knowledge of local needs, and make the case for change to people at a local level. But for this

1 D. G. Green et al., "For and Against: Social Insurance – The Right Way Forward for Health Care in the United Kingdom?" *British Medical Journal (International Edition)* 325:7362 (2002).

to succeed, accountability structures in the health system will have to change to reflect this shift in responsibility and power. Local people must be able to hold commissioners to account if primary care trusts (PCTs) are to have sufficient legitimacy to make tough decisions that will be necessary over the next decade.

Granting autonomy to local commissioners will also improve the efficiency and quality of services by stimulating innovation in service delivery and allowing appropriate local services to develop. Additionally, inappropriate utilisation of healthcare can be reduced through high quality commissioning that can help to manage referrals from primary care, thus reducing overall demand. Local choice and local variation must become the guiding principles of the health system, with central government playing a significantly reduced role, primarily guaranteeing standards and patients' rights.

Allocating scarce resources

But empowering local commissioners to improve the use of existing resources alone will not be enough to secure the future of the NHS over the next ten years. One option is to introduce additional charges in an attempt to raise extra revenue for the health service. However, revenue raising charges soon run into serious ethical problems, due to the fact that to raise money charges have to either impact on the poor and the long-term ill, or have to be set at a very high level; neither of which is a satisfactory situation.

It is clear, therefore, that charging to raise money is not a plausible option. But what is also clear is that with the spending tap closed, rationing of some sort is unavoidable. This fact must be confronted head-on in a strategic manner otherwise rationing by the backdoor will undermine the NHS. If nothing is done about the need to ration healthcare in some way, then we will see a return to the days of rationing by waiting list, crumbling infrastructure and a poor quality service. Such a route cannot be countenanced as it would ultimately destroy the NHS with higher income members of

society opting to pay for private treatment instead of being treated by the NHS. This would weaken support for a universal, tax funded system, leaving behind a poor quality health service for those who cannot afford to pay their way out.

The question, then, must be how to ration while safeguarding key principles of equity and universalism, and maintaining a high quality service. What is needed is a mechanism to encourage people to ration themselves: a limited demand management tool that is consistent with protecting the quality of the NHS and ensuring continued middle-class buy in. Introducing limited charges for those who can afford to pay, solely as a demand management tool, is the most likely route to achieve this goal. Any form of charging is unpalatable, but if designed correctly, with a fairly low charge and a total exemption for those who cannot afford to pay, charges are the progressive option which will help to safeguard the NHS for everyone.

To deal with the challenge described above, this report sets out a number of recommendations that are detailed below.

RECOMMENDATIONS

EQUITY (CHAPTER 2)

Perhaps the most important criteria that healthcare systems must fulfil is that they are fair. Equity in the NHS should be about providing equal access for equal need in health services.

Recommendation 1: Central to the concept of equity in the NHS should be a definition of equal access to equal need.

This will mean that health inequalities no longer form part of the resource allocation formula applied by the NHS, with the

focus shifting instead to providing equal access to treatment for equal need.

Health inequalities are so important that rather than being the responsibility of the NHS, they should be overseen by the whole of government. Government action to deal with health inequalities should be joined up, with the NHS only one part of a wider agenda.

Recommendation 2: A Cabinet Office minister for Health Inequalities should be introduced with responsibility for co-ordinating action across government to narrow the gap in health within the population.

Equity is an essential principle for health services but there are many different definitions of equity that support a range of different types of health service. There is a need for a defined set of NHS values that reflect a new understanding of the role and capacity of health services. The NHS values must reflect a realistic assessment of the need to maintain universal access in a time of scarcity, with an open acknowledgement that wealthier people may need to pay more for services if they can afford it. Furthermore, these values should reflect the local priorities that will be necessary if the NHS is to manage public expectations and maintain public support for a tax-funded health system.

Recommendation 3:

An NHS set of values should include:

- **Universal access:** no-one is excluded from necessary treatment because of their ability to pay, but some people contribute if they can afford to.

- **A comprehensive range of services:** the NHS will provide a comprehensive range of services that offer good value for money.
- **Equal access to treatment:** the NHS will make sure that everyone has equal access to treatment regardless of age, gender, income or ethnic background.
- **Local services for local need:** the NHS will provide a range of services appropriate for different local areas. PCTs will work with local people to decide what is needed, and to justify the difference between different areas.

FUNDING (CHAPTER 3)

The cost of healthcare in the developed world has increased tremendously in recent times, and questions about how best to fund healthcare is an unending source of controversy. There is almost no chance that the health system as it is currently designed will be able to maintain or improve standards of care with the severe resource constraints that will be in place for the foreseeable future. However, it is crucial that any alterations to the system of funding maintain the central principle of fairness.

It is clear that in our society there is a general willingness to spend money on good health. Spending on alternative medicine and general health and fitness products in the United Kingdom is high and is increasing. This does not mean, however, that it is possible to translate private spending on health into extra revenue for the NHS. In fact, often patients choose to spend money on alternative medicine precisely because it is not part of the conventional health system.

Despite this there are some important lessons for the future of the NHS. Many diverse groups choose complementary and alternative medicine because it offers a ‘whole person’ service – something not always found in conventional healthcare settings. This insight offers PCTs the potential to raise satisfaction rates with local healthcare services by encouraging a clinical approach that recognises the importance of treating the whole person, not simply managing an illness.

Recommendation 4: The desire to access ‘holistic’ medical services indicates that PCTs could improve satisfaction rates by offering patients a greater array of support services to help manage the whole of their health, not just their illness.

Recommendation 5: GP led health centres should be promoted as ‘wellness centres’ to engage individuals who particularly value a holistic service, and counter concerns that they will lead to a more impersonal form of medical treatment.

Private spending on healthcare also shows that individuals value their health and are willing to make a financial commitment to maintaining it.

Recommendation 6: Many individuals are willing to prioritise their health in financial terms. Local and national decision-makers in healthcare must engage people in a realistic discussion about adequate levels of resources in health services.



The future of “top-up” payments

The newly changed rules on the use of ‘top-ups’ in the NHS, following a review by Professor Mike Richards, mean that patients can now purchase privately drugs not available on the NHS and, if they are administered privately, continue to receive publicly funded treatment.

As such, it seems likely that the next decade will see a thriving market in insurance based products that offer supplements to NHS care. These will complement existing private medical insurance products that offer an alternative to the NHS for some treatments.

The rise of such insurance products should not, however, pave the way for the introduction of a social insurance system of healthcare in this country. There is simply no evidence that a shift to social insurance would be a desirable move.

Recommendation 7: The NHS should continue to be funded primarily from general taxation. A move to a system of social insurance should not be considered by policymakers over the next decade.

Private payments

There are a range of private payment mechanisms that stop short of social or private insurance models but which if introduced might contain costs by affecting behaviour or raise revenue.

However, without a significant change in the system of funding, that would shift the cost from the state to the individual, it is difficult to see much scope for the NHS to raise money from individual patients to cover potential NHS budget shortfalls.

Recommendation 8: New private payments should not be introduced in an attempt to raise revenue.

Recommendation 9: Scarce public resources mean that abolishing existing charges (prescription, dental and optical) should not be a priority for the NHS. Instead, charges should be reformed so that exemptions are made on ability to pay, rather than somewhat arbitrary categories such as retirement and pregnancy. This should be achieved through the tax credit system.

Demand management

While new charges are not an appropriate method for raising revenue, could they be used as a rationing mechanism? It is possible to see a system of limited charges being introduced that safeguard the poor and the sick while still reducing overall demand for healthcare.

Recommendation 10: A limited range of charges, capped at circa £100 per annum, for initial consultations with GPs and other primary care practitioners should be introduced. The charges would be designed to incentivise wealthy individuals to avoid seeking unnecessary initial consultations with clinicians. All those individuals and families in receipt of tax credits would be exempt from all NHS charges.

NATIONAL STANDARDS AND GOVERNANCE (CHAPTER 4)

This report argues that the NHS should be designed around local needs rather than national standards. This raises the question: if

commissioners represent the heart of the NHS, what role is left for national government?

While local health commissioners require greater autonomy in order to improve health services there is still an important role for national standards, management and political control in healthcare in the years ahead.

Recommendation 11:

The following roles should continue to be undertaken at a central level:

1. Setting the basic framework for health policy.
2. Making strategic decisions on the development of health resources.
3. Regulation concerning public safety.
4. Monitoring, assessment and analysis of the health of the population and healthcare provision.

However, the number of centrally set national standards and targets should be substantially reduced in order to free up commissioners to innovate locally and design services that meet local need.

Recommendation 12: The list of national standards and targets should be substantially reduced to become a minimum service guarantee.

Recommendation 13: National government should continue to have responsibility for revenue raising, resource allocation, limited national standards and defining NHS values.

DECENTRALISATION (CHAPTER 5)

Ultimately, any decision to devolve power in a health system is a political choice that must take into account the country's political and historical context. In the case of the health service in England, the NHS has been subject to a decade of centralised control which has succeeded in raising activity levels, but which has failed to improve productivity and has left staff disillusioned. In this context decentralisation is the best option for improving the quality, productivity and responsiveness of the health service in a time of significant fiscal restraint.

However, a balance needs to be struck in which local level decision-makers have responsibility for a wide range of service related decisions, while the national level retains core strategic, revenue raising and regulatory responsibilities.

Recommendation 14: Political and fiscal decentralisation is not desirable, but administrative decentralisation should be extended.

COMMISSIONING (CHAPTER 6)

At the heart of a social market approach to healthcare is the idea that a pluralistic and diverse approach to the delivery of services is the best way to stimulate innovation and to ensure that those services suit the needs of local people, thus improving both quality and efficiency.

Getting commissioning right will be key to squeezing out as much performance in the health service as possible over the coming years, in a context of what looks certain to be a much tighter funding settlement post-2011, coupled with rising health costs.

Some commentators have suggested that an integrated system, such as Kaiser Permanente (KP) in the USA, which combines commissioning and provision within the same organisation, would be more successful than doggedly persisting with an internal market in health. However, there is no indisputable evidence that a KP-type model would provide better or cheaper care than is currently achieved in the NHS². Furthermore, introducing such a system into England would require a rejection of the purchaser/provider split and would entail significant structural change.

There is no appetite in the health sector for any more extensive structural change, so it is essential to get the systems that are in place working as well as possible.

Recommendation 15: The purchaser/provider split should be maintained and attention should be focused on improving commissioning performance within existing structures.

SKILLS

If commissioning is to succeed in driving up quality in the NHS, the capability, capacity and profile of individuals who work for commissioning organisations, and the organisations themselves, need to be strengthened. The world class commissioning framework sets out 11 useful commissioning competencies. However, a nationally dictated set of skills and competencies will not meet all requirements; PCTs will need different skill sets to meet different needs. As such commissioning skills should be developed at a local, regional and national level.

2 A. Talbot-Smith et al., "Questioning the Claims From Kaiser", *British Journal of General Practice* 415 (2004).

Recommendation 16: PCTs must continually assess the skills and competencies that they require to successfully commission at a local level, and then strive to develop those capabilities.

Investment in commissioning skills

Currently there is a cap on the number of personnel a PCT is allowed to employ. Good local commissioning will only be achieved if PCTs are enabled to develop their management skills and capacity.

Recommendation 17: The cap on PCT personnel numbers should be removed, granting PCTs responsibility for determining their own staffing levels.

Professional standards

Commissioners, both as individuals and organisations, would benefit from the development of mechanisms for increasing their influence, developing their skills and capabilities, and raising their profile. However, formal recognition of commissioning as a professional discipline may not be the best approach. Commissioning is an organisational responsibility, not an individual task and defining a standardised qualification or accreditation criteria would be hard to achieve and could detract from the important task of addressing specific local development needs.

Recommendation 18: A formal set of individual commissioning competencies should not be developed for NHS commissioners.

While a role is not envisaged for standardised commissioning qualifications, the voice of commissioners should be strengthened to enable them to stand up to provider organisations, recruit high quality staff and stamp their authority on the health service.

Recommendation 19: The current PCT Network should develop to take on a role similar to a Royal College, as a way of strengthening commissioners in the NHS.

NICE

NICE provides commissioners with crucial support and information. Health minister Ara Darzi has set out an expanded role for NICE, which is now expected to make more rapid appraisals of new drugs and set national quality standards.³ This is to be welcomed, but it is important that NICE appraisals do not end up focusing exclusively on new pharmaceuticals at the expense of existing devices and procedures. If commissioners are going to drive out ineffective practice they will rely on NICE to assess old technologies, as well as new ones, so that they can commission the most cost-effective treatment.

Recommendation 20: The capacity of NICE to appraise existing procedures, as well as new ones, needs to be strengthened.

The expansion of NICE's role will require additional resources which will be hard to find in a time of fiscal consolidation. NICE has begun to offer consultancy services to foreign governments and to offer scientific advice to companies seeking to tap into

3 Department of Health, *High Quality Care for All: NHS Next Stage Review Final Report*, by Ara Darzi (London: HMSO, 2008).

NICE's experience in health technology assessments.⁴ Both of these ventures could provide significant revenue streams for NICE.

Recommendation 21: The commercial capacity of NICE to offer consultancy to governments and private sector companies should be expanded.

Integration

The health system in England is far too focused on acute, hospital based care and there is insufficient collaboration between healthcare sectors. Integrated care can flourish under the current system, but it is important that integrated services are allowed to develop organically at a local level to meet local need, rather than the Department of Health dictating how integration should develop and what integrated care models should look like.

Recommendation 22: PCTs and local providers must be given the freedom to develop integrated care organisations at a local level to meet local need.

National contracts

The growth of integrated multidisciplinary organisations that provide care across sectors will lead to the development of new professional roles and the need for contracts to reflect new ways of working. It seems sensible for PCTs to be able to set pay and working conditions as part of contractual negotiations with providers. This would lead to the emergence of innovative services and new clinical roles that meet local need and emerging demand, and could also lead to better value for money.

4 Richard Robinson, "New Look NICE", <http://www.fleishman-hillard.co.uk/uploads/documents/NewLook.pdf>.

Recommendation 23: National contracts for GPs, Consultants and other medical staff should be abolished, and renegotiated at a local level when they come up for renewal.

Joint working

In the future localisation must become the watchword of the health service, with devolved responsibilities a major driver of improvement. However, PCTs are geographically too small and lightly staffed to successfully carry out certain important tasks. As such PCTs must be encouraged to work together in partnership to undertake joint commissioning.

At the moment the world class commissioning framework does not explicitly incentivise PCTs to work together. This must be changed if joint working is to become a reality.

Recommendation 24: Competency two of the World Class Commissioning Assurance Framework should be re-worded to require PCTs to work collaboratively with local and regional PCTs and prevent needless duplication.

FESC

The government launched the Framework for procuring External Support for Commissioners (FESC) to provide PCTs with easy access to a set of private companies to support them in undertaking their commissioning functions. However, FESC has transpired to be a very slow and bureaucratic process. PCTs should be trusted to purchase support from whichever private sector organisations they think offer them the services that they need, rather than

solely those government approved organisations on the FESC. This will stimulate the market to innovate and help reduce costs.

Recommendation 25: FESC should be abolished.

Public engagement

Involving the public in the design and commissioning of health services is an important element of ensuring effective local accountability. To help achieve patient participation Local Involvement Networks (LINKs) have been established to offer a range of different ways for local people to have a say, both through links with local voluntary sector organisations and by using a range of techniques for engaging the public, such as focus groups and surveys.

Currently a LINK has the power to refer an issue to their local council health Overview and Scrutiny Committee (OSC) which can formally question, scrutinise and influence the decisions of local NHS bodies. However, the OSC has no duty to respond to the LINK. This should be changed to ensure that users have more influence over services.

Recommendation 26: OSCs should be required to produce a public response to any referral made by a LINK.

The world class commissioning framework stresses the importance of patient and public involvement. The vision for world class commissioning states that there should be “local ownership and accountability” for decisions,⁵ but in reality no PCT is close to achieving this vision. PCTs must go much further in engaging with local people.

⁵ Department of Health, “World Class Commissioning”, <http://www.dh.gov.uk/en/managingyourorganisation/commissioning/worldclasscommissioning/index.htm>.

Recommendation 27:

To improve public engagement PCTs must:

- Develop a statement of the aims and purposes of patient and public involvement in their local area and set out a two year programme to demonstrate how these aims will be achieved.
- Commission research to identify effective strategies for engaging patients and local people.
- Ensure senior managers take public engagement seriously, providing it with adequate staffing and resources.
- Dramatically improve their public profile, ensuring that members of the public know that they exist and understand what they do.
- Change their names to indicate that they are the NHS body for that area. For example, NHS Hull rather than Hull PCT.
- Launch local information campaigns to clarify how the health system works at the local level and how individuals and groups can become involved.
- Work hard to recognise when, where and how members of the public want to be involved and ensure that as wide a range of the public are involved as possible.
- Ensure that even when the public is happy to leave decision-making up to the PCT the public is still kept informed about how and why decisions are made and have a means to give feedback which is responded to.

But this will not happen spontaneously: a national framework is needed to kick start the process and ensure that PCTs take patient and public involvement and engagement seriously.

Recommendation 28: The Department of Health should develop a national framework to measure and evaluate the effectiveness of PCTs' public engagement programmes. The results of the evaluation would feed into the world class commissioning assurance framework.

Practice-based commissioning

Practice-based commissioning (PBC) was introduced in 2004 and seeks to grant GPs more decision-making power over how NHS resources are spent and enable them to deliver new services or commission others to do so. However, PBC is currently not operating effectively: progress has been slow and in some areas the policy is grinding to a halt.⁶ Tens of millions of pounds have been spent trying to encourage GPs to commission services, but on the whole there is no great appetite amongst the profession for PBC.

Abandoning PBC would be a blow to those GPs who have invested a lot of time, energy and resources into developing organisational structures for PBC to work. So rather than the Department of Health simply scrapping the policy, where PBC is succeeding it should be allowed to continue, but the government should stop spending on incentivising its adoption in practices that have shown little interest thus far.

Recommendation 29: The focus of policy should be on: strengthening PCT commissioners; ensuring clinicians are closely involved in PCT commissioning decisions; and stimulating a thriving provider market. This will allow current PBC consortia to evolve into integrated care

⁶ Natasha Curry et al., *Practice-Based Commissioning: Reinvigorate, Replace or Abandon?* (London: The King's Fund, 2008).

organisations focused on providing joined up services, rather than attempting to both commission and provide services.

If local commissioners are to become the main drivers of improvement in the health service the accountability structures in the health system will have to change to reflect this shift in responsibility and power. As PCTs gain more control over the shape of the NHS in the future, it is going to become increasingly important that they are effectively held to account at a local level.

ACCOUNTABILITY IN A LOCAL SYSTEM (CHAPTER 7)

Currently accountability mechanisms face upwards. PCTs and providers are accountable to the Secretary of State for Health, Parliament and national regulators. However, with the ever increasing complexity of the health service, and with local PCTs holding more power and responsibility, it will be crucial for accountability to flow down to local people, as well as up to central government.

Over the last few years there has been an attempt to strengthen the tie between the NHS and local authorities. Overview and Scrutiny Committees have been established, but their powers should be significantly enhanced so that they can properly hold PCTs to account.

Recommendation 30 :

- **OSCs should have the power to report issues of concern, relating to a PCT, directly to the PCT regulator.**
- **The regulator should be required to make a public response to the OSC.**

- If the regulator's response does not successfully address the issue of concern the OSC should have the power to trigger an external review of PCT performance.
- This review should have the power to remove the PCT board and put in place a turnaround team.
- After a maximum of 12 months from the introduction of the turnaround team a new board should be elected by the local population.

It is not just OSCs who need the power to trigger an external review of an underperforming PCT. The general public should also be able to make it clear when they are not happy with the performance of their PCT, and to force action to be taken. This level of accountability will be needed if PCTs are to have the necessary legitimacy to make difficult decisions over the next decade.

Recommendation 31:

- A public petition of an agreed proportion of the local population should have the power to trigger an external review of PCT performance.
- This review should have the power to remove the PCT board and put in place a turnaround team.
- After a maximum of 12 months from the introduction of the turnaround team, a new board should be elected by the local population.

REGULATION (CHAPTER 8)

This report sets out a vision for a system in which local commissioners increasingly have responsibility for the quality of

NHS services. External review and inspection is the correct method for ensuring safety but is not particularly suitable for securing continuous quality improvement which is a long term, internal process. Commissioner organisations, which are based at the same local level as the provider and have a long term relationship with them, are much better placed to stimulate and support this internal improvement.

Recommendation 32:

- **The quality of provider organisations should be assured and developed through PCT contracts.**
- **The Care Quality Commission should maintain responsibility for setting minimum safety and quality standards as part of the licensing arrangement, and collecting comparative data on providers across the health service.**

However, a radically localised system does not mean a system without national regulation. In fact, it is essential that a system in which power is held at a local level is supported by centralised standards and evaluation of performance.⁷ As such, the way in which PCTs are regulated is of key importance.

Currently, PCTs report to four different bodies on different aspects of their performance: the Department of Health; the Audit Commission on financial performance; Strategic Health Authorities; and the Care Quality Commission. There are two major problems with this structure. First, it provides unnecessary work for hard-pressed commissioners as they have to report to four different bodies, each of which has different requirements and different

⁷ Karsten Vrangbaek, "Key Factors in Assessing Decentralization and Recentralization in Health Systems," in *Decentralization in Health Care: Strategies and Outcomes*, eds. Richard B. Saltman, Vaida Bankauskaite and Karsten Vrangbaek (Berkshire: Open University Press, 2007). 72.

processes. Second, it is difficult for patients to access information about PCT performance, as it is not held in a single repository. It is imperative that patients and the public can easily access high-quality information about how their local commissioner is performing. There should be a consolidation of PCT regulation, with a single body overseeing the performance of PCTs and providing information for the public about the performance of their local PCT.

Recommendation 33: A single commissioning regulator and inspectorate should be introduced – the NHS Commission – to sit alongside the Care Quality Commission.

As a corollary of the consolidation of PCT regulation the SHA is left redundant, and should be abolished.

Recommendation 34: The SHA should be abolished.

CONCLUSION

Whatever the political rhetoric, the NHS will not be immune from a spending squeeze that will be worse than any previously experienced by the vast majority of civil servants and public sector workers. There is an urgent need to obtain better value for money from health spending through greater efficiency and a proper focus on demand management. If the NHS cannot do more for less, then its future is in doubt. The long waiting lists and low quality care of the past must not return if the health service is to maintain public support in the years ahead.

The recommendations set out in this report recognise the need to take radical action but within politically realistic limits. The NHS has suffered in recent years from the sheer number of reorganisations it has undergone. There is no doubt that in some cases reorganising the health service has not helped it to perform better. The conclusions of the SMF Health Project acknowledge that while a revolution in structures is undesirable, a revolution in attitudes is essential. Policymakers in central government must become genuinely committed to devolving power to frontline commissioners. Those frontline commissioners must become the driving force of NHS improvement, taking on vested provider interests. And a dialogue with patients should be begun to help users recognise the desirability of a diverse, varied system that responds to the needs of local people, rather than aspiring to an unrealistic and inefficient idea of national uniformity.

The move towards a system of local control and local variation is essential if the NHS is to survive the crisis in public finances. The limits of centrally driven performance management have been reached. While there has been substantial improvement as a result of the reform and investment of the past few years, the ability of central government to make the savings that will be needed is questionable. High quality local commissioning offers the best chance to deliver value for money, not performance management from the centre. It is time to try a new approach; one that harnesses the creativity and energy of local professionals. Additionally, the hard decisions that lie ahead can only be justified to local people by local health organisations, backed by local accountability mechanisms, not the Department of Health.

There will undoubtedly be political pain in the move from a centralised service to one where local commissioners drive improvement. However, public opinion research carried out as part of the SMF Health Project shows that people are realistic about the limits of NHS care, and open to the idea that resources should

be distributed according to the needs of different areas. Political courage will be needed if a move away from the persistent idea that the NHS is the same everywhere is to be achieved. But the benefits of local choice must supersede concerns about postcode lotteries.

A diverse, varied service is one that fits with social market principles. Markets in healthcare provision can provide a pluralist, innovative and efficient system. Social goals of fairness and universal access can still be achieved through accountable commissioning organisations, and strong regulation. The benefits of a market approach to healthcare could be considerable, and can be achieved largely within existing NHS structures.

What does the future hold for the health system? It is a rocky road ahead. The year on year rise in health spending as a proportion of GDP cannot be continued indefinitely. It may be that the recession will present an opportunity to radically transform health services to save money in the long term. This transformation will require policymakers to consider options that have hitherto been politically unacceptable – including user charging.

In many different sectors of politics and society a new consensus is emerging that public services must be substantially reformed to deal with the challenges ahead. Old solutions that look to management by central government to make savings and improve outcomes for patients will not succeed in delivering value for money. Instead, a radical redistribution of power must take place. With strong commissioners, functioning provider markets and better accountability through national regulation and local accountability mechanisms, the NHS has every chance of a strong future. Without these much needed reforms, the future is bleak.

CHAPTER ONE: INTRODUCTION – A SOCIAL MARKET APPROACH TO HEALTHCARE

This report represents the final conclusions of the SMF Health Project. Over the past two years the project team has examined the challenges facing the health system in England. Some of these challenges are well known and much discussed. A set of background papers, published in July 2008, analysed the likely impact of demographic change, new technologies and patient expectations on healthcare.⁸ But since the publication of this analysis a new challenge has emerged: perhaps the most serious economic downturn for many decades. The impact of the recession on public finances is severe, and will shape British politics for many years to come. This presents a fresh challenge to health policymakers, making more urgent the question of how to extract best value for money from health services now that future funding will be highly limited.

The research presented below shows how high-quality healthcare can be maintained into the long-term future. The methodology used has been to extrapolate current policy and economic trends and determine their likely impact on the way care is funded and provided. In ten years' time the health system will look very different from how it is today. What follows is an insight into what changes we should expect and how they should be achieved.

This analysis is not based on wishful thinking, but on a realistic assessment of what will be possible to achieve in both political and policy terms. Many discussions of the future of the health system begin with an assumption that the current system is undesirable or unsustainable, and they look to offer an alternative. But it is clear that perhaps the least desirable option for healthcare in the years to come is a substantial structural overhaul. While there are undoubtedly

8 D. Furness et al., *SMF Health Project Background Papers* (London: Social Market Foundation, 2008).

lessons to learn from other health systems, some of which are explored in subsequent chapters, it is clear that the NHS will remain a central and recognisable part of the health system in this country. So the recommendations that follow do not propose radical changes to the structure of healthcare. Instead, ideas are explored that will both deliver good value for money and equip the health system to deal with the substantial challenges it faces, without having to rip up the structures that already exist and start afresh.

The conclusions and recommendations featured in this report are strongly influenced not only by the available evidence about what works in health policy but also by a major piece of quantitative and qualitative research into public attitudes about the future of healthcare, carried out by the SMF Health Project team.⁹ If the principles of a universal health system are to be maintained, public support for change is crucial, and, therefore, an understanding of how the public views the health service is essential. The findings of this public opinion research have already been published, and its implications are reflected throughout this report. In addition to this, the project team has conducted a range of seminars and interviews with health policy experts, practitioners and patients which inform the conclusions presented below.

As well as being politically realistic and based firmly on the need to maintain public support for universal access to healthcare, this report also adopts a distinctively social market approach to healthcare. The social market philosophy is the guiding principle of the Social Market Foundation and offers a useful analytical framework for making policy. Markets are uniquely capable of delivering a prosperous society and improved public services. But while market mechanisms are valuable, a wholly free market approach cannot deliver the outcomes that a fair society demands.

⁹ D. Furness and B. Gough, *Local Control and Local Variation in the NHS: What Do the Public Think?* (London: Social Market Foundation, 2009).

As a result, markets must be limited and supplemented with necessary, but careful, design and regulation. A social market approach is therefore “pro-market”, but not “free-market”.

This principle guides the thinking throughout this report, explaining why, for instance, the idea of private markets in healthcare financing is rejected, while the improvements in care that could be achieved with a better-functioning provider market are welcomed. Above all, though, this research is informed by the idea that healthcare is a valuable social good, and that universal access to high-quality healthcare is central to a fair society and is therefore a goal we must continue to aspire to reach.

Discussing the recession in *The Times*, Peter Riddell wrote:

The public debate avoids the real choices. The arguments of the populist right and the public sector left have mirror image flaws. The former claim the answer lies in wars on waste and bloated bureaucracy, while the latter treats any cuts as threatening the whole welfare state.¹⁰

A social market approach falls into neither of these categories. Although there is scope for reducing bureaucracy to achieve greater efficiency, this cannot be the whole solution; and adopting pluralistic approaches can drive innovation and value for money. At the same time, cuts and radical reinventions of welfare state services, such as healthcare, cannot be rejected out of hand, particularly where it can be shown that radical transformation can be achieved without sacrificing important social values.

In 2009, there is one central challenge for policymakers in healthcare: how to deal with the huge public spending squeeze that will inevitably follow the current recession. This requires

10 P. Riddell, “Public to Brace for Pain to Get Economy Back on Track,” *The Times* (21 April 2009), 45.

policymakers to deal with the future finance of healthcare, and also to examine radical ways of securing better value for money through local decision-making.

FINANCING – CHALLENGING TIMES AHEAD

Previous SMF Health Project research has shown that fears over the likely impact on health services of an ageing population and the advent of new medical technologies are largely overblown.¹¹ However, since the publication of this analysis, the economic climate has changed for the worse, and the impact of the recession on public services has been significant. As the BBC political editor Nick Robinson recently commented: “The whole of the public sector is bracing itself for a squeeze the like of which few have experienced before.”¹² Forecasts made by the Chancellor of the Exchequer in the 2009 budget have been criticised for being overly optimistic,¹³ and, even under the scenarios he described, public services face a tough time – annual increases of 0.7% from 2011.¹⁴ Furthermore, a report from the Institute for Fiscal Studies has concluded that departmental expenditure limits (DELs) that include NHS spending could be the worst hit – budgets might have to be reduced by 2.3% per annum in 2011–14.¹⁵ For years, healthcare discussions have raged about whether health systems are sustainable, given the trend of increasing costs. Now, though, instead of focusing on the cost implications of ageing, new technologies, rising public expectations and an increase in chronic disease and poor public health, the debate must instead turn to the impact of a dramatic slowdown in health budgets.

11 D. Furness et al., *SMF Health Project Background Paper 2: Demography and Technology: External Pressures for Change* (London: Social Market Foundation, 2008).

12 N. Robinson, “Age of Austerity”, http://www.bbc.co.uk/blogs/nickrobinson/2009/04/age_of_austerit.html.

13 L. Elliott, “City Pours Scorn on Treasury’s GDP Forecasts”, *Guardian* (23 April 2009).

14 HM Treasury, *Budget 2009: Building Britain’s Future* (London: HMSO, 2009).

15 G. Tetlow, *Budget 2009: Public Spending* (London: IFS, 2009).

This report analyses current policy and economic trends in healthcare and sets out a series of reforms that will help to achieve a sustainable health system for the next decade and beyond. The challenge facing the health service in England is not a small one, and failure to achieve greater efficiency and productivity may mean that the entire post-war settlement of healthcare funding and provision will be undone. To maintain public support for the current system, the public must be convinced that what is offered by state services is of a high quality. And healthcare providers face a stiff task in achieving continuing quality improvements at a time of rising government debt, rising taxes and falling investment in public services. While the recommendations set out below offer the health system the best chance of achieving its goals, it is possible that they will fail. If this occurs, it is difficult to see the NHS continuing in its current form beyond 2020 – radical options for restructuring and refinancing will become the only way to guarantee ongoing universal access to healthcare into the future.

REDEFINING THE NHS – NATIONAL FRAMEWORKS, LOCAL STANDARDS

There is clearly a big challenge for future financing. Associated with this is the urgent need to secure better value for money in healthcare provision. To achieve massive efficiency savings, and to drive through the cutbacks, reconfigurations and decommissioning that will be required in the years ahead, it will be necessary to redefine radically some of the principles of healthcare provision that have seemed central since the inception of the NHS in 1948. Chief among these is the idea of a *national* health service.

There is an ongoing tension between central control and the drift of policy towards greater decentralisation to local primary care trusts (PCTs). Fears have been expressed that this will lead to a “postcode lottery” in healthcare. While unintended and unexplained variation in care should not be tolerated, variation itself should

be enthusiastically embraced by policymakers as the best way to ensure locally appropriate services that will save money overall. There should be an open acceptance that variation between local areas is desirable, leading to the efficient commissioning and use of resources, innovation in service delivery and appropriate local services. Local PCTs should be free to shape health services to meet local needs, but this autonomy should be coupled with systems that safeguard against unacceptable differences in quality, with regulators playing a key role in providing comparative information and setting minimum standards.

Local choice and local variation must become the guiding principles of the health system, with a significantly reduced role for central government. The state should remain as revenue raiser and resource distributor, but the key driver of change in healthcare should be local commissioners – PCTs. Commissioners must be strengthened and given true autonomy to develop provider markets that meet the needs and wants of local people, to which they will be sensitive and responsive. Patients and the public should be given an enhanced role in healthcare decision-making with real power to hold commissioners to account.

The status of commissioners within the health system must change, giving them greater power, to which providers are forced to respond. And commissioners must be able to justify to the people they serve the inevitability of an ever increasing degree of local variation within the health system. Without radically shifting power from the centre to the localities, and putting in place robust mechanisms of local accountability, there is no prospect either of significant efficiency gains and the development of innovative new services, or of justifying to people the tough choices about what to make available and what to cut in a publicly funded health system.

Along with the establishment of a truly local service, with autonomous commissioners driving improvement, a new definition

of NHS values is required. To ensure fair access into the future, the values at the heart of the health system must be set out clearly and should shape future policy. While fairness and universal access should still be at the heart of the system, setting charges as a tool of demand management must be considered. At the same time, the whole area of NHS charges needs to be overhauled to ensure that people on low incomes are offered genuinely free care. No longer should pensioners automatically be exempt from charges while the working poor pay for prescriptions. A radical redefinition of fairness and NHS values can and should go hand in hand with the shift from the centre to the frontline, from the national to the local.

DESCRIBING THE HEALTH SYSTEM OF THE FUTURE

The sections above have shown how, in the context of the immense financial challenge facing the health system, it is right to consider the role of national financing and governance together with locally driven healthcare options in order to secure good value for money. The chapters that follow each examine a particular aspect of the future of the health system. Recommendations are incorporated that set out how the system should change so as to achieve greater efficiency and quality and to transfer power from the centre to the frontline. In large part, conclusions are developed from a discussion of central principles of different aspects of health system design, and/or an exploration of recent health system reform. In this way the arguments presented in the following chapters are both a look ahead at the next decade of healthcare and also an opportunity to work from first principles. There is a great need to redefine the state itself and, with it, welfare provision in the context of a crisis in public finances. This report aims to contribute to an urgent political debate on how this should be achieved.

The report is split into two parts. The first is a description of what the future role of national frameworks and national governance should be, including how resources should be raised

and distributed, and how NHS values should be defined. The second analyses the way in which local health commissioners need to change in order to drive service improvement.

Throughout this report relatively little attention is given to the role of NHS providers as opposed to the commissioners of healthcare. This is a deliberate choice: the report argues that in the future the NHS will increasingly be responsible for commissioning rather than with providing healthcare. So there is a greater focus on how commissioners can develop strong provider markets than on, for instance, the future of NHS hospitals. Questions about who provides healthcare should become steadily less significant. A genuinely diverse market of providers rather than an unhelpful focus on NHS hospital care will be an important step in securing a sustainable future for the health system.

PART ONE

Chapter 2: Equity

Perhaps the most important criterion that healthcare systems must fulfil is that they are fair. Chapter 2 explores why fairness in healthcare is important, and how it can be defined. By comparing different conceptions of equity, it posits a radical redefinition of NHS values to ensure that universal access remains a priority, but, at the same time, that limitations in care and variation between areas are acknowledged. It is shown that the current definition of equity to which policymakers aspire is unhelpfully narrow, and that a broader idea of what is fair offers the best opportunity of securing an equitable health system.

Chapter 3: Paying for healthcare

Chapter 3 focuses on emerging challenges to the current model of healthcare funding. The cost of healthcare in the developed world has increased tremendously in recent times, and questions about how best to fund it is an unending source of controversy.

While fears about the impact of ageing or new technologies are overblown, there is a real challenge emerging as a result of the dire state of public finances. There is almost no chance that the health system as it is currently designed will be able to maintain or improve standards of care given the severe resource constraints that will be in place for the foreseeable future. However, it is crucial that any alterations to the system of funding maintain the central principle of fairness. This chapter marshals the evidence on sources of healthcare funding, including user charges. The discussion is framed in terms of a general public willingness to invest in health and healthcare. The chapter weighs the evidence and makes some radical proposals about how to maintain a universal health system without compromising the core values of the NHS.

Chapter 4: National governance

The framework set out in Part Two proposes a far more locally autonomous health system, with a greatly reduced role for national standards. In such a locally varied system what roles are left for national government? The final chapter in Part One sketches the process of recent NHS reform with an emphasis on the “target culture” that was a product of strong central performance management. Although this stifling approach should not be a feature of the health system in the future, there are still certain key tasks that central government must perform. Foremost among these concerns raising funds and distributing resources, as well as overseeing national regulators. It must also be the job of central government to define a set of values for the health system that provides a framework in which local commissioners will operate.

PART TWO

Chapter 5: Decentralisation

Chapter 4 examines decentralisation as a policy option and suggests a model that the English health system should adopt. Decentralisation has already become a feature of health policy

in the NHS with the introduction of PCTs and the establishment of foundation trusts. But there are still great tensions between national control and local priorities. This chapter explains how and why a decentralised model of healthcare should operate in the health system in this country.

Chapter 6: Commissioning

The era of central command and control in healthcare is over. Chapter 5 focuses on the ever more important role that commissioners will have to play in the health system. In order to achieve the economies that will be necessary to meet the challenge posed by recession, the only real option for the NHS is significantly to strengthen commissioning. Even this may not be enough – the evidence base for the potential of better commissioning must be strengthened. But there are many ways in which commissioning skills can be developed, the capacity of commissioning organisations improved and the status of commissioners within the health system raised. The strength of commissioners can only be improved if government relinquishes control of significant parts of healthcare decision-making. And if commissioners are to succeed, they must be free to develop new roles and provider markets. Indeed, the *provision* of healthcare must become less important in the public mind than the *purchasing* of it – over time the provider market should move away from the monolith of NHS provision towards a genuine market of competing providers from the public, private and third sectors. These changes must lead to a locally varied service that reflects the benefits of true local choice.

Chapter 7: Accountability

By changing the way healthcare is delivered, it will also be necessary to introduce new systems of accountability. No longer can accountability be centred on Parliament, with the Secretary of State answerable for every dropped bedpan across the NHS. In creating a localised health system, it is crucial, if legitimacy is to be maintained, that new models of accountability are designed. In



this there is a role for democratic processes. But local democracy should not, as some have argued, play a central role in allocating local resources. The results of SMF Health Project public opinion research suggest that people do not want to be involved in this sort of decision-making unless something goes wrong – the systems of accountability set out in chapter 7 reflect this.

Chapter 8: Regulation

There has recently been substantial change to healthcare regulation with the introduction of the Care Quality Commission (CQC) representing a consolidation of previous regulators across health and social care. But in the future it is commissioners, rather than an arm's length national regulator, who should be responsible for securing the quality of local providers. The way in which commissioners are regulated should also change so that their crucial role in local health provision is recognised. Chapter 8 sets out these arguments and establishes the right principles for the future development of healthcare regulation.

PART ONE

CHAPTER TWO: EQUITY IN THE HEALTH SYSTEM

It is rightly held that the values of the NHS are precious and should be maintained. Chief among these is equity – the idea that health services should be fair. This chapter is an examination of the way in which different conceptions of equity in health and healthcare play out in reality. It argues that while there is a good deal of consensus about the desirability of equity in healthcare, there are real problems in translating this into a reality that ordinary people would regard as equitable. Because of this, problems are encountered in the areas of resource allocation and the rules and regulation of health systems that the available literature does not help to solve. Equity is important in health policy because it sets the overarching framework of what is considered acceptable, particularly with regard to policy issues like charging. But without an agreed definition of equity, approaches to policy challenges in healthcare are without a secure foundation.

This chapter explores the idea of equity in healthcare. In particular it considers the various different health systems and structures that can be considered equitable and draws out implications for the future of the NHS. It goes on to ask how far various equity goals are fulfilled in the UK National Health Service (NHS) and explores which different policies can be deemed acceptable within a broadly equitable framework, with a particular focus on charging and appropriate access targets.

The chapter is split into two sections. The first looks at the theoretical literature on equity. Why is equity in healthcare considered important? What different types of equity are there? Can defining equity help us deal with policy challenges in healthcare? This approach demonstrates the limitations of applying a theoretical

approach to equity to practical problems in healthcare. Equity is a much discussed term, and a common aspiration for health systems, but it is clear from the arguments presented in this first section that the lack of common agreement about how it should be defined is a serious problem. The challenge of defining equity is ever more urgent given the financial restrictions that the NHS faces in the years to come. An equitable approach to healthcare will be crucial if public support is to be maintained for a system that faces difficult decisions about how best to allocate scarce resources.

The second part of the chapter is a brief survey of the extent to which equity goals are achieved in the NHS. This section shows how ideas about fairness have developed since the inception of the NHS in 1948. Interestingly, while equity is often referred to as a core principle of the NHS, ideas about fairness have changed remarkably since the Beveridge Report's original proposal for a national health service. Not only has the idea of equity as a policy goal changed over time, so too have approaches to putting equity into practice. The discussion here includes both the allocation of resources and access to healthcare for different groups – the extent to which the NHS spends its money equitably, and how different groups actually benefit from publicly funded care. It is clear from an examination of the evidence that serious challenges in providing equitable services remain, leading to an argument for a new approach to target-setting for equity in the NHS.

The chapter finishes with a suggested definition of equity in the NHS that builds on the set of values included in the NHS Constitution. This definition of equity both safeguards important principles of universal access to healthcare, while also providing policymakers with room for manoeuvre in responding to a move towards genuinely local health provision at a time of scarce public resources – a move that this report encourages.

The intention of defining equity more clearly, and in a practical sense, is both to inform policymakers and to engage public support

for the NHS as it seeks to deal with the ramifications of the crisis in public finances. The suggested definition of equity also shows that a health system can still be equitable even as it considers a range of policy options that have hitherto been politically unacceptable.

The NHS is deeply embedded in British society, and there is an undeniable sense that its values are important. However, while debates about these values and the importance of fairness evoke strong emotions, there is not necessarily any real agreement as to how equity in the health system should be defined. Public opinion research conducted as part of the SMF Health Project found that attitudes to local variation in the NHS were based on a range of different ideas about what is fair.¹⁶ That is why this debate is crucial for the future of the health system. Public support for universal healthcare must be maintained particularly during a period of severe financial constraints, and defining equity is an important political and policy goal towards achieving this aim.

WHAT IS EQUITY AND WHY DOES IT MATTER?

The first part of this chapter is an exploration of the different ways in which equity has been defined in an academic sense. This is an important debate, as it is through the academic literature that policymakers are led towards principles that can be applied in practice. However, while there is a wide acceptance that equity is desirable, there are significant difficulties in applying theoretical lessons to the real-world challenges that the health service faces in the years ahead.

Why is equity important in healthcare? It is accepted that citizens have different levels of income, live in different houses, eat different food and have different quality relationships. In general, inequality is tolerated in most areas of day-to-day life. However, in

16 D. Furness and B. Gough, *Local Control and Local Variation in the NHS* (London: Social Market Foundation, 2009).

developed countries there is general agreement that health should not be considered a consumer good in the same way that watches, cars or satellite television are. The most influential statement on the idea that health and healthcare are goods that should not simply be allocated according to capacity to pay was articulated by James Tobin in 1970.¹⁷ He argued in favour of “specific egalitarianism” – a view that health, among other goods, should be subject to special consideration in civilised societies because it is so fundamental to a good-quality life. This argument has been repeated many times,¹⁸ and is reflected in policy support for publicly funded health systems that attempt to ensure that there is equitable access to healthcare and an equal opportunity to be healthy, and that healthcare is of equal quality for all citizens.

It is accepted that healthcare should not be subject to a free market approach, and that equity in health systems is a desirable aim. So, do markets have any part to play in healthcare? The social market approach argues that they do. While it is socially desirable for individuals to share their risk of catastrophic healthcare expenditure, market mechanisms can certainly play a key role in the provision of healthcare without undermining equity.

But what is equity? The first answer to this question is that equity is not a concept that can easily be pinned down. There are many ways in which fairness or equity can be defined – “equity, like beauty, is in the eye of the beholder”.¹⁹ This is not a trivial point. Different definitions of equity in healthcare can result in very different relative outcomes for patients because of the different priorities that policymakers attempt to reflect in resource allocation.

17 J. Tobin, “On Limiting the Domain of Inequality”, *Journal of Law and Economics* (1970).

18 For example, see S. Anand, “The Concern for Equity in Health”, *Journal of Epidemiology and Community Health* (2002).

19 L. Cohen, “Health Care Equity Tackled From Many Angles at CHEPA Conference”, *Canadian Medical Association Journal* 147:4 (1992).

For example, some aspirations towards equity in healthcare can be so vague as to be almost meaningless. In 2003 came the development of a new intergovernmental initiative called the International Forum on Common Access to Health Services. This brought together health ministers from a diverse range of countries (Chile, Germany, Greece, New Zealand, Slovenia, Sweden and the UK), “united by the value that health systems shall ensure all citizens universal and equitable access to good health care”. For these ministers, equitable access meant “good care on equal conditions for all people, regardless of social circumstances or where in the country you live”.²⁰ Recognising diversity and responding to the individual needs of the patients were, as far as they were concerned, the key mechanisms to ensuring equity.

It is obvious that this alone is not an adequate framework for the difficult decisions that have to be made in healthcare systems. One wonders if, for example, on returning to Santiago the Chilean health minister found this definition of equity much use as he pondered the problems faced by his health system, which were perhaps very different challenges from those facing his counterparts in other nations.

Confusion over equity can be compounded by the realisation that, as Imre Loeffler puts it: “Equity stands for fairness, yet what is fair is not necessarily equal, and what is equal is not necessarily fair.”²¹ An example of this tension is “orphan drugs” where treatments for rare conditions can be extremely expensive. It might not be equitable to allocate so much to an individual patient, but it might seem unfair to deny care to someone unlucky enough to suffer from a very rare disease. This example is considered in greater depth below. Clearly, creating an equitable health system is not a simple business.

20 “International Forum on Common Access to Health Care Service,” *Euro Observer: Newsletter of the European Observatory on Health Care Systems*, 2003.

21 I. Loeffler, “Let’s Be Fair About Equity and Equality,” *British Medical Journal* 332:7543 (2006); I. Loeffler, *Let’s Be Fair About Equity and Equality* (British Medical Association, 2006).

Definitions of equity

Conceptions of equity in healthcare

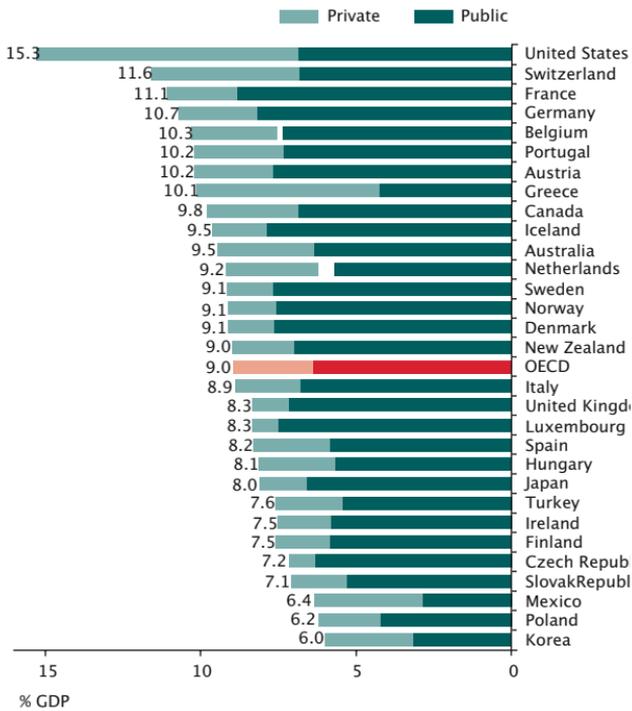
The OECD argues: that “The concern for equity extends both to the distribution of the payments for health care across the population (fair financing) and to the distribution of access to health services across the population (fair access).”²² This chapter is concerned less with the financing of healthcare, a discussion of which can be found in chapter 3, than with how health systems work in practice in terms of access to treatment. However, it is important to remember that financing systems profoundly influence equity in healthcare. The best example of this is the USA, where many millions of people do not have adequate health coverage, even though health spending is some 15% of GDP – significantly above the OECD average (see figure 2.1). This is because the USA operates a system of private health insurance with limited state-funded provision for those on lower incomes. The result is a fundamentally unfair system that would certainly not be acceptable in this country.

The other common funding mechanisms for health systems in OECD countries are general taxation or different forms of social health insurance. Typically, both systems provide virtually universal coverage, and take steps to ensure that access to healthcare is based on need rather than ability to pay. These systems are common in European countries. A survey of international health financing systems found that tax funding systems are proportional or mildly progressive, social insurance systems are regressive, and private insurance systems are even more regressive.²³ In this instance, progressive systems are judged as those where ability to pay impacts least on ability to access health services, and wealthier individuals contribute at a higher level than people with less money.

22 O. A. Arah et al., “A Conceptual Framework for the OECD Health Care Quality Indicators Project”, *International Journal for Quality in Health Care* 18: Supplement 1 (2006).

23 E. Van Doorslaer et al., “Equity in the Delivery of Health Care: Some International Comparisons”, *Journal of Health Economics* 11:4 (1992).

Figure 2.1: Health spending in OECD countries by GDP



Source: "OECD Health Data 2008: Statistics and Indicators for 30 Countries", www.oecd.org/health/healthdata.

While tax-funded and social insurance systems both tend to make sure that people with the lowest incomes are guaranteed access to care, tax systems are considered more progressive because there is no upper limit to a contribution a wealthier individual can make, while insurance premiums are normally capped at a certain limit.

Financing is not the only determinant of equity and both the mildly regressive social insurance schemes and the more progressive systems based on taxation tend to have universal access to treatment as a guiding principle. Universal access to healthcare without discriminating by ability to pay is therefore the most basic requirement of an equitable health system, and one which the NHS

should continue to meet in the years ahead. But agreeing this basic minimum leads to an important distinction in the analysis of equity in healthcare – horizontal and vertical analyses.

Vertical and horizontal equity

Vertical equity is a reasonably straightforward condition to satisfy. Vertical equity recognises that individuals do not all need to receive the same benefits from the health system – people in greater need should receive a greater proportion of the benefits. A health system that did not fulfil the condition of vertical equity would be a bizarre construction: healthy members of the public would be summoned to hospital to receive unnecessary treatment while the sick and the dying languish at home, receiving only the attention given to every other member of the population. It is generally assumed that developed health systems fulfil this basic consideration, so this chapter is not predominantly concerned with vertical equity.

Much more important is horizontal equity. In this sense an equitable service is defined as one that offers equal access to healthcare for those in equal need.²⁴ This is a much thornier problem. There is concern that many health systems, including the NHS, do not actually offer equal access for equal need.²⁵ Older patients, those from ethnic minorities, people with mental health problems or people with low incomes may not have equal access to treatment, for example.

The problem of defining need

There are problems of measurement here. First, there is a great deal of debate about the nature of need and how it can be measured. It cannot easily be defined and, once again, there is an enormous literature discussing the problem.²⁶ There is not space in

24 A. Dixon, *Is the NHS Equitable? A Review of the Evidence* (London: LSE Health and Social Care, 2003).

25 J. Gubb, "Why the NHS Is the Sick Man of Europe", *Civitas Rev* 5:1 (2008).

26 M. Asadi-Lari, C. Packham and D. Gray, "Need for Redefining Needs", *Health and Quality of Life Outcomes* 1:1 (2003).

this chapter to consider the multitude of definitions of need, but it should be noted that different definitions have very different implications for service design and resource allocation. For instance, Culyer defines need as “capacity to benefit” and for him this rests on the moral principle that good health is required for individuals to “flourish” in their lifetime.²⁷ This is very different from the typology approved by the International Forum on Common Access to Health Services, which use Bradshaw’s fourfold definition of (i) normative need (defined by experts or professionals); (ii) felt need (what the individual thinks they need); (iii) expressed need (what the individual says they need); and (iv) comparative need (where individuals in different locations are compared so that what each needs can be established).

Clinicians who have discussed the various definitions of need have concluded:

If needs analysis is intended to be meaningful rather than an academic exercise or political propaganda, definitions must reflect clinical reality. In this respect, current definitions fail to recognise the needs that we have identified among our own cardiac patients.²⁸

This clearly presents a challenge to those who would analyse horizontal equity in the NHS – if there is no agreement about what needs exist, then how can it be shown whether they are met?

Despite this limitation, the issue is not hopeless. The later discussion of equity within the NHS, in the second part of this chapter, demonstrates that some firm conclusions can be made about equal access to services based on need without having to thrash out an unlikely consensus reconciling the myriad definitions of need.

27 A. J. Culyer, “Equity – Some Theory and Its Policy Implications”, *British Medical Journal* 27:4 (2001).

28 Asadi-Lari et al., “Need for Redefining Needs”.



Defining equity in healthcare

The nature of fairness in healthcare is an issue that generates many different intellectual approaches. What follows is a brief survey of how equity can be defined. It illustrates how, far from being complementary, there are some direct contradictions between different approaches and, furthermore, it points out the limitations of the debate in equipping us to deal with the practical challenges faced by policymakers.

The World Health Organisation (WHO) definition is: "Equity is the absence of avoidable or remediable differences among populations or groups defined socially, economically, demographically, or geographically."²⁹ Thus, equity becomes an outcome measure, rather than a guiding set of principles for service design. The WHO's interpretation also demonstrates the extent to which some definitions of equity are intrinsically linked with health inequalities. Health inequalities are, of course, the product of many different factors outside access to healthcare. Education, wealth, housing, nutrition and access to exercise facilities all contribute to health inequalities. Equity in access to healthcare should be considered separately from the wider inequalities related to health that exist in any society, though unequal access to care will certainly widen the gap between the healthiest and the least healthy.

Equity is also a constituent part of the Ljubljana Charter on Reforming Health Care which applies to members of the European region of the WHO.³⁰ The charter states: "Health care reforms must be governed by principles of human dignity, equity, solidarity and professional ethics." Once again this demonstrates that institutional conceptions of equity do not necessarily help us in making practical decisions. What is equity? What is solidarity? Chinitz et al. have drawn attention to how vague these concepts are. For them,

29 "WHO: Equity", <http://www.who.int/trade/glossary/story024/en/>.

30 R. Saltman and J. Figueras, *European Health Care Reforms. The Ljubljana Charter on Reforming Health Care* (Copenhagen: World Health Organisation, Regional Office for Europe, 1996).

universal, equitable coverage in European health systems equates to “solidarity”. However, “During the past 50 years ... the term solidarity came to convey some vague notion about the welfare state”³¹ rather than a consensus view about what equity means in practical terms. Comparing their definition of solidarity with those from other sources demonstrates that there is certainly confusion about this term too.³²

As well as the definitions offered by bodies like the WHO, there is an extensive theoretical literature about equity. In an influential article, Culyer and Wagstaff suggest four definitions: utilisation, distribution according to need, equality of access and equality of health.³³ They argue that there are problems with each of the definitions, and that they are mutually incompatible. For example, equity based in principles of utilisation would contradict vertical equity criteria that require different levels of utilisation reflecting healthcare need. Some programmes that are popular with the public, such as “Health MOTs”,³⁴ might also be considered inequitable on these grounds as they direct resources towards the healthiest members of society. “It is self-evident that the principle of equalizing expenditures will conflict with the principle of distribution according to need, unless the persons in question are deemed to be in equal need.”³⁵

This is an important insight for policymakers, as this conclusion conflicts with views expressed by members of the public. Research conducted by the Social Market Foundation concluded that many

31 D. Chinitz, A. Preker and J. Wasem, “Balancing Competition and Solidarity in Health Care Financing”, in R. Saltman, J. Figueras and C. Sakellariades (eds), *Critical Challenges for Health Care Reform in Europe* (Buckingham: Open University Press, 1998).

32 According to the International Forum on Common Access to Health Services, solidarity means access to a reasonable minimum range and standard of care

33 A. J. Culyer and A. Wagstaff, “Equity and Equality in Health and Health Care”, *Journal of Health Economics* 12:4 (1993).

34 Department of Health, *Choosing Health: Making Healthy Choices Easier* (London: HMSO, 2004).

35 Culyer and Wagstaff, “Equity and Equality in Health and Health Care”, 446.

people believe that the NHS should offer the same services to everyone, regardless of specific needs in particular areas: “When the NHS came round it was the same treatment for everyone, and I don’t think we should change that.”³⁶ While the NHS does not spend equally on different areas, it appears that people think it does. This presents a political challenge, and suggests that a new definition of equity is required in the NHS to reflect the actuality of health policy rather than the different view of fairness held by members of the public.

Culyer and Wagstaff go on to argue that policymakers tend to understand equity in terms of equality of access – the opportunity to access healthcare when it is required. To these authors, this is the wrong approach. Instead, equality of health should be the ultimate criterion for equitable health systems: “An equitable distribution of health care is simply one which gives rise to an equal distribution of health.”³⁷ However, there is a difficulty in judging health systems by their ability to distribute health equally (i.e. reducing health inequalities): too many external factors are influential in determining health to make it a fair test for healthcare providers. A 2008 report for the Department of Health stated that it is “ever clearer that the Department of Health and the NHS cannot reduce health inequalities in isolation from other public services”.³⁸ This is a serious problem when it comes to applying Culyer and Wagstaff’s methodology to the evaluation of health systems. The NHS needs a more straightforward definition of what is equitable than “equal distribution of health”. This discussion is explored in greater detail below.

What about those who actually try and apply principles of equity? The National Institute for Health and Clinical Excellence

36 D. Furness and B.Gough, *Local Control and Local Variation in the NHS: What Do the Public Think?* (London: Social Market Foundation, 2009).

37 Culyer and Wagstaff, “Equity and Equality in Health and Health Care”, 452.

38 Department of Health, *Health Inequalities – Progress and Next Steps* (London: HMSO, 2008), 10.

(NICE) is charged with evaluating technologies and reducing variation in clinical standards across the whole of the NHS. Equity, according to NICE, “refers to fairness in the ways in which the costs and benefits of available care are distributed among all who use the NHS”.³⁹ This definition is not particularly remarkable, and it does not represent a broad consensus on what equity should mean. This is perhaps because, as NICE chairman Sir Michael Rawlins remarks, “Much of the philosophical literature on equity is far from being applicable in the real world.”⁴⁰

More practical definitions of equity have been supplied by writers like Whitehead. Referring specifically to the NHS, she lists the features of the service that fall under her overarching concept of equity, without focusing on an explicit philosophical framework. Whitehead’s equity criteria are:

- service for everyone;
- free at the point of use;
- comprehensive range of services;
- geographic equality;
- high standards – levelling up not down;
- selection on need, not ability to pay;
- high ethical standards.⁴¹

This approach is much more useful in equipping policymakers to deal with the challenges to equity that are discussed in more detail below than the more abstract approaches to the design of services and allocation of resources found in much of the literature.

Conclusion

The preceding discussion has shown that equity in healthcare is

39 M. D. Rawlins and A. J. Culyer, “National Institute for Clinical Excellence and Its Value Judgments”, *British Medical Journal* 329:7459 (2004).

40 *Ibid.*

41 M. Whitehead, “Who Cares About Equity in the NHS?”, *British Medical Journal* 308:6939 (1994).

a nebulous concept, difficult to define precisely and the subject of a great deal of academic debate. While many different health systems have equity as a central aim, it is impossible to detect a consistent approach. Even among the academic community there is an acknowledgement that translating theoretical knowledge about equity into practically applicable principles for service design and resource allocation is a sticky problem. As one of the architects of recent NHS reform, Julian Le Grand, writes: “The practical notions of equity that should inform policy and the ways in which these should be implemented are far from clear.”⁴²

This lack of clarity about how equity should be defined indicates that to apply principles of fairness consistently requires a less abstract, more practical definition of what is considered equitable. The second part of this chapter suggests how equity should be defined in the context of a severe squeeze on healthcare resources and in an increasingly localised system with ever more variation of service between different localities.

EQUITY AND THE NHS

The first part of this chapter outlined the academic debate about equity in health and healthcare. The discussion on different conceptions of equity in health systems has demonstrated the limits of a purely theoretical approach. The truly important question is how equity is applied in practice – how to make health services fair. This section looks specifically at how equity has been approached in the NHS from its inception in 1948. It then examines how equitable the service is now. Challenges to conventional ideas about equity are then discussed before a number of policy recommendations are suggested as a response to changing circumstances.

42 F. Sassi, J. Le Grand and L. Archard, “Equity Versus Efficiency: A Dilemma for the NHS. If the NHS Is Serious About Equity It Must Offer Guidance When Principles Conflict”, *British Medical Journal* 323:7316 (2001).

Equity at the birth of the NHS

A brief look at the Beveridge Report

William Beveridge's 1942 report, *Social Insurance and Allied Services* (known as the Beveridge Report), served as the basis for the post-war welfare state, including the National Health Service. The report argued, notably, that social insurance is only one part of a "comprehensive policy of social progress", thus allowing for the NHS to be paid for out of general taxation rather than via national insurance.⁴³

The report also set limits on the future NHS and welfare state, arguing that the state "should not stifle incentive, opportunity, responsibility; in establishing a national minimum, it should leave room and encouragement for voluntary action by each individual to provide more than that minimum for himself and his family." Beveridge argued that this system would provide a minimum standard of living "below which no one should be allowed to fall".

The establishment of the NHS

The implementation of the report was carried out by Aneurin ('Nye') Bevan, who was appointed Minister of Health in 1945. The shape that the NHS took in its early years was to a large degree dominated by the statist and centralist Fabian version of socialism that dominated the Labour Party at that time. Under the final settlement for the NHS, 2,688 voluntary and municipal hospitals in England and Wales were nationalised and came under Bevan's supervisory control. Nothing in the Beveridge Report had demanded this degree of central control.

The scope of Bevan's NHS was also greater than Beveridge had envisioned. Bevan established a service free at the point of delivery for all, where "every person, regardless of wealth or position, would

43 W. H. B. Beveridge, *Social Insurance and Allied Services* (London: HMSO, 1942).

have access to excellent health care". This is a much more expansive vision than Beveridge's idea of minimum of treatment for those who could not afford to pay for it.

Bevan's vision was to "universalise the best",⁴⁴ which fits with Whitehead's "levelling up" criteria for equity. However, it is worth noting that the words equity and equality were not mentioned in early NHS documents.⁴⁵ This is very likely to be because an acknowledged definition of equity was not necessary when the NHS was founded. The prospect of orphan drugs or top-up payments for cancer care was not anticipated in 1948. This lack of clarity about equity in the early NHS was demonstrated when Bevan, appointed Minister of Labour in 1951, resigned in protest at Hugh Gaitskell's (then Chancellor of the Exchequer) introduction of prescription charges for dental care and spectacles – created in order to meet the financial demands imposed on the budget by the Korean War. Implicit in this decision seems to be a maximalist view of equity whereby any form of limitation to free care is considered inequitable and, therefore, unacceptable. But it is clear that this view is not sustainable, and has never been reflected in the realities of the health service.

Developing the idea of equity in the NHS – allocating resources

The NHS (with some exceptions, such as dental and eye care) does not deny care to people on the basis of their ability to pay. So the challenge is largely one of distributive equity – making sure that resources are directed to areas with the greatest need.

Since 1976 healthcare equity has been an explicit part of resource allocation in the NHS. At that time it was decided that healthcare should be geographically distributed to ensure equal access for equal risk. The mechanism through which this was to be

44 T. Delamothe, "Founding Principles", *British Medical Journal* 336:7655 (2008).

45 T. Delamothe, "Universality, Equity, and Quality of Care", *British Medical Journal* 336:7656 (2008).

achieved was the Resource Allocation Working Party (RAWP), which was appointed to oversee the process.⁴⁶

As the methodology developed, the RAWP was replaced by the Advisory Committee on Resource Allocation which, in 1999, added a new requirement that resource allocation should contribute to reducing health inequalities.⁴⁷ This seems to embody a conception of equity as an equal opportunity to be healthy, which is not the same as equal access based on need (a definition discussed in the preceding section).

The NHS model of resource allocation has continued to develop, and since 2003–4 the AREA model has been in place. Utilisation is used as a proxy for need in determining the level of resource an area receives. So, areas where there are high levels of healthcare utilisation are assumed to have high levels of need. There are problems with this approach. Adopting utilisation as a proxy assumes that need is fair; that people can and do access healthcare only when they need it. This may have the inadvertent effect of depressing the “need” of areas that have real health problems, many of which may be connected with a failure to seek timely medical care.

The Department of Health explains: “A weighted capitation formula determines each PCT’s target share of available resources, to enable them to commission similar levels of health services for populations in similar need, and to reduce avoidable health inequalities.”⁴⁸ This formula is based on factors such as educational attainment, birth rate, low income and morbidity in under 65-year-olds.

46 S. Asthana and A. Gibson, “Health Care Equity, Health Equity and Resource Allocation: Towards a Normative Approach to Achieving the Core Principles of the NHS”, *Radical Statistics* 96 (2008).

47 Asthana and Gibson, “Health Care Equity, Health Equity and Resource Allocation”.

48 “About NHS Allocations: Department of Health – Managing Your Organisation”, http://www.dh.gov.uk/en/Managingyourorganisation/Financeandplanning/Allocations/DH_076547.

The methodology adopted to allocate resources is not just a technical question, but one that reflects the central purpose of the NHS, and its approach to equity. As the Department of Health makes clear, the current formula is intended to narrow health inequalities and, as such, it devotes a greater share of resources to urban areas that tend to have higher levels of deprivation. But this approach has been subject to criticism – described as the “medicalisation of socioeconomic inequality” by Sheena Asthana.⁴⁹ More affluent areas tend to have a higher proportion of older people, and may be relatively underfunded compared to areas that meet more of the criteria set out by the current formula, which places a higher emphasis on reducing health inequalities than on treating actual ill health. In reality, this might mean that rural areas are disadvantaged relative to cities because they have an older population, but suffer less from economic deprivation. Others have criticised the opacity of the methodology. Nigel Hawkes sums up the mystery that surrounds the resource allocation process: “Wizards uttering incantations dance around a cooking pot stocked with tasty data, brewing up heaven knows what. The light is dim, and understanding is even dimmer.”⁵⁰

The resource allocation formula was reviewed in late 2008, but did not change in response to criticisms about possible bias against rural areas. There was an acknowledgement, however, that in defining a resource allocation formula it is impossible to reconcile need and inequalities. One formula can define need, while another is needed to define avoidable health inequalities. It is a ministerial decision as to how much weight is given to the inequalities formula relative to the need formula in allocating resources. This was a recommendation of the advisory committee on resource allocations, “as no technical way of assessing how

49 Quoted in S. Gainsbury, “NHS Inequalities Row Shrouded in Secrecy”, *Health Care Analysis* (11 September 2008).

50 “Resource Allocation – It’s a Jungle Out There”, *British Medical Journal* 338 (14 January 2009).

much weight should be given to the health inequalities formula has been found".⁵¹

This shows how far decisions about equity are political rather than based on clear-cut academic formulae. It also reflects a wider tension between two definitions of equity. One definition, connected with health inequalities, sees the NHS as aiming to offer equal opportunities to be healthy. The other definition, reflected in the aim of the formula assessing need, sees "equal opportunity to access health care for people at equal risk"⁵² as central to equity.

It is clear that these two competing definitions lead to significantly different approaches to resource allocation in healthcare. But what is reflected in the NHS itself? How far does it meet the equity goals that it sets itself? What follows demonstrates why a more limited definition of equity, based on equal access for equal need, is a more appropriate and sustainable goal for the future of the health service.

Equity in the NHS today

The NHS does not in fact provide a horizontally equitable service. That is to say that people in need do not get the care they should. Problems may be to do with access (e.g. geographic variations in care) or institutionalised discrimination (perhaps against older people). These inequalities are not necessarily connected with the resource allocation debates described above, but they do reflect different problems in the NHS.

A 2003 review conducted on behalf of the Number 10 Strategy Unit concluded that, relative to their need, poorer people were

51 Department of Health, *Report of the Advisory Committee on Resource Allocations* (London: HMSO, 2008), 3.

52 Department of Health, *Report of the Advisory Committee on Resource Allocations*, 16.

less likely to access healthcare than richer people.⁵³ The authors speculated that the impact of late presentation of symptoms might be the main cause of inequity in chronic care, and also looked at issues such as transport in preventing equal access to care.

Other authors have been much more explicit about the institutional inequity of the NHS. Nigel Rice and Peter Smith have raised the problem of geographical inequity:

[V]ery rural communities may suffer a lower level of services than their urban counterparts, may have to travel further to secure such services, or may receive healthcare in a different manner (for example through greater use of telemedicine). The issue of rurality exemplifies the trade-off that exists between equity and efficiency in the allocation of health care resources.⁵⁴

In other words, it is simply not efficient to try and even up healthcare resources around the country given, for example, the current distribution of hospitals, throughout England.

The inequitable distribution of healthcare in the UK is also demonstrated in figure 2.2, which shows GP coverage per 100,000 weighted population. Clearly there is a great deal of variation across the country.

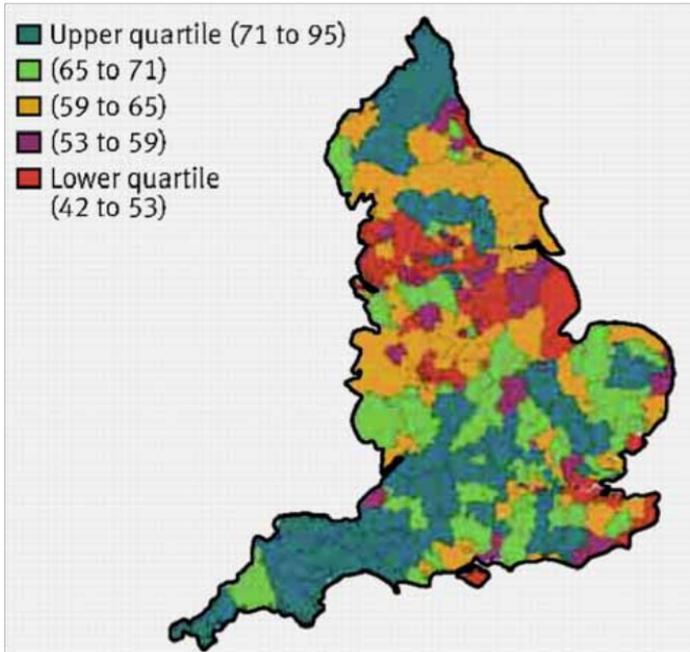
Another challenge to equity is universal standards of care. Recent research has pointed out that regardless of the quality of its advice, NICE guidance is being ignored by many healthcare professionals. The Healthcare Commission reported that failure to implement NICE guidance is one of the most common self-reported failures of compliance to the Healthcare Commission.⁵⁵

53 Dixon, *Is the NHS Equitable?*

54 N. Rice and P. C. Smith, "Ethics and Geographical Equity in Health Care", *British Medical Journal* 27:4 (2001).

55 Ibid.

Figure 2.2: GPs per 100,000 weighted population, by primary care trust



Source: T. Delamothe, "Universality, Equity, and Quality of Care," *British Medical Journal*, 336: 7656 (2008).

Variations in care are present not only on a geographic basis. A 2008 study of treatment for angina found that, after adjusting for need, older people were less likely to be treated than younger patients, women less than men, South Asians less than white people and socially deprived people less than better-off individuals.⁵⁶

A review of PCT performance relative to spending in certain key treatment areas also found levels of variation that could not be explained by reference to other factors such as the socio-economic make-up of patients in a particular location.⁵⁷

56 N. Sekhri et al., "Inequity of Access to Investigation and Effect on Clinical Outcomes: Prognostic Study of Coronary Angiography for Suspected Stable Angina Pectoris", *British Medical Journal* (2008).

57 J. Appleby and S. Gregory, *NHS Spending: Local Variations in Priorities: An Update*. (London: King's Fund, 2008).

Equity, NHS targets and health inequalities

So there is some compelling evidence that the NHS does not always meet high standards of horizontal equity and that access to care can be determined by geography, age, gender, race and income rather than medical need. This is despite attempts to distribute resources equitably, and central targets aimed at reducing unequal access to care.

The long-term future of the health system is local. If the NHS is to deal with the challenge of a changing population, new technologies and a funding squeeze related to what may be the worst recession for many decades, it will have to make decisions at a local level, and follow through on the policy trends embodied in the world class commissioning programme. PCTs should be properly equipped to work with local communities to design services appropriate to them. This implies that the major aim of the NHS should be to offer equal care for equal need for a defined community. Health inequalities, after all, primarily reflect the differences between rather than within different areas. In terms of NHS targets, this would result in targets that, instead of focusing on health inequalities overall, focus on inequalities of access. What this would look like for the NHS is explored in a discussion of appropriate NHS targets in chapter 4.

The argument that health services should be charged only with securing equal access for equal need does not imply that the importance of health inequalities should be downgraded. In fact, health inequalities should move up the political agenda. There has been substantial progress in improving health in the most disadvantaged groups. Life expectancy for men in the Spearhead groups (where most attention has been focused) has increased by more than two and a half years in the period since 1995–7.⁵⁸

58 Department of Health, *Health Inequalities – Progress and Next Steps*, 20.

However, there are still enormous problems – the gap in life expectancy between the poorest and richest groups continues to widen.⁵⁹ And government policy already admits that a range of stakeholders, not just the NHS, is needed to try and narrow inequalities. “The role of central government is crucial – but limited. The most important actors are local: including primary care trusts, primary care practices, schools, houses, employers, Jobcentre Plus and community midwife teams.”⁶⁰ As the House of Commons Health Committee concluded: “Measures to enable people to adopt healthier lifestyles involve a range of government departments. These Departments could do far more than they do at present.”⁶¹ These agencies should not be coordinated by the NHS, but from a single point within government with oversight across the whole range of government activity.

Equity in the NHS should be about providing equal access for equal need in health services. This will mean that health inequalities no longer form part of the resource allocation formula applied by the NHS, with the focus shifting instead to providing equal access to treatment for equal need.

Health inequalities are so important that rather than being the responsibility of the NHS, they should be overseen by the whole of government. Government action to deal with health inequalities should be joined up, with the NHS only one part of a wider agenda. This is a more appropriate and achievable goal for health services because:

- the NHS does not currently provide equal access for equal need;
- health inequalities will not be narrowed by health services alone but by coordinated government action.

59 Ibid.

60 Ibid., 16.

61 House of Commons Health Committee, *Health Inequalities: Third Report of Session 2008–09, Vol. 1* (London: HMSO, 2009), 7.

Recommendation 1: Central to the concept of equity in the NHS should be a definition of equal access to equal need.

Recommendation 2: A Cabinet Office minister for Health Inequalities should be introduced with responsibility for coordinating action across government to narrow the gap in health within the population.

Equity in other health systems

The discussion so far has focused on the limitations of a theoretical approach to equity and traced the development of equity in the NHS since its inception. A conclusion of this discussion has been that central to the idea of equity should be equal access for equal need. But while this might make a difference to how resources are distributed, there are further implications of how equity is defined, particularly with regard to patient charging.

The tax-funded NHS is considered broadly equitable. But so are most other health systems that do not rely on private insurance or out-of-pocket payments for the bulk of healthcare provision. In fact, most systems that offer universal coverage are seen as equitable. However, there is not a clear picture about what equity looks like in practice. The case of the NHS shows that even with a progressive system of funding and clear targets to improve horizontal equity, inequalities remain both in health and access to healthcare. But the example of other European countries shows that in order to remain equitable, the NHS should consider implementing policy options that have hitherto been deemed unacceptable.

The case of user charging

In the UK, user charges are seen as embodying all that is inequitable about healthcare delivery. This sentiment was expressed by former

Secretary of State for Health, Patricia Hewitt MP, who said: “The people who propose co-payments and top-up fees are attacking the fundamental principles of the NHS.”⁶² However, other health systems that provide broadly equitable universal coverage include user charges without a sense that they are a fundamental challenge to equity or that they threaten the future of collective health provision. “Cost sharing is widely used in Western European health systems to moderate demand and/or raise revenue.”⁶³ Table 2.1 provides a useful summary of the different types of charges.

Table 2.1: Types of out-of-pocket payment

Form	Definition
Direct payments	Payments for goods or services obtained from the private sector in “pure private” transactions – for goods or services not covered by any form of pre-payment or insurance
Cost sharing/ user charges	Require the individual covered to pay part of the cost of care received
Informal payments	Unofficial payments for goods or services that should be fully funded from pooled revenue; sometimes referred to as envelope or under-the-table payments.

Source: A. Timmis and E. Mossialos, *What Are the Equity, Efficiency, Cost Containment and Choice Implications of Private Health-Care Funding in Western Europe?* (WHO Europe: WHO Regional Office for Europe, 2004)⁶⁴

France is a good example of a health system that is considered equitable while also charging for care. It is a system that is often held up as an exemplar for the rest of Europe, ranked number one in the world by the WHO in 2000.⁶⁵ This is “due in large part to its high level of population health, degree of freedom for physicians and patients, easy access to health care for most people, absence

62 Speech by the Rt Hon Patricia Hewitt MP, Secretary of State for Health, 14 June 2007: London School of Economics, http://www.dh.gov.uk/en/News/Speeches/DH_075592.

63 A. Timmis and E. Mossialos, *What Are the Equity, Efficiency, Cost Containment and Choice Implications of Private Health-Care Funding in Western Europe?* (Copenhagen: WHO Regional Office for Europe, 2004), 2.

64 Timmis and Mossialos, *What are the equity, efficiency, cost containment and choice implications of private health-care funding in western Europe?*

65 S. Sandier et al., *Health Care Systems in Transition: France* (London: European Observatory on Health Care Systems, 2004).

of waiting lists for treatment and universal coverage".⁶⁶ This ranking was achieved with a funding system that would be politically unacceptable in the UK.

The French system provides comprehensive coverage and is mainly funded through statutory health insurance. Patients pay for their treatment and are then reimbursed (with some exceptions such as cosmetic treatments and those of unproven effectiveness). However, reimbursement does not extend to the total cost of treatment, with higher levels of charges for outpatient care and pharmaceutical products and lower levels for hospital treatment. In 2000, these user charges raised 11.1% of total health expenditure.⁶⁷ This is a far greater proportion than private spending in the UK. Figure 2.1 (above) showed the relatively minor role of private payments in the UK relative to other OECD countries, including those that are (a) also considered equitable and (b) higher performing.

It is clear that a broad conception of "equity" allows for great variation in health system design, including the option to charge users for healthcare. Chapter 3 contains a full discussion of potential user charges in the UK, including a recommendation that some limited charges be introduced for those who can afford to pay, in order to reduce demand. But it is clear from the international evidence that charges are not the affront to the fundamental principles of the NHS that some have argued. The authors of an OECD study rightly maintain that universal coverage is the basis of an equitable health system, but demonstrate that many systems can flourish within this broad definition:

In Switzerland, mandatory health insurance is the sole source of cover for the entire population. Some countries' public insurance rules, like Australia, Belgium, Finland,

66 Ibid.

67 Ibid.

France, Norway and Portugal, require their insured to pay co-payments which vary depending on the type of services, while in many other countries (like Denmark, Canada, Germany, Spain, Portugal and the UK) visits to public sector doctors are free at the point of delivery. In yet other countries, like Hungary and Greece, care is officially free at the point of delivery but, in practice, unofficial payments to doctors are widespread.⁶⁸

The NHS should not be considered inequitable simply because it charges those who can afford to pay for some services including dental care and prescriptions. Health systems with varied sources of funding can be considered equitable, and the example of user charges shows that what is considered a fundamental principle in one country is not considered so important in another. In fact, about the only thing that “equitable” health systems have in common is an idea of universal access: that patients *should* have access to healthcare whatever their income. The defining characteristic of an equitable health system is therefore universal access, not a limited notion that services should be “free at the point of use”.

A definition of equity for the NHS

The European Observatory on Health Systems and Policies defines equity thus: “The principle of being fair to all, with reference to a defined and recognised set of values.”⁶⁹ What is the NHS’s defined and recognised set of values? An important product of Lord Darzi’s Next Stage Review was the NHS Constitution, published early in 2009.⁷⁰ It contains a list of NHS values, namely:

- respect and dignity;
- commitment to quality of care;

68 E. Van Doorslaer and C. Masseria, “Income-Related Inequality in the Use of Medical Care in 21 OECD Countries”, in *OECD, Towards High-Performing Health Systems* (2004).

69 “European Observatory on Health Systems and Policies - Equity”, <http://www.euro.who.int/observatory/Glossary/TopPage?phrase=Equity>.

70 Department of Health, *The NHS Constitution: The NHS Belongs to Us All* (London: HMSO, 2009).

- compassion;
- improving lives;
- working together for patients;
- everyone counts.

However, it did not address wider debates about NHS values, including the discussion of equity outlined throughout this chapter. In the context of scarce public resources, and a change to the charging structure of the NHS, the health system must develop a new definition of values reflecting the reality of healthcare in this country. There are limitations to a purely theoretical approach, and it is essential that a set of values is accessible and comprehensible to people who use health services.

The SMF Health Project public opinion research revealed that fairness remains a central priority when it comes to health services, though the research showed that people have different understandings of what this actually means in practice. Some prefer the idea that health services are the same across the country, while others think that services should be distributed according to local need.⁷¹ For both groups, charging for some services was an option discussed to safeguard the continuation of universal health services overall. But their different understandings of fairness suggests that there is a need for a defined set of NHS values that would make clear what is actually the case in health services – that services are different in different locations, and that people contribute according to their means.

Recommendation 3:

An NHS set of values should include:

- **universal access: no one should be excluded from necessary treatment because of an inability to pay, but those who can afford it should contribute more;**

71 Furness, *Local Control and Local Variation in the NHS*.

- **a comprehensive range of services:** the NHS should provide a comprehensive range of services that offers good value for money;
- **equal access to treatment:** the NHS should make sure that everyone has equal access to treatment regardless of age, gender, income or ethnic background;
- **local services for local need:** the NHS should provide a range of services appropriate for different local areas; PCTs should work with local people to decide what is needed and to justify the difference between different areas.

These defined values reflect a new understanding of the role and capacity of health services. They reflect a realistic assessment of the need to maintain universal access in a time of scarcity, with an open acknowledgement of limitations and the need for wealthier people to pay more if they can afford it. Furthermore, these values reflect the local priorities that will be necessary if the NHS is to manage public expectation and maintain public support for a tax-funded health system.

Equity is an essential principle for health services. But it is clear that definitions of equity are many, and their application is inconsistent and encompasses many potential systems of healthcare delivery. By defining NHS values more carefully, government can safeguard public support for a system of universal access that, while it might not have satisfied Nye Bevan, is a realistic assessment of the future of his creation.

CONCLUSION

Equity will continue to play a central role in determining the future design of the health system. However, equity should be clearly



defined in a set of codified NHS values rather than being a vague aspiration. As part of this move towards a clear definition of equity, the NHS should no longer be primarily responsible for narrowing health inequalities and should instead focus on ensuring that individuals have equal access to treatment when they fall ill. Health inequalities are a task for the whole of government, and should be the responsibility of a minister in the Cabinet Office who can coordinate the action of multiple agencies.

But equity should not be as narrowly defined as it is in the current political debate about healthcare in England. Many other health systems are considered equitable that have systems of funding and charges that would not be politically acceptable here. The crisis in public finances means that what is considered fair now may not be desirable in the future. There is a great need for a clearly defined set of values for the NHS that will provide a guide for policymakers and also help to engage the public in the difficult decisions that lie ahead.

CHAPTER THREE: PAYING FOR HEALTHCARE

The prognosis for the public finances is dire. The economy is in recession, with a consequent fall in tax revenues and a massive increase in expenditure, both reflected in unprecedented levels of government borrowing. While public spending continues apace in the short term to stave off depression, the outlook for the coming decade is a sharp spending squeeze once the worst of the recession is over. It is in this uncertain context that it is vitally important to look again at the future financing of public services. The NHS has been the beneficiary of record levels of investment in recent years, but the days of largesse are over. The research presented below analyses prospects for NHS spending in an economic downturn. It also examines the potential for increased private payments in the UK health system and includes a number of policy proposals. It looks at the likely development of private finance for healthcare over the long term, and examines what can be learnt from the example of other international health systems.

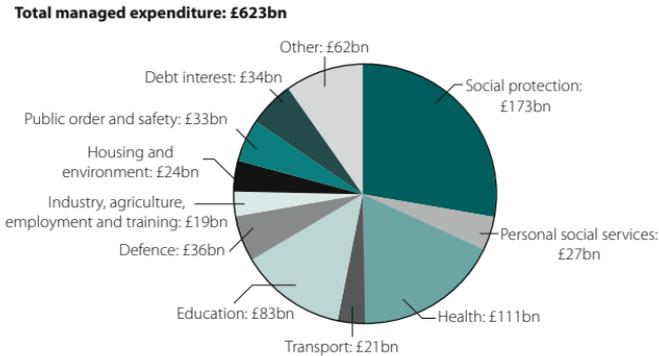
It is vitally important that the political debate about healthcare develops to become an open and honest discussion concerning the challenges facing the health system in the years ahead. This discussion is necessary to ensure that the bold reforms that will be necessary to guide the NHS through the downturn are put into place. If this fails to happen it will be the least well-off members of society who are most badly affected as it is they who rely most on publicly funded health services.

Public services and the downturn

Health services have been one of the main beneficiaries of the extraordinary levels of public spending that we have seen in the past few years. As Carl Emmerson of the Institute for Fiscal Studies (IFS) put it, as public spending increased “the NHS was one of the

winners".⁷² The NHS budget has risen from £35 billion in 1997 to a projected £111 billion in 2010/11.⁷³ And this out of a total managed expenditure of £623 billion (see figure 3.1).⁷⁴

Figure 3.1



Source: HM Treasury 2008-09 near-cash projections. Spending re-classified so functions compared to previous publications and is now using methods specified in international standards. Other expenditure includes spending on general public services (including international services); recreation, culture and religion. Public service pensions: plus spending yet to be allocated and some accounting adjustments. Social protections includes tax credit payments in excess of an individual's tax liability, which are now counted on AME, in line with OECD guidelines. Figures may not sum to total due to rounding.

It therefore follows that the need to cut public spending sharply over the coming years to fill a huge structural hole in the public finances is likely to have a severe impact on healthcare, as well as on other public services. No one, it seems, expects that the NHS will enjoy anything like the 6.4% real-terms increases it received between April 1999 and March 2008.⁷⁵ Indeed the longer the recession goes on, the more likely it becomes that public spending will in fact need to undergo a prolonged contraction in real terms over the coming years.

To set decisions about future financing of healthcare in context, Derek Wanless's 2002 report on the future of healthcare suggested

72 C. Emmerson, "NHS Spending – What Does the Future Hold?" *Health Service Journal* (15 August 2008), 16.

73 HM Treasury, *Pre-Budget Report and Comprehensive Spending Review* (London: HMSO, 2007).

74 HM Treasury, *Pre-Budget Report 2008* (London: HMSO, 2008).

75 *Ibid.*

that even in the most optimistic of scenarios (in which the health service becomes much more productive, and people take better care of their health) health services would require average real-terms increases in spending of 4.4% up to 2012/13 to achieve continued improvement. His least optimistic scenario suggested that spending would need to rise by 5.6% per annum.⁷⁶

PricewaterhouseCoopers recently published an analysis suggesting that the government faces a fiscal gap of around 3% of GDP by 2013/14 – equivalent to around £43 billion at today's prices. The options for meeting this gap are not palatable – an unprecedented freeze in spending, or a slowing in spending increases that would still require extra taxation of around £25 billion.⁷⁷ The 2009 budget confirmed much of this message, with the Chancellor announcing that public services will see average real-terms rises of 0.7% from 2011 to 2014⁷⁸ – way below the level of increases that have previously been enjoyed by the NHS and which have generally been seen as the minimum for continued improvement in quality. An IFS analysis of the 2009 budget concluded that the situation for departmental expenditure limits (DELs) spending would be even worse. Departments, of which the NHS is the largest, can expect annual spending decreases in real terms of 2.3% between 2011 and 2014 (see figure 3.2).

In addition to a slowdown in funding, the public sector will be required to find £9 billion of annual efficiency savings by 2013–14.⁷⁹ Chief Executive of the King's Fund, Niall Dickson, has said: "This is a wake up call for the health service – no matter who is in power from 2011 the NHS will have to manage with very low or no growth in its funding."⁸⁰

76 D. Wanless *Securing Our Future Health – Taking a Long Term View* (London: HMSO, 2002), 75.

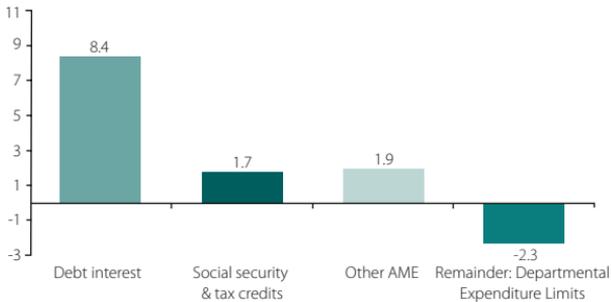
77 J. Hawksworth and N. Jones, *Dealing With Debt: Reforming Public Services and Narrowing the Fiscal Gap* (London: PricewaterhouseCoopers, 2009).

78 HM Treasury, *Budget 2009: Building Britain's Future* (London: HMSO, 2009), ch. 6.

79 *Ibid.*, 123.

80 "Budget a Wake-Up Call for the Health Service Ahead of 2011 Budget Squeeze", http://www.kingsfund.org.uk/what_we_do/press/budget_a_wakeup.html.

Figure 3.2: Average annual real increases, April 2011 to March 2014



Source: Institute of Fiscal Studies

And even before the current economic downturn, many experts had predicted that demand for, and the costs of, health services would rise at a greater rate than our ability to pay for them through taxation. One authoritative report, an analysis conducted by NERA and Frontier Economics, suggested that the NHS will face a funding gap of £11 billion by 2015 if we maintain current (up to 2010) levels of annual spending increases.⁸¹ While changing circumstances mean that precise predictions about future levels of funding are virtually impossible to make at this point, it is clear that health systems in all developed countries are facing potential shortfalls in their ability to deliver a level of service that modern consumers expect within existing budget constraints.⁸²

With a prolonged contraction in public spending as a proportion of GDP over the next decade being inevitable, there are two challenges for healthcare. Can extra sources of revenue be found, and can efficiency savings mitigate the impact of a downward trend in spending? These are crucial questions not only because it is important to provide high-quality healthcare through

81 E. Bramley-Harker et al., *Mind the Gap: Sustaining Improvements in the NHS Beyond 2008* (London: BUPA, 2006).

82 D. Furness et al., *SMF Health Project Background Paper 2: Demography and Technology – External Pressures for Change* (London: Social Market Foundation, 2008); D. Furness et al., *SMF Health Project Background Paper 5: Patients in the Health System* (London: Social Market Foundation, 2008); A. Gurria, "Strategic Options to Finance Pensions and Healthcare in a Rapidly Ageing World", http://www.oecd.org/document/14/0,3343,en_2649_37407_42125070_1_1_1_00.html.

the NHS, but also because it is questionable whether public support for the health system can be maintained if the NHS fails to continue its recent improvement. A failure to find more money and/or make significant economies could be the end of the current political settlement in healthcare that has existed for the past 60 years.

Part Two of this report presents a series of recommendations for efficiency savings in the health system that can be achieved through high-quality commissioning. As a means of achieving improved commissioning, this report also recommends new accountability mechanisms and a new responsibility for designing locally varied services that will enable local health commissioners to engage their local populations. But, as chapter 6 makes clear, it is difficult to quantify the likely savings associated with improvements in commissioning. It seems unlikely that efficiency savings will be enough to deal with the severe squeeze in NHS budgets that is now imminent. In this chapter we will therefore consider whether changes to the way the health system raises revenue could be used as a way either to increase resources or to manage demand.

This chapter explores the potential of increasing revenue for the NHS from sources other than taxation, and also considers options for limiting expenditure. Such issues raise a huge number of questions that go to the heart of what the NHS was set up to achieve. Would the introduction of private payments be desirable for the NHS? What might their impact be on health finances, service for patients and fairness in accessing healthcare? While private payment for public services has, since the inception of the NHS, largely been seen as undesirable, it is clear that people are willing to pay for products they believe will help them to secure good health. Complementary and alternative therapies thrive, as do health, fitness and nutritional services. Can this willingness to pay for good health be translated into a systematic willingness to pay for good healthcare? The discussion in this chapter is informed by a series of public opinion polling and discussion groups that

explored how people would choose to make up shortfalls in health budgets.⁸³

PUBLIC WILLINGNESS TO PAY FOR HEALTHCARE

It is clear that in our society there is a general willingness to spend money on good health. This raises a question about whether there are ways to translate this willingness to pay for health and healthcare into new sources of funding for the NHS. Anecdotally, the popularity of gym memberships, vitamin supplements and “detox” programmes supports the idea that the public is willing to make a financial commitment to maintaining good health. It has been suggested that it might be possible to harness this willingness to pay for good health and translate it into an extra revenue stream for the NHS. This section of the report looks at the evidence for general health spending and what motivates it, before drawing some conclusions for the future of the NHS.

What does the public spend on good health?

This section considers health expenditure that does not fall under the category of conventional healthcare. Taxation and National Insurance, private medical insurance or self-payments for hospital treatment are not relevant here. In general, the focus here is on complementary and alternative medicines, physical exercise equipment and related subscriptions (gym memberships), nutritional supplements and “health” foods. However, this list is not exhaustive, as this sector is not coherently defined. Despite this, there is convincing evidence that it is growing, perhaps indicating that people are increasingly interested in securing improved health.

A meta-analysis of studies of the use of complementary and alternative medicine (CAM) found that true prevalence is difficult to measure. However, “the data suggest that complementary/

83 D. Furness and B. Gough, *Local Control and Local Variation in the NHS* (London: Social Market Foundation, 2009).

alternative medicine are used frequently and increasingly".⁸⁴ Thomas et al. conclude that around 10% of the population in England use CAM in a given year, representing expenditure of about £450 million.⁸⁵ The House of Lords select committee investigation concluded: "These rather limited data seem to support the idea that Complementary and Alternative Medicine use in the United Kingdom is high and is increasing."⁸⁶

The Stockholm Network has estimated the global health and wellbeing industry at £1 trillion, with a total UK market of over £11 billion.⁸⁷ It reports "exponential" growth in health spending, with a 58% increase in the sale of over-the-counter medicines between 1997 and 2007 and a 678% increase in sales of physical exercise equipment from 1990 to 2000.⁸⁸

The exact figures in this area are less important than the clear scale of spending. Over recent years, the NHS has found itself highly concerned with deficits and surpluses of around £1 billion. Surely, then, it might be possible to translate some of the evident spending on good health into extra revenue for a cash-strapped health service? Unfortunately, the reality is not so simple.

Why do people choose to spend money on health-related products?

There are many different reasons why people choose to spend money on health-related products. While some are straightforward – people join gyms to benefit from easier access to physical exercise

84 E. Ernst, "Prevalence of Use of Complementary/Alternative Medicine: a Systematic Review," *Bulletin of the World Health Organisation* (2000): 78.

85 K. J. Thomas, J. P. Nicholl and P. Coleman, "Use and Expenditure on Complementary Medicine in England: a Population Based Survey", *Complementary Therapies in Medicine* 9:1 (2001).

86 House of Lords Science and Technology Committee, *Complementary and Alternative Medicine* (London: HMSO, 2000).

87 D. Torstensson and G. Isyanova, *A Healthy Market? The Health Quality Agenda* (The Stockholm Network, 2008).

88 *Ibid.*, 17.

– others are less obvious. For example, Dr Ben Goldacre, author of the well-known Bad Science blog, argues that the current popularity of “detox” products that claim to cleanse the body of harmful elements is in fact an updated version of ancient purification rituals, with most products no more effective than a glass of water and a rest.⁸⁹

Most of the literature in this area is concerned with why people choose to use CAM, with relatively less attention paid to other health-related products such as vitamin supplements. There is a limited amount of CAM available through NHS referral and the vast majority is privately funded. There are some important lessons for the future of the NHS to be learned from understanding why individuals choose to spend money outside the conventional health system.

The data here is subject to some serious limitations. CAM users are not distinct from users of health services in general, and much usage is occasional, periodic and may not reflect a wider outlook on health services. However, it is possible to make some broad generalisations from examining studies both of disease-based cohorts and CAM users in general.

Motivations for choosing CAM can generally be divided into “push” and “pull” categories. “Push” factors might include a dissatisfying experience with conventional medicine, while “pull” factors include a worldview that correlates with that espoused by a particular form of CAM.

Ong and Banks, writing for the Federation for Integrated Health, offer an example of this push/pull or negative/positive typology for those who choose complementary and alternative medicines:⁹⁰

89 B. Goldacre, “Detox Debunked”, *Sunday Times* (18 January 2009), http://www.timesonline.co.uk/tol/life_and_style/health/features/article5517912.ece.

90 C. K. Ong and B. Banks, *Complementary and Alternative Medicine: The Consumer Perspective* (London: Prince of Wales’s Foundation for Integrated Health, 2003).

Negative

- poor outcomes from conventional treatment;
- adverse reaction to pharmaceuticals;
- negative doctor–patient relationship;
- anti-conventional view of health.

Positive

- good outcome from CAM;
- active participation in care;
- positive doctor–patient CAM relationship;
- view of their own health is in line with principles espoused through CAM.

This description is fairly typical of the literature. It is significant to note that different types of people in different countries all tend to ascribe particular significance to the “holism” of CAM as compared to conventional medicine. In this sense, CAM treats the “whole person”, while conventional medicine is seen sometimes as treating merely the illness. This holistic view ascribes more importance to an individual’s values and perceptions. Italian mental health patients and US army veterans were just two very different groups where research found that this holistic approach was a key motivation for choosing CAM.⁹¹

In the context of the increasing popularity of CAM it is possible that this “pull” motivation of a holistic approach is becoming ever more significant. Sirois compared data on CAM consumers in 1997–8 and 2005 to investigate whether there was any change in why people chose to access CAM. The study identified “[a] shift towards

91 K. Kroesen et al., *US Military Veterans’ Perceptions of the Conventional Medical Care System and Their Use of Complementary and Alternative Medicine* (Oxford: Oxford University Press, 2002); N. Pellegrini and M. Ruggeri, “The Diffusion and the Reason for the Use of Complementary and Alternative Medicine Among Users of Mental Health Services: a Systematic Review of Literature,” *Epidemiologia e Psichiatria Sociale* 16:1.

motivations focusing more on the positive aspects of CAM and less on the negative aspects of conventional medicine ... for the 2005 consumers".⁹² So, the use of CAM is becoming more widespread, and seems to be linked to a feeling that a holistic approach to medicine is more desirable than the medicalised approach of conventional health services.

Our research suggests that it would be very difficult to translate the enormous private spending on health (as opposed to private healthcare) into extra revenue for the NHS. The evidence suggests that the variety of motivating factors behind choosing CAM (though there is evidence that holism is particularly important) will make it difficult for policymakers to direct this spending into the collectively funded health system. It is not correct to see spending on CAM and other health products as substitutes for conventional healthcare. Indeed, it is clear that patients often choose to spend money on alternative medicine precisely because it is not part of the conventional health system. It is therefore difficult to see how the large amounts of money spent each year on a whole range of health and wellbeing products could be translated into extra resources for the NHS. Despite this, there are some important lessons for the future of the NHS. Most important, while it may not be possible to move spending on wellbeing-related products into the public health system, the market for health indicates a general willingness to pay for healthcare. This has implications for the NHS, particularly with regard to charging. This issue is explored in greater detail later in this chapter.

IMPLICATIONS FOR THE HEALTH SYSTEM

Satisfaction rates and PCTs

Measuring satisfaction rates for healthcare will become increasingly

92 F. M. Sirois, "Motivations for Consulting Complementary and Alternative Medicine Practitioners: A Comparison of Consumers From 1997 and 2005", *BMC Complementary and Alternative Medicine* 8:1 (2008).

important as PCTs become more responsive to the wants and needs of their local populations. It is clear from the evidence that many diverse groups choose CAM because it offers a “whole person” service – something not always found in conventional healthcare settings. This insight offers PCTs the potential to raise satisfaction rates with local healthcare services by encouraging a clinical approach that recognises the importance of treating the whole person, not simply managing an illness. There is great potential for GP-led health centres which hold within them a range of clinical services to develop into local “wellness centres” that will engage with individuals who particularly value a holistic service and who may currently be investing money in ineffective alternative medicine, possibly to the detriment of their overall health.

Recommendation 4: The desire to access ‘holistic’ medical services indicates that PCTs could improve satisfaction rates by offering patients a greater array of support services to help manage the whole of their health, not just their illness.

Recommendation 5: GP led health centres should be promoted as ‘wellness centres’ to engage individuals who particularly value a holistic service, and counter concerns that they will lead to a more impersonal form of medical treatment.

Spending on health and wellbeing and NHS charging

While the data is not perfect, there is certainly a substantial market in the UK for health and wellbeing products in general, and CAM in particular. This indicates a willingness by individuals to invest financially in their own good health. A review of the evidence

about CAM users found little correlation between high income and use of CAM; a stronger association was found with higher levels of education.⁹³ So it is not just the very wealthy who choose to spend money on health and wellbeing – it is true of all sorts of people. And some aspects of health and wellbeing spending are certainly high – gym membership rates can often exceed £50 per month.

In this context, it is appropriate to question why the political debate over healthcare attaches such a high priority to the principle of “free” healthcare for everyone – even those who are wealthy enough to spend large amounts on CAM and gym memberships. This spending indicates that many people are willing to monetise decisions about their health and wellbeing. Our research with members of the public also demonstrated that people are willing to countenance charging if public resources are scarce. Government and NHS decision-makers can use this insight to encourage an open and honest public debate about the need to levy charges on some individuals in order to safeguard the accessibility of healthcare for the poorest people and those in ill health. How this might work is explored below.

Recommendation 6: Many individuals are willing to prioritise their health in financial terms. Local and national decision-makers in healthcare must engage people in a realistic discussion about adequate levels of resources in health services.

THE FUTURE OF “TOP-UP” PAYMENTS

The discussion so far has been of the potential to integrate private spending on health into the health system itself. This section

93 F. L. Bishop and G. T. Lewith, “Who Uses CAM? A Narrative Review of Demographic Characteristics and Health Factors Associated With CAM Use”, *Evidence-Based Complementary and Alternative Medicine* (2008).

examines the possible future of top-up payments that have only recently been introduced into the NHS. The newly changed rules⁹⁴ following a review by Professor Mike Richards, mean that patients can now purchase privately drugs that are not available on the NHS and, if they are administered privately, continue to receive publicly funded treatment. Before this change, individuals who purchased privately drugs that were not approved by NICE had their NHS care withdrawn.

Central to this discussion is a consideration of the potential for top-up payments to undermine public support for the NHS model, which, until now, has generally been based on the idea that care provided for all patients is of the same standard. While “hotel” services such as bedside phone services have been paid for by individual patients for some time, it is a new approach to allow certain privately funded treatments to be delivered alongside NHS care. Opponents of top-up payments have argued that this is simply the beginning of a gradual process of defining an NHS core package of minimum treatments and allowing wealthier individuals to purchase an enhanced package of care. Despite this concern, there is little evidence that the introduction of top-ups allows for such a change. The range of treatment subject to top-up payments is extremely limited – generally restricted to expensive cancer drugs that have not been judged cost-effective by NICE. There are few areas of medicine where there is so clear a line between what is a “core” service and what is a “supplementary” service where patients can top-up their NHS entitlement. In other words, without radical action to exclude a large range of current treatments from NHS funding, the prospect for the introduction of top-up payments to lead inevitably to a core package is extremely limited. Instead, as the following discussion demonstrates, it is more likely that top-ups will remain on the margins of the health system.

94 Department of Health, *Improving Access to Medicines for NHS Policy: A Report for the Secretary of State for Health*, by M Richards (London: HMSO, 2008).

Following the change to NHS rules, it is still too early to tell what effect the introduction of top-ups is having. There are clearly equity challenges to overcome, as many poorer people will simply never be able to afford the same access to medicines as those with higher incomes. But it may be that the public mood on this issue has shifted. A Populus poll conducted in late 2008 found that 71% of people agree that “It is right to give people the chance to buy treatments the NHS is unable to provide”. Of those polled, 77% believed that the new system of top-ups was fairer, or no more unfair, than the system it replaced.⁹⁵ It would seem appropriate to conclude that people would rather face the equity challenges of this new system than to “level down” and deny all individuals the chance to purchase potentially efficacious new drugs. This reduces the possibility that top-ups will undermine overall support for a universal public health system – people are realistic about the limits of what can be provided, and where individuals should bear more of the financial risk for expensive medicines that are not necessarily cost-effective.

But what is the possible future for top-up payments? There are several potential scenarios, detailed below:

- top-up payments remain on the margins of the health system, affecting only a tiny minority of patients;
- mechanisms evolving from the collection of top-up payments enable the NHS to introduce across-the-board co-payments;
- a greater focus on eradicating ineffective treatments leads to a much bigger market for top-ups, covering a whole range of unfunded treatments.

The discussion below considers these scenarios and their implications.

95 “NHS Top Ups Poll Summary”, http://www.populus.co.uk/uploads/NHS_top_ups.pdf.

The issue of access to drugs is prominent in the political debate on health. PCTs are required by the NHS Constitution to offer access to NICE-approved treatments, and the Richards review makes provision for patients who wish to top up their NHS care with non-approved medicines. At the moment this ruling affects only a very small number of patients, and relatively few drugs have been rejected by NICE on cost-effectiveness grounds. However, despite the fact that the overall drugs bill is unlikely to destabilise the financial state of the NHS, it seems probable that many more expensive health technologies will become available in the next decade.⁹⁶ So, the likelihood is that top-ups will become ever more significant, rather than simply remaining a marginal concern for only a very few individuals. Furthermore, the pressure on public finances over the years to come implies that NICE is likely to maintain a hard line on treatments it does not consider can be justified on the grounds of cost-effectiveness.

But what will be the impact of a more prominent role for top-ups in NHS care? It is likely that insurers will play a bigger role in insuring individuals against the possibility of requiring non-NICE-approved treatment – the development of a genuine market in top-up products is on the cards. There are already examples of this, such as with WPA's "My Cancer Drugs" policy, but more products of this type should be expected. A spokesman for the Association of British Insurers told the BBC: "Potentially the market is enormous."⁹⁷

The key issue here is where government draws the line at topping up. At the moment, patients can top-up only for non-NICE-approved drugs. But there are many areas of private treatment where patients might choose to "mix and match" with NHS care – from private rooms to post-operative rehabilitation. The years to come are likely to see

96 Furness et al., *SMF Health Project Background Paper 2: Demography and Technology – External Pressures for Change*.

97 G. Satchell, "Insurers Eye NHS Top Ups Market", <http://news.bbc.co.uk/1/hi/health/7669230.stm>, accessed 17 April 2009.

many more patients demanding to top up different aspects of their care where they want more than the NHS can provide. Now that the principle has been established that “It is right to give people the chance to buy treatments the NHS is unable to provide”, it will be hard, and perhaps impossible, for government to deny people the opportunity to buy what they want. The next decade will see a thriving market in insurance-based products that offer supplements to NHS care. These will complement existing private medical insurance products that offer an alternative to the NHS for some treatments.

It is certainly possible that the NHS will develop payment mechanisms that would enable the wholesale extension of co-payments into other areas of provision. Patients will have to pay somehow for the private drugs and staffing time that supplements NHS standards if they choose to top up, and these amounts will not be trivial. High-quality procedures will develop, most likely through PCTs, to collect money from patients. This does not mean that co-payments are likely to become widespread. The evidence set out in this chapter indicates that while there is merit in the argument to introduce a limited range of charges in an attempt to lessen the free rider problem, there is no justification for systematic co-payments in the NHS. Despite this, top-ups mean that the NHS is further advanced in its ability to charge, perhaps offering options to policymakers that have hitherto been impractical.

Most importantly, top-up payments make explicit the rationing that has always been a largely unacknowledged feature of healthcare in the UK. The debate over top-up payments has at its heart an acceptance that there are certain things that the NHS cannot or will not pay for. And research carried out by the SMF shows that patients are willing to consider charging and decommissioning of services to ensure the most efficient use of NHS resources,⁹⁸ especially in a severe economic downturn. Because

98 Furness and Gough, *Local Control and Local Variation in the NHS*.

of this, the most profound implication of top-up payments is likely to be that they enable government and the NHS to engage in an open debate about the limitations of care, and where cuts might be made or charges imposed. In this discussion, the key player is the PCT. PCTs are central to the sustainability of the NHS as they have the responsibility of working with local people to design a range of services appropriate to the needs of a particular area. So, PCT accountability mechanisms become ever more important as the implications of top-up payments become known. A full discussion of commissioning and appropriate accountability mechanisms is included in chapters 6 and 7 of this report.

PRIVATE PAYMENTS

The preceding sections have established that there is a clear willingness to pay for good health expressed in a thriving market for health-related products. While this spending may not be easily translated into systematic contributions to the NHS, it does add to the sense that some form of private payment in healthcare may be acceptable to the public. The recent change to allow top-ups in NHS care are a further indication of changing public views, with a majority of people in favour of this blurring of the lines between public and private care. However, it does not seem desirable that top-ups should develop in order that health spending can be managed through the gradual establishment of a core package of NHS treatments. The practical and political difficulties of this approach, coupled with evidence suggesting that core packages often do not achieve their goals, mean that this is the wrong route for the NHS to take. There is far more potential to have an impact on the financial sustainability of health services through private payments. If the NHS is not to become a minimal system excluding many forms of treatment, then the only possible option is to see whether revenue can be raised and/or demand for health services constrained through a limited range of private payments. This section examines the evidence for the impact of private payments

in healthcare and draws conclusions about how they could be applied in this country.

What is the current situation?

Health systems across the world, even those with common aims of universal access to healthcare, are funded through a whole range of different mechanisms. Among OECD countries, it is clear that the UK stands out in the proportion of healthcare that is publicly funded. Even Scandinavian countries, including Norway and Sweden, traditionally seen as having a particularly strong emphasis on publicly financed services, have more private expenditure in their health system than the UK. The figures are not directly comparable, however. The UK has a fairly unusual structure for health services, in which a private sector exists in parallel to publicly funded services, offering an alternative way to access treatments that are generally also available on the NHS. So, the private financing of healthcare in the UK is largely in the form of medical insurance or out of pocket payments for private care. This sets the UK apart from other systems, which have an element of co-payment for publicly funded care, and no parallel private sector. However the table 3.1 is a clear indication that healthcare in the UK relies particularly heavily on public money. And, in an economic downturn, this leaves the UK health system particularly vulnerable to spending constraints resulting from a reduction in tax revenues.

Table 3.1: Public expenditure on health, 2006, as a percentage of total expenditure on health

Australia	67.7
Canada	70.4
Denmark	84.1
France	79.7
Germany	76.9
Greece	61.6
Ireland	78.3

Italy	77.2
Norway	83.6
Slovak Republic	68.3
Spain	71.2
Sweden	81.7
United Kingdom	87.3
United States	45.8

Source: "OECD Health Data 2008: Statistics and Indicators for 30 Countries", www.oecd.org/health/healthdata

This is one of the reasons that some have argued for the replacement of the NHS by a system of social insurance with a significantly higher proportion of private finance.⁹⁹ Social insurance systems are not markets in a pure form; they tend to offer market incentives to competing insurers in an attempt to drive up efficiency while also seeking to guarantee universal access to healthcare. It has been argued that one of the major reasons for the failings of the NHS is its monolithic structure and lack of market mechanisms.¹⁰⁰ Recent reform of the UK health system has gone some way to introducing markets to healthcare, particularly on the provider side, but without going as far as allowing patients to choose the purchaser of their healthcare.

Social insurance systems can be designed in a number of different ways, and are not straightforward to describe. There are as many different systems as there are European countries that have adopted social insurance as their guiding principle – Austria, Belgium, France, Germany, Luxembourg, the Netherlands and Sweden all have social insurance models.¹⁰¹ Saltman and Dubois argue that social insurance systems grew out of the unique social fabrics of European countries – reflecting a growing sense of

99 D. Green, "This Is Why It Pays Never to Fall Ill in Britain", <http://www.civitas.org.uk/pubs/Times16April02.php>.

100 Ibid.

101 R. Saltman, "Social Health Insurance in Perspective: The Challenge of Sustaining Stability", in R. Saltman, R. Busse and J. Figueras (eds), *Social Health Insurance Systems in Western Europe* (Maidenhead: Open University Press, 2004).

solidarity in health services.¹⁰² Despite their differences and unique characteristics, social insurance systems share two key features:¹⁰³

- insured people pay a regular, defined (normally wage-based) contribution;
- independent quasi-public bodies (normally called sickness funds) manage the system and act as payers for healthcare.

Within this broad framework, different systems allow for different rules. Membership of a sickness fund may be compulsory, although there are systems in which individuals are allowed to opt out. There may or may not be a degree of risk-pooling between funds to equalise their liability to healthcare costs. There are different degrees of competition between funds, with patients sometimes allowed to switch between different purchasers of care. In other systems patients are allocated to a particular fund based on their occupation, geographical location or both, rather than being allowed to choose.

There are strong arguments against the adoption of a social insurance scheme in the UK, even in the context of a severe threat to the NHS model. First, it would be an enormous policy gamble. While some systems have moved from an insurance-based model to one that is predominantly tax-funded, there has never been an example of a change in the opposite direction.¹⁰⁴ While it is always difficult to make direct comparisons between health systems, it would be very risky to embark on a massive structural reform in the UK without any international evidence about how best to proceed.

102 R. Saltman and H. Dubois, "The Historical and Social Basis of Social Health Insurance Systems", in R. Saltman, R. Busse and J. Figueras (eds), *Social Health Insurance Systems in Western Europe* (Maidenhead: Open University Press, 2004).

103 E. Mossialos, *Funding Health Care: Options for Europe* (Buckingham: Open University Press, 2002); C. Normand and R. Busse, "Social Health Insurance Financing", in E. Mossialos et al. (eds), *Funding Health Care: Options for Europe* (Buckingham: Open University Press, 2002).

104 D. G. Green et al., "For and Against: Social Insurance – The Right Way Forward for Health Care in the United Kingdom?" *British Medical Journal* (International Edition) 325:7362 (2002).

Additionally, there is little evidence that social health insurance performs much better than tax-funded systems, and the same challenge of scarce resources applies: “Because resources are never sufficient to satisfy all demands, some form of rationing or priority setting is inevitable. A shift from tax financing to social health insurance does not change this.”¹⁰⁵ Indeed, many European countries, including France and Germany, spend a greater proportion of their GDP on healthcare than the UK does. Social insurance is not a “magic bullet” to reduce costs.

That said, there is some evidence that per capita spending under social health insurance systems is lower than in tax-financed systems – perhaps 3–4%. But this is more than outweighed by the potential burden on employers. In many social insurance systems, employers play a bigger role in financing healthcare than they do in the UK, where NI contributions make up a relatively small proportion of the overall health budget. An analysis conducted by the World Bank found that social health insurance can have an impact on overall levels of employment – reducing total employment by up to 6% as employers choose not to take on staff in order to avoid health costs.¹⁰⁶ At a time of economic crisis it is not right to take risks with the economy by placing additional costs on employment.

While it is undoubtedly true that there are features of other health systems that are better than the English NHS, there is simply no evidence that a shift to social insurance would be a desirable move. Reform of this kind could not be achieved without a significant structural overhaul of the NHS. And, given the large-scale organisational reform of recent years and the current economic uncertainty, it would be extremely undesirable to make this a policy priority. Our wide range of both formal and informal interviews with

105 Normand and Busse, “Social Health Insurance Financing”, 76.

106 A. Wagstaff, *Social Health Insurance vs. Tax-Financed Health Systems – Evidence From the OECD* (Washington, DC: World Bank, 2009).

stakeholders throughout the health system indicates little support for a radical overhaul of the way the NHS is funded.

Recommendation 7: The NHS should continue to be funded primarily from general taxation. A move to a system of social insurance should not be considered by policymakers over the next decade.

However, there exists a range of private payment mechanisms that stop short of social or private insurance models. Might any of these prove appropriate for the NHS of the future?

CONTAINING COSTS OR RAISING REVENUE?

The sections above have outlined the severe threat to the health system posed by the economic crisis. It is clear from the popularity of a whole range of health and wellbeing products that individuals value health and are prepared to pay for it. Neither defining a core package nor replacing the NHS with a system of social insurance is a desirable option for meeting the financial challenge of the years ahead. What choices does that leave for closing this fiscal gap? The major policy option left unexplored is user charging. There are two possible reasons for introducing charges into health systems. One is to contain costs by affecting behaviour – the behaviour of the patient is affected by the introduction of a charge. The other reason is to raise revenue – bringing more money into the system through a system of charges. These approaches are considered below.

Revenue raising

Is there potential for the NHS to raise additional money through the introduction of a system of user charges? This argument rests on the idea that there is a level beyond which the public is unwilling to pay higher taxes, even for better services. This assumption is

partly borne out through our own opinion polling, in which higher levels of taxation were not a popular option for meeting increased demand for healthcare. Only 18% of people said that higher taxation would be their preferred way of meeting potential shortfalls in health budgets.¹⁰⁷ Some participants in the SMF Health Project's specially commissioned discussion groups suggested that, to preserve the ability of the NHS to deal with serious illnesses, people should pay for the most common or most trivial conditions. This was often coupled with the idea that people using NHS services irresponsibly (by not turning up for appointments, for example) should be penalised.¹⁰⁸ A discussion of the potential for charges to affect behaviour in seeking healthcare features later in this chapter.

Leaving aside questions of equity, one problem with this approach is that it requires a huge level of charges to have any significant impact as a proportion of a vast health budget. The OECD estimates that in 2006 the UK spent 8.4% of its GDP on health,¹⁰⁹ and that by 2010–11 the NHS budget will be around £110 billion. So, to make an impact on such a large item of government spending would require substantial user charges.

One obvious example of an aspect of health services where charges could be introduced is in primary care – GP and practice nurse appointments. The NHS Information Centre estimates that in 2007 there were 283,480,000 consultations in GP practices.¹¹⁰ These include consultations with GPs, practice nurses and other primary care professionals. It is assumed that there would be no behavioural response to charging on the part of the public – for example in the number of appointments made. But in fact, this would not be the case – a discussion that is explored in greater detail below.

107 Furness and Gough, *Local Control and Local Variation in the NHS*.

108 Ibid.

109 "OECD Health Data 2008: Statistics and Indicators for 30 Countries", www.oecd.org/health/healthdata.

110 "Research Report on Consultation Rates in General Practice 1995–2008", <http://www.ic.nhs.uk/statistics-and-data-collections/primary-care/general-practice/qresearch-report-on-trends-in-consultation-rates-in-general-practices-1995-2008>.

Table 3.2

Number of appointments = 283,480,000	
Charge for appointment at a GP practice (£)	Revenue gain (£)
5	1.42 billion
10	2.83 billion
20	5.67 billion
30	8.5 billion

Table 3.2 indicates that charges for primary care consultations might be a potential option to raise extra revenue for the NHS, albeit set at a relatively high level if they are to make a significant impact on overall health budgets. To raise £8.5 billion in charges from only one aspect of healthcare would certainly be desirable. However, equity considerations are central: 52% of all GP appointments are accounted for by people with long-term conditions such as diabetes and arthritis.¹¹¹ It would clearly be unfair and inefficient to consider charging people with long-term conditions to visit the doctor. Not only does this effectively penalise people for falling ill, it would also be likely to result in fewer consultations per patient and worsening health status as a result. Table 3.3 reconsiders the data on charging for primary care consultations, assuming that 52% of consultations would be exempt from charging.

Table 3.3

Number of appointments subject to a charge = 136,070,400	
Charge for appointment at a GP practice (£)	Revenue gain (£)
5	680 million
10	1.36 billion
20	2.72 billion
30	4.08 billion

Obviously, primary care appointments constitute only one area of NHS services. Charges in other areas might have a different

111 H. Vaughan Jones and L. Barham, *Healthy Work: Challenges and Opportunities to 2030* (London: BUPA, 2009).

effect. But, as is clear from the basic calculation above, the idea of raising significant revenue from user charges very quickly runs into ethical problems. In secondary care an even greater majority of NHS resources are devoted to those people who suffer from long-term conditions: 65% of all outpatient appointments and 72% of all inpatient hospital stays are accounted for by people with long-term conditions. This means that charges for healthcare aimed at raising revenue would have to be targeted at a relatively small number of patients (assuming that people with long-term conditions remain exempt), and thus set at a very high level. Without a significant change in the system of funding that would shift the cost from the state to the individual – across the board co-payments – it is difficult to see much scope for the NHS to raise money from individual patients to cover potential budget shortfalls. Even if a system could be introduced that might reasonably expect to raise £4.08 billion a year in charges, this represents only around 3.6% of the NHS budget for 2010/11. A gain of this size would be wiped out with perhaps only a year of standard funding increases. This finding is consistent with the experience of other OECD countries. As Peter Smith has commented: “Developed countries do not currently rely to any great extent on charges as a significant source of finance.”¹¹² The SMF Health Project does not believe that the NHS will, or should, become an exception to this general rule.

Recommendation 8: New private payments should not be introduced in an attempt to raise revenue.

Existing NHS charges

In this discussion about the desirability of the revenue-raising potential of charging for NHS services it should not be forgotten

112 P. Smith, “The Future Role of User Charges in the National Health Service”, in House of Commons Health Committee, *NHS Charges: Volume III* (London: HMSO, 2006), 155

that some charges are already in place. Charges for dentistry, optical services and prescriptions have been in place for several decades. There is no clear rationale for why these things in particular should be subject to charges, while other services are not. As the House of Commons Health Committee pointed out, charges have developed “piecemeal” and there are “no comprehensible underlying principles”.¹¹³

While charges are levied for certain services, many people find themselves exempt. For example, retired people, pregnant women and the unemployed are all exempt from prescription charges. Certain long-term conditions are exempt, while others are not. Although 50% of people are subject to prescription charges, only 16% of prescriptions are actually paid for.¹¹⁴ But do NHS charges actually raise much revenue? As of 2006, NHS charges raised approximately £1 billion per annum,¹¹⁵ or around 1% of the NHS budget. This is in line with the evidence explored above, where it is clear that charges have only a very limited impact in raising money for expensive health services. It could be argued, therefore, that existing NHS charges should be scrapped or substantially reformed, especially if they have an adverse impact on equity in the health system.

The existing system of charges is inequitable. Those on low incomes are disadvantaged and are discouraged from seeking the healthcare they need. A 2001 survey by the Citizens Advice Bureau found that 28% of people liable to pay prescription charges did not have their medicines dispensed in full. Of these, 38% were single parent households, and 37% had long-term conditions.¹¹⁶ This is not necessarily an argument for the abolition of charges, but instead compelling evidence that the current system should be reformed.

113 House of Commons Health Committee, *NHS Charges: Volume III*, 3.

114 *Ibid*, 15

115 *Ibid*, 15.

116 National Association of Citizens Advice Bureaux, *Unhealthy Charges* (London: NACAB, 2001).

The SMF Health Commission, examining the question of health charges in 2004, concluded: “The fiscal case for new charges, increased charges or extensions of existing charges is weak at a time when the NHS is receiving increased levels of revenue, but might become stronger during crisis periods when demand for services outstrips investment levels.”¹¹⁷ The public services are no longer in a time of plenty. The NHS is in no position to forgo revenue from existing charges, however insignificant it might be in terms of the overall NHS budget. Instead, the system of charges should be entirely overhauled to reflect income rather than status in determining exemptions. It is unclear why the wealthy pensioner should be exempt from prescription charges while working people on low wages pay the full charge. In a severe economic downturn that will undoubtedly have a significant impact on the state’s ability to fund health services in the years ahead, it is wrong to object on ideological grounds to charging. Instead, those charges that are levied should be fair, and must not deter people from accessing necessary healthcare. Importantly, while prescription, optical and dental charges are not popular, they are at least accepted by the public. It is far easier to adjust the existing system than to introduce new charges. It should not be a priority for the NHS to deny itself over £1 billion per annum by abolishing patient charges that are generally accepted. Instead, the system of prescription charges must be adjusted to make it fair.

Recommendation 9: Scarce public resources mean that abolishing existing charges (prescription, dental and optical) should not be a priority for the NHS. Instead, charges should be reformed so that exemptions are made on ability to pay, rather than somewhat arbitrary categories such as retirement and pregnancy. This should be achieved through the tax credit system.

117 SMF Health Commission, *User Charges for Healthcare: The Social Market Foundation Health Commission – Report 2D* (London: Social Market Foundation, 2004), 5.

Containing costs

It has been established that private payments for healthcare are unlikely to prove a useful policy tool in providing extra revenue for the NHS. A more fruitful line of enquiry is to ask whether, especially with an ever-improving understanding of behavioural psychology in public policy,¹¹⁸ private payments should be introduced to contain demand for NHS services. This might help to maintain the health system in the face of potentially overwhelming cost pressures.

The SMF Health Project has concluded that neither the ageing population nor new technologies are unlikely seriously to unbalance the NHS model.¹¹⁹ However, the upward trend in health spending coupled with the downward trend in tax revenue means that the issue of constraining demand for healthcare is of central importance. Apart from the limited range of charges outlined in the section above, the NHS is essentially free at the point of use. In classical economics, that means there is a free-rider problem. If healthcare goods are priced at zero, then there is no incentive not to consume too much. Just as the shopper would load up their trolley with unnecessary goods if everything on the shelves were free, so the individual has no economic incentive either to avoid the need to consume healthcare resources, or to use health services responsibly. For example, the Adam Smith Institute has argued: "If we had to fork out £30 to see our GP, we might opt for self-treatment via our local chemist's shop, and save the doctor's skills for more serious ailments."¹²⁰ This argument rests on the premise that there is unnecessary consumption of healthcare resources because people seek treatment either when they don't need it, or in the wrong setting. It is not easy to determine the extent to which the NHS

118 J. Prendergrast et al., *Creatures of Habit? The Art of Behavioural Change* (London: Social Market Foundation, 2008).

119 Furness et al., *SMF Health Project Background Paper 2: Demography and Technology – External Pressures for Change*.

120 A. Singleton, "Time to Charge for GP Appointments", <http://www.adamsmith.org/think-piece/health/time-to-charge-for-gp-appointments-2004082475/>.

might be able to constrain demand for healthcare without adversely affecting health – in an effort to reduce over-consumption on the part of some, there is clearly a risk that necessary consumption by others would be deterred. But there is some evidence that patients do not always access healthcare appropriately.

One common criticism of the way some people use the NHS is the number of patients who present at Accident and Emergency departments with minor conditions. Since provision of this service is very expensive, such cases threaten to deprive people with true emergency problems from the quality of healthcare they need. Norwich University Hospital claims that up to 70% of patients attending A&E could have been treated in another setting, and has launched a public information campaign under the slogan “A&E – do you really need to go there?”¹²¹ to encourage people to avoid using the service unnecessarily. But could charging people for healthcare more generally really lead to a more responsible attitude to using valuable services?

The evidence on unnecessary consumption of healthcare rather than the inappropriate use of services, sometimes described as “frivolous” demand, is less strong. There is a great deal of concern expressed about the “worried well” and their impact on healthcare resources, but little evidence to suggest that frivolous demand for healthcare has a real impact on NHS budgets. However, there is some international evidence, examined below, about the impact of charging and reduced demand on health status – a reasonable guide to action for the NHS.

The SMF has no ideological objection to patient charges. A social market approach is not consistent with the idea that charging for healthcare is wrong in principle, especially since in the final analysis no healthcare is “free” – the costs are simply

121 “A&E – Do You Really Need to Go There?”, <http://www.nnuh.nhs.uk/TrustDoc.asp?ID=126>.

shared through taxation and met in advance of treatment. Market mechanisms reflecting the price of services can be appropriate in healthcare, as they can in other public services, if they help to achieve the desired social goals. However, in making the case for extending private payments in an attempt to constrain costs, the principle of universal access, rather than market efficiency alone, must be the main consideration. In this, it is important to heed a reminder from Carrin and Hanvoravongchai: "Society's preferences, and not just economics, have an important impact on choosing the appropriate amount of care."¹²²

For any new system of charging to be acceptable for the future of the NHS it ought to adhere to the following criteria:

- demand for healthcare is reduced, with a subsequent reduction in costs;
- overall population health is not adversely affected by charging;
- people on low incomes are not deterred from seeking necessary care;
- people with ongoing health problems are not deterred from seeking necessary care; and
- the costs and difficulty of implementing the system of charges does not outweigh the benefits of reducing demand.

What follows examines the potential for each of these criteria to be satisfied.

Key features of the evidence

One of the challenges in discussing the future of charging in the NHS concerns the limitations of the evidence. Most of the evidence on the impact of charging on healthcare consumption

122 G. Carrin and P. Hanvoravongchai, "Provider Payments and Patient Charges As Policy Tools for Cost-Containment: How Successful Are They in High-Income Countries", *Human Resources for Health* 1:1 (2003).

comes from Europe and the United States rather than the UK. The radically different healthcare systems and political preferences of these countries mean that it is not always straightforward to apply lessons from the US to the UK. Also, as Dixon and Mossialos write: “There are no randomised control trials of the effect of user charges on utilisation in Europe; most studies trace the effects of a policy change.”¹²³ This means that to some extent policy on UK health charges cannot be based on sound evidence. However, there are clear principles that can be discerned from international evidence, even if they are sometimes difficult to apply to this country.

Reducing demand for healthcare

There is clear evidence that introducing charges can reduce demand for healthcare. The best example of this is the famous RAND Health Insurance Experiment, which took place in the US. This is one of the only examples of a randomised trial examining the impact of charges on healthcare utilisation and health status. In this experiment more than 7,700 individuals were randomly assigned to a healthcare plan in which there were varying levels of co-payments or charges. These ranged from completely free access to 95% co-insurance up to an annual maximum of \$1,000.¹²⁴ Although this was a US experiment and was concluded in 1982, it remains the best source of data for policymakers studying the effects of charges.

The RAND experiment has proved highly controversial, but one of its findings is clear. Charges can significantly lower demand for healthcare. Table 3.4 includes data on hospital visits, admission rates and overall spending for individuals on different types of plan. This indicates that there is substantial potential for the NHS to reduce demand for its services by levying charges across the board.

123 A. Dixon and E. Mossialos, “Funding Healthcare in Europe – Recent Experiences”, in J. Watson and P. Ovsieiko (eds), *Health Care Systems: Major Themes in Health and Social Welfare* (New York: Routledge, 2005), 61.

124 R. Brook et al., “The Health Insurance Experiment: A Classic RAND Study Speaks to the Current Health Care Reform Debate”, 2006

Table 3.4: Use and spending per person in the RAND Health Insurance experiment

Coinsurance (%)	Visit rates		Admission rates		Spending (2003\$)	
	Number	SE	Number	SE	Number	SE
0 (free care)	4.55	0.17	0.128	0.0070	1,377	58
25	3.33	0.19	0.105	0.0070	1,116	51
50	3.03	0.22	0.092	0.0166	1.032	58
95 (high deductible)	2.73	0.18	0.099	0.0078	946	47

Source: R. Brook et al., "The Health Insurance Experiment: A Classic RAND Study Speaks to the Current Health Care Reform Debate" (2006).

The figures from the RAND experiment demonstrate that healthcare spending on groups with the highest level of co-payment was significantly lower – just 68.7% of what was spent on groups with free care. Rates of admission were also reduced. In NHS terms, this offers the potential for significant changes. To illustrate this, table 3.5 shows the NHS budget as of 2009/10, and a figure of 68.7% of that amount.

Table 3.5

NHS budget 2010/11	£111 billion
68.7% NHS budget 2010/11	£76.25 billion
Differential	£34.75 billion

Potentially, then, a radical system of co-payments could significantly reduce healthcare expenditure. This effect of reduced utilisation was largely due to the behavioural impact of charges on individuals – people initiated substantially fewer episodes of care. Once a patient entered the health system, the extent of cost-sharing between individual and insurer did not significantly affect either the intensity or the cost of an episode of care.¹²⁵

125 Ibid.

Where available, other evidence corroborates the findings of the RAND experiment in this area. Peter Smith cites the example of Belgium, where the introduction of charges reduced demand for GP home visits.¹²⁶

The RAND experiment has been subject to criticism for its conclusion that health expenditure is reduced when users are charged. Some have argued that it gives only a partial analysis of the costs and benefits of charging: “[A]lthough the RAND results showed that cost-sharing reduced third-party payer expenditure on the services subject to these charges, providers could, over time, expand activity on alternative services and thereby increase overall expenditure.”¹²⁷ Despite this, the substantial difference in doctor visits between groups indicates that charging does indeed have an impact on demand for healthcare. Additionally, the RAND experiment took place over five years, in which time one might reasonably expect provider behaviour to have changed in response to the basket of goods covered by co-payments.

The evidence fits with the economic idea that patients over-consume healthcare because it is priced at zero. It therefore fulfils our first criteria for the potential introduction of charging into the NHS – that it reduce overall demand for healthcare, with a subsequent decline in costs. However the challenge is in ensuring that people are not denied the healthcare they need on the basis of ability to pay. After all, demand for healthcare could easily be reduced with the introduction of prohibitively expensive co-payments, but the real test of the policy would be in its impact on health. It is here that the RAND experiment has proved most controversial.

126 Smith, “The future role of user charges in the National Health Service”.

127 Mossialos, *Funding Health Care: Options for Europe*, 176.

Overall population health and charging, and the impact on the poor and the sick

The RAND experiment measured not only healthcare utilisation but also the overall health of the individuals involved. The study concluded that “free care had at most a small impact on any of five general health measures for the average enrollee”.¹²⁸ In other words, “cost sharing in general had no adverse effects on participant health”.¹²⁹ This would seem to be conclusive evidence that charging is an appropriate policy tool for the NHS to help reduce demand for healthcare.

However, data from the RAND experiment demonstrated that when charges are levied for healthcare, it is those who are least well-off who suffer the most significant adverse effects. As Ray Robinson writes: “The RAND Health Insurance experiment showed that cost-sharing tended to be associated with especially marked reductions in the probability of medical use and outpatient visits among lower income groups.”¹³⁰ In some cases, this reduction in healthcare utilisation had significant, even fatal, consequences for poor patients. The poorest patients with hypertension in the groups subject to charging had a 10% higher rate of mortality than comparable patients with access to free care.¹³¹

This effect appears to be more than simply a question of system design. Further evidence suggests that other types of charging can deter the poor and the sick from seeking the care they need. Dixon and Mossialos cite an analysis of user charging in Sweden, where patients who reported their financial state as poor were ten times more likely to forgo care than those who reported their financial state

128 R. H. Brook et al., *The Effect of Coinsurance on the Health of Adults*, (Santa Monica, CA: RAND Corporation, 1984), 4

129 Brook et al., “The Health Insurance Experiment”.

130 R. Robinson, “User Charges for Health Care”, in Mossialos, *Funding Health Care: Options for Europe*, 177

131 Brook et al., *The Effect of Coinsurance on the Health of Adults*.

as good.¹³² Other studies conclude that charges can affect those in poor health. A review of charges for prescription medication found that charges were associated with increased use of other healthcare services for patients with congestive heart failure, diabetes and schizophrenia.¹³³ A WHO cross-country analysis found that cost-sharing (or patient charges) led to a significant reduction in the use of healthcare, with implications for equity.¹³⁴

Tantalisingly though, the generally accepted conclusion of the RAND experiment is that charging can lead to significant reductions in healthcare demand, without compromising the health of the average person. And research carried out by the SMF in conjunction with Ipsos-MORI found that members of the public are willing to countenance the idea of charging for certain minor conditions if that safeguards the ability of the NHS to treat the most seriously ill.¹³⁵ Is there a way of safeguarding the poor and the sick while still reducing overall demand for healthcare? For the NHS, the context for this discussion is a likely level of funding increases that may not otherwise be adequate to maintain the service at current levels.

For the NHS, it is clear that the following are true:

- there are few cost incentives to deter people from using health services in the most efficient way;
- there are already charges in place that are broadly accepted by the public;
- charging is an effective mechanism for reducing demand and expenditure;
- a very small drop in demand among some groups would

132 A. Dixon and E. Mossialos, "Shifting Costs to Patients", in Dixon and Mossialos, "Funding Healthcare in Europe - Recent Experiences", 61.

133 D. P. Goldman, G. F. Joyce and Y. Zheng, "Prescription Drug Cost Sharing" JAMA 298:1 (2007).

134 S. Thomson and E. Mossialos, *What Are the Equity, Efficiency, Cost Containment and Choice Implications of Private Health-Care Funding in Western Europe?* (Copenhagen: WHO Regional Office for Europe, 2004).

135 Furness and Gough, *Local Control and Local Variation in the NHS*.

help to manage expenditure in a time of scarce public resources; and

- clinicians play the key role in determining whether referral for diagnosis or secondary care is appropriate.

Given the above, the SMF Health Project recommends the introduction of a very limited range of charges.

Recommendation 10: A very limited range of charges for initial consultations with GPs and other primary care practitioners should be introduced.

The charges would be designed to incentivise wealthy individuals to avoid seeking unnecessary initial consultations with clinicians. Those who do not have the ability to pay would be totally exempt from the charges. These charges would be so limited as to be virtually symbolic, representing the introduction of weak price signals to guide demand as well as a shared acceptance that lean times mean that all health service users must do their utmost to use services appropriately and when necessary. As a participant in an SMF Health Project discussion group said: "If they start charging for the minor stuff they can put the money towards the big stuff." A system of charges should be introduced as a way of affecting behaviour in an attempt to "Save the NHS". The public may well be receptive to this message as the full impact of the recession on public services becomes clear.

Despite advocating limited charges, it is our conclusion that patients who require diagnosis and/or treatment following initial consultation should not be subject to further charging. This reflects the reality that as clinicians play a key role in managing demand for expensive health services, it is not appropriate to levy charges on patients following referral from the GP. Indeed, the system proposed is highly limited in the range of services for which charges would be

introduced, and the overall limit to charges. Charges are something of a “blunt instrument” in affecting demand for healthcare, with the potential for individuals to be deterred from seeking both necessary and unnecessary healthcare. The system outlined below attempts to minimise the likely negative impact of charging by applying charges only to those who have the ability to pay. The discussion earlier in this chapter about overall spending on health-related products reinforces the idea that many individuals are already contributing financially to their wellbeing. The charging system proposed here therefore attempts to build on this willingness to pay for care. Key features of this proposed system are outlined below:

What would patients be charged for?

Patients would be charged for initial appointments with GPs and other primary care practitioners.

What would not be subject to charging?

No treatment resulting from referral from the GP would be subject to charging. No community-based treatment resulting from GP referral would be subject to charging.

Who would be exempt from charges?

Exemptions from charges would be linked to receipt of:

- Working Tax Credits
- Child Tax Credits
- Incapacity Benefit/Employment and Support Allowance
- Income Support
- Jobseeker’s Allowance
- Pension Credit
- In addition, everyone aged 18 years or younger would be totally exempt from charges

We propose that any patient from a family in receipt of tax credits be automatically exempted from charges. This would

automatically exempt at least 3.9 million families with children from charges¹³⁶ – representing the poorest 52% of families in the UK and 13.6 million adults and children in total. Exempting people in receipt of Income Support, Jobseeker's Allowance and Incapacity Benefit, and retirees receiving Pension Credit would exclude a further 7.5 million from charges. Individuals in receipt of these qualifying benefits should also be exempted from prescription charges as part of a wider overhaul of that system. Not only does benefit and credit eligibility identify those on low incomes, it also provides the most effective administrative mechanism to identify those who should be exempt from charges. All in all, this approach would exempt the lowest income one-third of people in the UK from paying any charges at all.

What would be the level of charges?

The RAND experiment shows that charges set at a modest level can still have an impact on demand for healthcare. The level of charges should be as low as possible – perhaps £20 for an initial appointment with a GP or primary care practitioner. It should be noted that this is still below the actual cost of a GP consultation – estimated at up to £36 by the PSSRU.¹³⁷

What would be the limit of charges?

Total health charges (including existing prescription charges and the new charges proposed above) should be limited at the same level as current prescription charges – currently £102.50 per annum (the cost of a 12-month prescription pre-payment certificate). This low upper limit to charges indicates that our primary aim is to reduce free-riding rather than introduce significant co-payments into the NHS.

136 House of Commons Public Accounts Committee, *HM Revenue and Customs: Tax Credits and Income Tax, Fourteenth Report of Session 2008–09* (London: HMSO, 2009), 9

137 L. A. Curtis, *Unit Costs of Health and Social Care 2008* (University of Kent: Personal Social Services Research Unit, 2008), 109.

Who would be responsible for collecting charges?

The main responsibility for collection should rest with GP practices which hold patient records and can monitor most easily the number of consultations by any one individual.

What safeguards should be put in place?

A number of safeguards should be put in place to ensure that the criteria outlined above are fulfilled through the small-scale charges proposed. The Department of Health should monitor primary care consultation rates in different groups, and report publicly on the findings. There should be a particular focus on those with low incomes, with extensive public information campaigns explaining that no one receiving benefits or credits will be subject to NHS charges for consultations, or for prescription charges for medication.

The Department of Health should also monitor rates of attendance at A&E to analyse whether patients are avoiding GP charges by accessing healthcare in other ways, potentially at greater expense to the NHS.

What change in utilisation and spending could be expected from the introduction of a £20 charge for initial consultations in primary care?

Data is lacking on the income levels of patients consulting primary care practitioners. There is also a lack of modelling applicable to the UK that would indicate the likely drop in utilisation from charges set at different levels. However, given that in the RAND experiment there was up to a 30% difference in healthcare spending in groups subject to charges relative to those who received free care, it is reasonable to assume that any form of charging introduced into the NHS would result in a drop in utilisation and spending among some groups. Even a modest drop in demand for NHS services of 5% would effectively represent a year of decent funding increases for the health service. In conjunction with the supply-side reforms aimed at improving the commissioning function outlined elsewhere

in this paper, some limited charges aimed at managing demand are entirely appropriate to secure the future of universal healthcare in an environment where resources are tightly squeezed.

Additionally, the system of charges should be annually reviewed to ensure that it is impacting on demand without adversely affecting health among groups subject to charges. It should be comprehensively revised, or indeed abandoned, if it cannot be shown that these criteria are being met.

CONCLUSION

Radical change is inevitable in the next decade of the NHS. Some of this will be clinically driven, while some will be the product of social pressure or political choice. Most pressingly, the pressures of a severe economic recession and the subsequent need for retrenchment in public spending mean that the financial situation for the NHS in the decade ahead is likely to be extremely tight. Elsewhere in this final report, a number of policies are proposed aimed at creating better value for money in the NHS, largely built around a radically local model of accountability in which services can be designed to meet specific needs. But as well as increasing value for money and efficiency on the supply side, demand management will also be necessary if quality improvements are to be secured in a tight fiscal environment.

Charging is a crude form of demand management, but preferable to a decline in quality that would see, for instance, the reappearance of unacceptably long waits for treatment which would impact most heavily on the poor and the sick. Charging has limited revenue-raising potential, but evidence from abroad indicates that it can significantly reduce demand without affecting health status for the average person. As a result of this, the system outlined above totally exempts from charges those people on low incomes and a huge proportion of working families with children. In fact, the overall situation for these individuals would, under these proposals,

improve, since it is recommended that receipt of benefits or credits should qualify for the exemption from prescription charges too.

The proposals outlined establish a system that slightly lessens the free-rider problem in the NHS. However, it explicitly avoids the possibility that patients will be subject to extensive charges by excluding entirely secondary care from the charging regime, and capping charges at a very low level. Thus, the challenge to equity from charging is minimised, with the possibility of efficiency gains significantly enhanced. The discussion of equity in health systems in chapter 2 makes clear that charges for some better-off patients need not challenge the principle of universal access to care. Indeed, the NHS already charges for services, and does not always make sure that people who cannot pay do not pay. The rationalisation of existing prescription charges coupled with a new system of limited charges for initial consultation provides the demand-side reform that the health system requires to deal with the funding challenges it faces. This will go hand in hand with SMF Health Project recommendations set out below for greater efficiency savings through high-quality commissioning, and an increased role for NICE in determining the overall cost-effectiveness of NHS treatments.

Radical solutions to the need for increased resources do not require a fundamental change in how the NHS is funded, with taxation replaced by social health insurance. While people may be willing to pay for other health-related goods, it will not be possible in the next decade to translate that willingness directly into extra NHS revenue. However, this adds weight to the argument that robust processes must be developed that will enable local populations to make tough decisions about the allocation of scarce resources. Individuals make mature decisions about spending on health – the popularity of products aimed at improving and extending life are testament to this. It is this understanding that good health is worth paying for that policymakers must look to build on in the next decade.

CHAPTER FOUR: NATIONAL STANDARDS AND GOVERNANCE

This chapter examines the question of what future role national government should play in an NHS that is designed around local needs rather than national standards. Where does central government fit into a system that is dominated by high-quality local commissioners developing provider markets to deliver appropriate local services? If commissioners represent the heart of the NHS, what role is left for the centre? This chapter briefly outlines the history of command and control through central targets in the NHS, and draws conclusions about the future financial and governance responsibilities of central government.

As discussed throughout this report (see chapter 2 on equity), the NHS has always aspired to be a national service. At its inception, Aneurin Bevan spelled out his intention to “universalise the best” – spreading best practice across the whole country. The national character of the health system is reflected in finance and management. Almost the entirety of the budget for the public health system is provided by nationally collected taxation, and the Secretary of State for Health remains the key figure in determining healthcare policy. National standards and national control have long been a notable feature of the management of the NHS. The most memorable evocation of this principle is a much quoted line of Bevan’s: “a dropped bedpan would resound through the corridors of Whitehall”.

Clearly, performance in the NHS has been closely aligned, with central control originating in central government. And what had been a principle that arose with the post-war Labour government was enthusiastically adopted by its New Labour successor post-1997 – the NHS was driven from the centre. As Klein writes of the first years of that government “The number of performance

indicators multiplied. So did the number of targets. ... At the peak, NHS managers reckoned they had to meet 300-plus targets.¹³⁸

And targets have worked. Few doubt that the dramatic improvement in waiting times exhibited by the NHS in recent years would have occurred without central performance management and a real political focus on that issue. Waiting times began to decline from the introduction of the 18-week target in the 2000 NHS Plan, and have continued to fall. "From the patient's viewpoint, the new form of target represented a significant improvement."¹³⁹ But over time, this emphasis on top-down performance management as a mechanism for improvement has receded. There are good reasons for this shift. Central targets can lead to staff dissatisfaction, unintended outcomes and lack of autonomy for local decision-making.

In *Delivering the NHS Plan* (2002), the government clearly set out its desire to move away from "a top-down, centralised system that inhibits local innovation",¹⁴⁰ stating that, instead, "power needs to be devolved to locally run services with the freedom to innovate and improve care for patients".¹⁴¹ This policy shift was reflected in the creation and consolidation of primary care trusts that are now charged with designing a range of services appropriate to their local communities.

Recent NHS reform has seen unprecedented devolution of money and authority to PCTs at a local level. The vision set out in the world class commissioning framework aims for a "new NHS – locally driven". It describes how commissioning will be "developed,

138 R. Klein, "The New Model NHS: Performance, Perceptions and Expectations," *British Medical Bulletin* (2007), 3.

139 *18 Week Waiting Times Target: an Update* (London: King's Fund, 2007).

140 Department of Health, *Delivering the NHS Plan: next steps on investment, next steps on reform* (London, HMSO, 2002).

141 Department of Health, *Delivering the NHS Plan: Next Steps on Investment, Next Steps on Reform* (London: HMSO, 2002), 28.

articulated and owned by the local NHS, with a strong mandate from local people and other partners".¹⁴² In practice, this will mean ever more variation between different areas.

But it is not at all clear how national standards and targets will evolve in response to the increasing power of local commissioners who have been told to "look outwards not upwards"¹⁴³ – becoming accountable not to central government but to local people. In fact, it is not certain that local commissioning actually has as much power as the Department of Health makes out. David Nicholson, NHS Chief Executive, states that "the conditions are now absolutely right for developing a framework within which PCTs, in conjunction with their local communities, can set more of their own ambitions rather than having them mainly set by Whitehall."¹⁴⁴ However, PCTs are not exempt from central control. The *NHS Operating Framework 2008–2009* shows that national targets still form an important part of healthcare policy. It describes a set of "key non-negotiable national NHS targets" for local PCTs.¹⁴⁵ These include access targets such as the 18-week maximum waiting time, as well as those aimed at specific diseases, such as the extension of the NHS bowel cancer screening programme. As David Stout, Director of the PCT Network, points out, there are at least "60 instructions to PCTs, and some of those are instructions which have other instructions within them". He declares that the *Operating Framework* "does not sit well with a localised approach".¹⁴⁶ There is also a sense that the pressure on NHS funds might lead to even more central control as national government looks to secure efficiency savings and better

142 Department of Health, *World Class Commissioning Framework: Vision* (London: HMSO, 2007), http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_080956, accessed 6 April 2008.

143 Ibid.

144 Department of Health, *NHS Operating Framework 2008-2009* (London: HMSO, 2008), 3.

145 Department of Health, *NHS Operating Framework 2008-2009*.

146 Quoted in S Gainsbury, "Operating Framework Reasserts DoH's Central Control," *Health Service Journal*, December 19, 2007.

value for money.¹⁴⁷ This tension between national standards and increasing levels of local variation is crucial in discussing the future of healthcare.

What should be the role of national government in the years to come? How will national standards change to enable, and in response to, the development of high-quality commissioning? After a brief discussion of the role of central government in financing and resource allocation, the bulk of this chapter is devoted to an exploration of the future of national targets and national governance.

NATIONAL GOVERNANCE, LOCAL VARIATION

It is argued throughout this report that local health commissioners require much greater autonomy in order to continue to improve health services. Chapter 6 explores the potential for healthcare commissioning to deliver better value throughout the health system. Enabling this approach will require a new political settlement in which central control recedes, allowing local innovation to flourish. In later chapters the necessary changes to regulation, accountability and resource allocation are defined, within the broader context of the decentralisation of health services. Earlier work undertaken by the SMF Health Project shows how local people can be engaged in the process of designing a range of truly local services.¹⁴⁸ But there is still an important role for national standards, management and political control in healthcare in the years ahead. What follows is a description of what this role should be in the future. This fits with the literature on the limits to decentralisation: international evidence makes it clear that some powers should be retained centrally (decentralisation is discussed

147 R. Evans R and S Gainsbury, "David Nicholson Warns NHS: "All Bets Are Off"," *Health Service Journal*, June 4, 2009.

148 D. Furness and B. Gough, *Local Control and Local Variation in the NHS: What Do the Public Think?* (London: Social Market Foundation, 2009).

in more detail in chapter 5). For example, Hunter et al. argue not only that there is a need for balance between national and local control, but also that there are four key areas where decision-making power should never be decentralised:

1. *The basic framework for health policy.* Health policy involves value choices that affect other areas of social life. Strategic decisions set out in the framework for a nation's health policy should therefore be made by the central government that also sets the framework for other public sector policy.
2. *Strategic decisions on the development of health resources.* Resource-related decisions require a broad overview to ensure an appropriate balance, as well as efficient use, of scarce resources.
3. *Regulations concerning public safety.* Regulation should be a matter for central control. Experience in some Central and Eastern European and Commonwealth of Independent States countries suggests that lower levels of authority may be more susceptible to corruption than higher levels.
4. *Monitoring, assessment and analysis of the health of the population and healthcare provision.* Assessment can be an efficient tool for influencing the behaviour of decentralised units. Since decentralisation involves central government granting authority to lower-level bodies, it is important that the centre remains able to monitor whether these new bodies are performing adequately.¹⁴⁹

This typology is reflected in the roles for national government set out below.

149 D. J. Hunter, M. Viononen and W. C. Włodarczyk, "Optimal Balance of Centralized and Decentralized Management", in R. B. Saltman, J. Figueras and C. Sakellariades *Critical Challenges for Health Care Reform in Europe* (Buckingham: Open University Press, 1998).

Recommendation 11: The following roles should continue to be undertaken at a central level:

1. Setting the basic framework for health policy
2. Making strategic decisions on the development of health resources
3. Regulation concerning public safety
4. Monitoring, assessment and analysis of the health of the population and healthcare provision

Revenue raising

Chapter 3 includes a full discussion of future prospects for NHS finances, and an analysis of the likely impact of future cost pressures can be found in *SMF Health Project Background Paper 2*.¹⁵⁰ This research concluded that the NHS will continue to be funded predominantly from taxation. This argument is made in part on equity grounds – taxation is the most progressive form of revenue raising – and in part on practical grounds – over the next decade it would not be desirable for the NHS to go through the kind of structural overhaul that radical reform to the system of funding would entail. So national government has, and will retain, the central role in raising money for health services.

Resource allocation

Chapter 2 contains a full discussion about the appropriate resource allocation mechanisms that should be in place in an equitable health system. What is clear from this is that, regardless of the agreed formula for allocating resources, this is a task that must be carried out by a central agency – the government. The task of distributing resources from central taxation to individual localities

¹⁵⁰ D. Furness et al., *SMF Health Project Background Paper 2: Demography and Technology: External Pressures for Change* (London: Social Market Foundation, 2008).

is central to the fair funding of healthcare and, as such, must be carried out at a national level.

National targets

One of the most contentious aspects of national control of health services is central target-setting. And while there has been a move away from a target culture of command and control towards an attempt to measure health outcomes, the current list of NHS targets shows that there is still a long way to go before true autonomy for PCTs can be achieved. The most up to date NHS targets and priorities are set out in the *NHS Operating Framework 2008–2009*. David Nicholson emphasises in the foreword that the government and the Department of Health are seeking to move away from national targets, instead allowing PCTs, in conjunction with their local communities, to “set more of their own ambitions rather than having them mainly set by Whitehall”.¹⁵¹ However, despite this rhetoric, there remains a great number of centrally set demands. The framework outlines new national priorities which cover cleanliness and healthcare-associated infections, improving access, cancer, stroke, children, maternity, staff satisfaction and engagement, public engagement and emergency preparedness.

In addition to these national priorities, the framework also states that PCTs should set local improvement plans for areas of concern. The document argues that this “marks a radical shift in NHS planning and is designed to give more authority to local NHS organisations and their communities”.¹⁵² However, despite this sentiment, the framework then goes on to highlight “issues requiring local attention”,¹⁵³ in effect setting out priorities that are determined centrally, but addressed locally. These include equality, mixed-sex accommodation, learning disabilities, diabetic

151 Department of Health, *NHS Operating Framework 2008-2009*, 3.

152 Department of Health, *NHS Operating Framework 2008-2009*, 20.

153 *Ibid.*

retinopathy, crisis resolution, improving access to psychological therapies, dementia, end-of-life care and disabled children.

On top of this, the framework makes it clear that PCTs are also expected to determine and set their own local priorities and targets. Finally, the document reveals that the 21 existing national targets still apply.

NATIONAL TARGETS

Set out below are the key non-negotiable national NHS targets.

Cleanliness and healthcare associated infection

- maintain the annual number of bloodstream infections at less than 50% of the number in 2003/04;
- from April 2009 all elective admissions must be screened for MRSA in line with Department of Health guidance; and
- differential Strategic Health Authorities envelopes to deliver nationally a 30% reduction in cases of MRSA by 2011 compared to 2007/08 baseline figures.

Improving access

Key targets for referral to treatment waiting times:

- 90% of pathways where patients are admitted to be completed within 18 weeks; and
- 95% of pathways where patients are not admitted to be completed within 18 weeks;
- PCTs to be expected to maintain the reductions in waits for direct access audiology and hearing aid services that they planned for delivery in 2008/09, and to support benchmarking of active health partner (AHP) services; referral to treatment data to become mandatory from April 2010.



Key targets for primary care access:

- 50% of practices to continue to offer extended opening times as well as ongoing progress in improving GP services, such as guaranteeing access to a GP within 48 hours and booking appointments further ahead;
- advance in securing and opening of GP-led health centres that allow patients access to GP services 12 hours a day, 365 days a year;
- improved patient satisfaction as measured by the GP Patient Survey; and
- continue to ensure year-on-year improvements in the number of patients accessing NHS dental services, including a review of dental commissioning strategies.

Improving health and reducing health inequalities

- no patients should wait more than 31 days for radiotherapy by December 2010;
- all patients with breast cancer symptoms referred to a specialist must be seen within two weeks of referral by December 2009;
- NHS Breast Cancer Screening Programme will be extended to all women aged 47–73 by 2012;
- NHS Bowel Cancer Screening Programme will be extended from 2010 to invite men and women aged 70–75 to take part;
- cancer treatment (surgery and drug treatment) Patients wait no more than 31 days from decision to treat to start of treatment – all cancer treatments by 2010;
- all patients with suspected cancer, detected through national screening programmes or by hospital specialists, wait no more than 62 days for referral to treatment by 2009;
- all women should receive the results of their cervical screening tests within two weeks by 2010.

Existing commitments to be maintained

- a four-hour maximum wait in A&E from arrival to admission, transfer or discharge;
- guaranteed access to a primary care professional within 24 hours and to a primary care doctor within 48 hours;
- a maximum wait of 13 weeks for an outpatient appointment;
- a maximum wait of 26 weeks for an inpatient appointment;
- a three-month maximum wait for revascularisation
- a maximum two-week wait standard for Rapid Access Chest Pain Clinics;
- thrombolysis “call to needle” of at least 68% within 60 minutes, where thrombolysis is the preferred local treatment for heart attack;
- guaranteed access to a genito-urinary medicine clinic within 48 hours of contacting a service;
- all patients who have operations cancelled for non-clinical reasons to be offered another binding date within 28 days, or the patient’s treatment to be funded at the time and hospital of the patient’s choice;
- delayed transfers of care to be maintained at a minimal level;
- all ambulance trusts to respond to 75% of Category A calls within eight minutes;
- all ambulance trusts to respond to 95% of Category A calls within 19 minutes;
- all ambulance trusts to respond to 95% of Category B calls within 19 minutes;
- a two-week maximum wait from urgent GP referral to first outpatient appointment for all urgent suspected cancer referrals;
- a maximum wait of one month from diagnosis to treatment for all cancers;
- a maximum wait of two months from urgent referral to



treatment of all cancers;

- 100% of people with diabetes to be offered screening for the early detection (and treatment if needed) of diabetic retinopathy;
- deliver 7,500 new cases of psychosis served by early intervention teams per year;
- all patients who need them to have access to crisis services, with delivery of 100,000 new crisis resolution home treatment episodes each year;
- all patients who need it to have access to a comprehensive child and adolescent mental health service, including 24-hour cover and appropriate services for 16- and 17-year-olds and appropriate services for children and young people with learning disabilities;
- chlamydia screening programme to be rolled out nationally.

There are a number of criticisms of this set of targets. The most significant of these is the sheer scale of national targets that commissioners and providers must meet. There are 35 key performance measures outlined above. It is questionable whether, after making all of these a priority, commissioners will have the capacity to address other areas of need in their communities. PCT staff interviewed by the SMF Health Project Team revealed that there is still a large amount of central oversight that restricts their ability to innovate locally.

The second criticism is that targets are not necessarily coherent. Why, for example, is diabetes represented, but not arthritis? Why is there a specific target for the speed of referral for suspected breast cancer, but other cancers do not receive the same attention? Surely a more effective way of meeting patient expectations would be for local commissioners to determine the key priorities of people in their area.

The third criticism is that there is a bias in the set of national targets towards acute elective care, and access to it. The biggest drain on NHS resources is care for patients with chronic conditions, but there are no targets to reduce unnecessary admissions to hospital for people with ongoing health needs. Do targets really reflect the NHS in its entirety?

Chapter 8 describes a new approach to regulating the performance of local health services, putting responsibility on commissioners to ensure quality in their local area. This cannot be reconciled with a set of national targets that deny local commissioners the autonomy they need to be innovative, and to determine local priorities. This was a sentiment repeatedly expressed by commissioners and primary care professionals at SMF Health Project research seminars.

Alan Milburn, architect of much of the Blairite reform of the NHS, said:

Top-down Whitehall control has tended to stifle local innovation. It has too often ignored the differing needs of different local communities. It is not surprising, therefore, that staff sometimes feel disempowered, local communities are disengaged, and patients have traditionally had little say and precious little choice. Our reform programme – indeed, any reform programme – for the health service should be about addressing these weaknesses so that we can build on the NHS's great strengths.¹⁵⁴

Mark Britnell, when head of world class commissioning at the Department of Health, commented on the benefits of local autonomy: "Staff feel more accountable for solutions and you

154 "House of Common Hansard Debates for 8 Jan 2003", <http://www.publications.parliament.uk/pa/cm200203/cmhansrd/vo030108/debtext/30108-08.htm>.

certainly cannot blame your performance on anybody else."¹⁵⁵
 A good start in rejecting a model of top-down Whitehall control would be to reduce the range and scale of national targets.

Recommendation 12: The list of national standards and targets should be substantially reduced to become a minimum service guarantee.

Reducing the number and scale of national targets

This would achieve two goals:

1. It would free up commissioners to innovate locally.
2. It would acknowledge the desirability of a service that is tailored to local need rather than aspiring to a set of national standards.

National targets should focus on core access measures where it is reasonable to set national standards, but leave local priorities for improvement to commissioners, who will have to justify them to the regulator and, more importantly, to their local populations.

A set of future national targets and core standards to replace the list above might include:

Guaranteeing access

- a four-hour maximum wait in A&E from arrival to admission, transfer or discharge;
- guaranteed access to a primary care professional within 24 hours and to a primary care doctor within 48 hours;

155 Quoted in N. Hawkes, "Independence Day?," *British Medical Journal*, 334: 7604 (2007).

- a maximum wait of 13 weeks for an outpatient appointment;
- a maximum wait of 26 weeks for an inpatient appointment;
- by 2010 , all cancer patients (surgery and drug treatment) to wait no more than 31 days from decision to treat to start of treatment.

Guaranteeing satisfaction

- patient satisfaction rates with local services to improve each year;
- quality of local healthcare provision as assessed by the CQC and through Quality Accounts to improve each year.

On this account, patients would be guaranteed access to healthcare, but targets for improvement would be based entirely at a local level. It should be noted that this would not limit the ability of central government to invest in things like screening programmes that require a national approach to be successful. It simply means that local health services would be encouraged to develop local priorities – reflecting their role at the heart of the NHS and the new regulatory and accountability structures recommended elsewhere in this report.

DEFINING NHS VALUES

Chapter 2 looks at how equity will be defined in the future. SMF polling work suggests that fairness is a key priority for the public, but that it means different things to different people. For some, fairness means that everyone should have access to exactly the same services, while for others it means that services should be strictly based on an analysis of local need¹⁵⁶. The tough financial environment in which health services will have to operate for the foreseeable future indicates that some elements that have

156 Furness and Gough, *Local Control and Local Variation in the NHS: What Do the Public Think?*.

previously been considered unfair are likely to be needed in the health system of the next decade – notably user charges. To reflect public views and to encourage a more open political debate about options for healthcare, there is a need for a stronger definition of NHS values, building on the existing NHS constitution. While local commissioners should determine local health priorities, national government should play the key role in determining and adjusting a defined set of NHS values.

The process of consulting and developing these values must be managed by central government, helping to move the political debate forward as new policy options for the health system are considered.

GOVERNING THE NHS – NO INDEPENDENT BOARD

Both the major political parties have raised the idea of an independent board for the NHS in an attempt to depoliticise decisions about the health system. As Chancellor of the Exchequer, Gordon Brown investigated the possibility of replicating in the NHS the model of the Bank of England and the BBC's operational independence. Under this kind of model, decisions about the strategic direction of the health system would be made by a panel of experts.¹⁵⁷ This has not become government policy, and meanwhile the Conservatives are also in favour of such independence: "[B]y establishing an independent board to run our NHS, we can take politicians out of its day to day management."¹⁵⁸ The NHS board that they envisage would have a statutory responsibility to secure comprehensive health services, deliver improvements in the physical and mental health of the population, and deliver improvements in the diagnosis and treatment of illness.¹⁵⁹

157 A. O'Dowd, "UK Chancellor Proposes Independent Board to Run NHS," *British Medical Journal*, 333: 7570 (2006).

158 *Renewal: Plan for a Better NHS* (London: The Conservative Party, 2008).

159 *Renewal: Plan for a Better NHS*, 18.

Proposals for an independent board to govern the NHS are in part a response to well-founded criticism of political micro-management within the service. One study cited the following examples of what they regard as unacceptable political interference:

- the fast-tracking of breast cancer drug Herceptin through the NICE process;
- top-slicing of PCT budgets to compensate for over-spends elsewhere in the system;
- the 2005 decision that PCTs should divest themselves of provider services, which was subsequently partially retracted.¹⁶⁰

There has undoubtedly been unhelpful political intervention in the management of the health system. But does this lead to the conclusion that an independent board should oversee the running of health services? While control by central government should certainly be reduced, there are several reasons why an independent board is not a desirable option.

Accountability

The first objection is accountability. As stated above, central government must retain a key role in raising resources. There are strong arguments that an independent board made up of experts would reduce overall accountability for a key part of government spending. While the BBC might be operationally independent, for example, it is able to sustain that independence through a Charter that allows it the right to raise its own revenue via the license fee and it operates in a competitive market. There is no precedent or parallel for spending more than £110 billion a year of taxpayer money through the direction of an independent board that the general public would have no way of influencing or holding to

160 J. Glasby et al., *Things Can Only Get Better? The Argument for NHS Independence* (Birmingham: Health Services Management Centre, School of Public Policy, 2007), 2.

account. This makes it almost inconceivable that any such board could or should possess or retain sufficient legitimacy to escape the pressure of elected politicians.

What the public want

The second objection to the notion of an independent board is that the public does not want one. As part of its work with members of the public, the SMF Health Project explored the question of how potential budget shortfalls in healthcare should be addressed. This included a consideration of whether NHS or government should lead prioritisation to save money. Many people were convinced that the government has a key role to play in providing leadership in health services – an implicit rejection of the idea of an NHS board. People were concerned that decision-making left solely in the hands of the NHS would be less accountable, and possibly less concerned with overall levels of finance.¹⁶¹ Many people argued that government has a key role in distributing resources to help achieve fairness. This is in line with the recommendations set out throughout this report: national government must retain a key role in raising money and allocating resources, but with much more responsibility devolved to local health services to design a range of services appropriate to local need. Thus, central government should lose its day-to-day responsibility for aspiring to the impossible (and undesirable) goal that the NHS should be the same across the country, while maintaining its key function of raising money and making sure it is distributed fairly. There is currently, therefore, no strong case for an NHS board, nor is there public support for the idea, particularly when political accountability for public spending is set to become increasingly important.

CONCLUSIONS

The future model for healthcare, if a high-quality universal system is to be sustained, will be substantially different from today's NHS.

161 Furness and Gough, *Local Control and Local Variation in the NHS: What Do the Public Think?*

There are no further gains to be made from obsessive central performance management designed to improve services across the board. The future of the health system must see limited national control, with as much authority and autonomy devolved to a local level as possible. However, there are still certain key functions that national government will undertake in the future.

Recommendation 13: National government should continue to have responsibility for revenue raising, resource allocation, limited national standards and defining NHS values.

These four key roles do not justify the introduction of a supposedly independent NHS board: the need for accountability for money spent and the views of the public support this conclusion. It should not be forgotten that any act of public spending is, and must remain, political, especially when it involves redistributing resources from rich to poor and healthy to sick through the tax system and the health system. While attempts should be made at all levels to try to mitigate the impact of inappropriate interference from central government, the politics of healthcare will not go away, nor should they. Instead, they will be conducted at a local level where the public can be involved in decisions about their care and where local commissioners can be truly accountable for the services they provide.

PART TWO

CHAPTER FIVE: DECENTRALISATION

It has been argued in chapter 1 of this report that, to enable the cutbacks that will be necessary in health services over the next decade, power should be moved from the centre to the frontline and from the national to the local. This chapter explores the advantages and problems with the various types of decentralisation, before applying these lessons to the health system in this country.

This chapter provides a context for the recommendations, set out in detail in chapter 6, that power should be devolved to local commissioners. It is argued that there is no single “right answer” about the appropriate level of central and local control in health systems. Ultimately, any decision to devolve power is a political choice that must take into account the country’s political and historical context. In the case of the health service in England, the NHS has been subject to a decade of centralised control which has succeeded in raising activity levels, but which has failed to improve productivity and has left staff disillusioned. In this context decentralisation appears to be the best option for improving the quality, productivity and responsiveness of the health service, at a time of significant fiscal restraint.

There has been much discussion over recent years, both in government and amongst health policy experts, about the importance of devolving more decision-making power to a local level. David Nicholson, NHS Chief Executive, declared in the 2007/08 NHS Operating Framework that “the conditions are now absolutely right for developing a framework within which PCTs, in conjunction with their local communities, can set more of their own ambitions

rather than having them mainly set by Whitehall¹⁶². Compared to the emphasis on top-down national targets that characterised the early health reforms under New Labour, this emphasis on the importance of local decision-making felt like a radical change of direction. However, decentralisation within health policy is nothing new; it has been an important issue in public policy right across Europe for more than 60 years.¹⁶³

WHAT IS DECENTRALISATION?

Decentralisation can be defined in general terms as: “The transfer of authority or dispersal of power in public planning, management and decision-making, from the national level to sub national levels, or more generally from higher to lower levels of government.”¹⁶⁴ At its simplest, decentralisation is the diffusion of power and tasks away from the centre towards more local levels of government or to more local stakeholders.

Rondinelli, writing in the 1980s, set out the best-known explanation of decentralisation. He identified four different types of decentralisation: deconcentration; devolution; delegation and privatisation.¹⁶⁵

Deconcentration

Deconcentration refers to the transfer of decision-making away from central government to lower-level government authorities who are upwardly accountable to central government.¹⁶⁶ Deconcentration is the weakest form of decentralisation, as it redistributes decision-

162 Department of Health, *The NHS in England: Operating Framework for 2007–08* (London: HMSO, 2006), 126.

163 R. B. Saltman and J. Figueras, *Health Care Reform: Analysis of Current Strategies* (Copenhagen: World Health Organization, 1997), 45.

164 D. Rondinelli, “Government Decentralisation in Comparative Theory and Practice in Developing Countries”, *International Review of Administrative Sciences* 47 (1981).

165 Ibid.

166 J. Ribot, *Democratic Decentralization of Natural Resources: Institutionalizing Popular Participation* (Washington DC: World Resources Institute, 2002).

making authority and financial and management responsibilities among different levels of the national government.¹⁶⁷

Deconcentration has been deployed in the past two decades in a number of Eastern European states as a reaction against the central control experienced under Soviet rule. In Poland, for example, major reform of public administration was carried out in 1990 as a way of breaking down the centralised model. The provincial authorities acquired significant powers and were actively involved in making decisions about the structure of health institutions.¹⁶⁸

Delegation

Delegation is a more extensive form of decentralisation, which involves the “delegation of decision-making and management authority for specific functions to organisations that are not under the direct control of central government ministries”.¹⁶⁹ Decision-making responsibility and administration of public functions is transferred away from central government to semi-autonomous organisations not wholly controlled by the central government, but ultimately accountable to it. Governments delegate responsibilities when they create non-departmental public bodies and quangos (quasi-autonomous non-governmental organisations).¹⁷⁰

Delegation takes institutions out of the direct control of government regulation, allowing management to be more flexible. The Italian health system underwent a process of delegation in 1992 when the administrative structure of large hospitals and “health units” was significantly reformed. The health units and large hospitals were made into “public enterprises” and

167 Decentralization Thematic Team, “What Is Decentralization?”, http://www.ciesin.columbia.edu/decentralization/English/General/Different_forms.html.

168 Saltman and Figueras, *Health Care Reform: Analysis of Current Strategies*. 45

169 D. Rondinelli, R. Nellis and S. Cheema, *Decentralization in Developing Countries: A Review of Recent Experience* (Washington DC: World Bank Staff Working Papers No. 581, 1983).

170 Decentralization Thematic Team, “What Is Decentralization?”.

“public hospital agencies” respectively, with organisational and administrative autonomy.¹⁷¹

In England, the same principle is behind the creation of foundation trusts in the NHS. The control originally exerted over these hospital trusts by the Secretary of State via Strategic Health Authorities has been delegated to the chief executives of foundation trusts, who enjoy a great deal of autonomy. In addition, foundation trusts are not regulated by the Care Quality Commission (which reports to the Secretary of State), but by the arms-length regulator Monitor, which answers not to the Secretary of State but to Parliament. This initiative is intended to delegate some control over NHS institutions away from the iron grip of Whitehall, and make health services more accountable and responsive to patients and local communities.¹⁷²

Devolution

Devolution refers to the process in which decision-making is transferred not to a lower administrative level, but to a lower political level. A process of devolution will require the strengthening or creation of new lower levels of government that are, to a significant extent, independent of central government.¹⁷³ These levels of government are typically regional or local, but in the case of devolution of power from Westminster to Scotland, Wales and Northern Ireland, power was devolved from the UK government to other national governments.

Devolution tends to result in a more radical restructuring of health service organisations than deconcentration. This can be seen by the way in which healthcare reform has evolved in the devolved nations. Scotland, Wales and Northern Ireland now all have significantly different healthcare policies from those of England.

171 Saltman and Figueras, *Health Care Reform: Analysis of Current Strategies*, 48.

172 E. Mayo and R. Lea, *The Mutual Health Service* (London: New Economics Foundation, 2002).

173 P. Clarke and J. Foweraker (eds), *Encyclopaedia of Democratic Thought* (London: Routledge, 2001), 126.

Privatisation

Rondinelli also includes privatisation in his typology of decentralisation because power is shifted away from the centre when tasks are transferred from public to private ownership.

CRITICISMS OF THE FOUR PART TYPOLOGY

Although Rondinelli's four-part typology of decentralisation is the best-known attempt to define the process, it is by no means undisputed. For example, it has long been argued by some commentators that deconcentration is not actually a form of decentralisation at all, as it does not lead to an increase in local discretion in decision-making.¹⁷⁴ Similarly, Rondinelli's inclusion of privatisation as a type of decentralisation is questioned by a number of academics. It is argued that decentralisation involves the transfer of authority and resources from the centre to the periphery within a single system. Privatisation, on the other hand, involves a transfer of power from the public sector to the private sector, which requires the adoption of a different system of managing activities. Hence, it is argued, decentralisation and privatisation are two different processes.¹⁷⁵

Because of the lack of clarity that surrounds the concept of decentralisation, several health sector reforms have been lauded as an example of the process even when it is far from clear whether decentralisation did actually occur. For example, some policy commentators highlight the shift of acute services from hospitals to home care, which has occurred in many advanced health systems over the past decade, as an example of decentralisation.¹⁷⁶

174 J. W. Fesler, "Centralization and Decentralization", in D. L. Sills (ed.), *International Encyclopedia of the Social Sciences* (New York: The Macmillan Company and the Free Press, 1968).

175 C. Collins and A. Green, "Decentralization and Primary Health Care: Some Negative Implications in Developing Countries", *International Journal of Health Services* 24 (1994).

176 J. Wasem, "A Study on Decentralizing From Acute Care to Home Care Settings in Germany", *Health Policy* 41 (2009).

However, such reforms do not entail a shift in the structure of power or authority, so it is questionable whether they can be described as decentralisation.

POLITICAL, ADMINISTRATIVE AND FISCAL DECENTRALISATION

The lack of clarity that surrounds the concept of decentralisation in the world of health policy suggests that Rondinelli's typology is not entirely satisfactory. Saltman and Bankauskaite point out that Rondinelli's definition was designed for application in the public sector in general and not for exploring the forms of decentralisation that have developed specifically within the health sector. Saltman and Bankauskaite therefore came up with their own definition of decentralisation, which is directly applicable to the health sector.¹⁷⁷ They split the process into three key functional dimensions: political, administrative and fiscal decentralisation.

Political decentralisation

Political decentralisation (like Rondinelli's devolution) refers to the shifting of policymaking responsibility from the centre to the localities within a country. In England, there is little appetite for political decentralisation of this type, which would see devolution of health policy to local authorities. One of the main objections to this is that PCT and local authority boundaries are not entirely contiguous. For local authorities to take over health functions would require yet another structural overhaul of the NHS. Additionally, the existing organisational capacity of local authorities does not include expertise on healthcare – the risk of this type of political decentralisation would be great. However, there is a need for greater cooperation between PCTs and local authorities, particularly where individuals have needs that are addressed by both health and social care.

177 R. B. Saltman and V. Bankauskaite, "Conceptualizing Decentralisation in European Health Systems: a Functional Perspective", *Health Economics, Policy and Law* 1 (2006).



Administrative decentralisation

Administrative decentralisation (like Rondinelli's deconcentration) refers to the transferral of decision-making to a lower administrative level. The concept of administrative decentralisation emerged within the field of public administration during the first half of the twentieth century. It became an alternative to the Weberian notion that bureaucracy imprisons individuals in an "iron cage", limiting individual human freedom and potential.

Instead, it was argued that public sector employees exercise far more autonomy than Weber thought, as they constantly make important organisational decisions. This recognition led to the development of strategies designed to harness the informal power of employees.¹⁷⁸ In the health sector, this generated arrangements to promote collective decision-making – for example, "consensus management" in NHS hospitals in the UK.

Ultimately, administrative decentralisation led to the emergence of the New Public Management (NPM) philosophy, which emphasises the importance of choice, competition and the operation of markets in the public sector. In the health sector, the idea of socially orientated entrepreneurialism has been central to the concept of the "self-governing trust" first proposed by the Conservatives in 1990, and more recently reintroduced in Labour's Foundation Hospital model.

There is scope to extend administrative decentralisation in the health system in England. The increasing role of PCTs represents an attempt to decentralise to local administrators. But, as chapter 6 makes clear, there is still a need for more power to be located at PCT level and for central government to rein in its interfering tendencies. At the same time much more must be done to strengthen local commissioners to ensure that they can carry out their responsibilities effectively.

¹⁷⁸ Ibid.

Fiscal decentralisation

Fiscal decentralisation refers to the practice of fundraising and/or expenditure activities being moved from the control of central government to be performed instead by lower (regional or municipal) levels of government.

The preceding chapters have shown that whatever system of supplementary funding is introduced in response to the recession, central government must remain responsible for raising money and distributing resources. In part, this is a pragmatic decision – any new form of financing would be difficult and costly to implement. Centralised funding also enables a collective decision to be made about the fair distribution of resource across the country. A regional or local approach here would make it very much more difficult to ensure equal access for equal need as poorer areas, particularly urban centres, would find themselves at a particular financial disadvantage.

ADVANTAGES OF DECENTRALISATION

The discussion above has outlined the typologies of decentralisation featured in the academic literature. But why might decentralisation be desirable? A common criticism of centralised administrations is that they are distant from service users and so find it difficult to make appropriate and sensitive responses to local preferences. On this critique, centralisation leads to poor-quality public services and public disillusionment with what they see as large, unresponsive, bureaucratic institutions. It is also argued that central administrations are slow to change, slow to innovate and are inefficient.

Proponents of decentralisation claim that these problems can be overcome by transferring power, authority and responsibility from the centre to lower and wider levels of government or more local institutions. They argue that decentralisation will lead to more flexible decision-making which will enable provision

to respond more rapidly to changing circumstances and needs. This freedom, it is argued, combined with pluralism, will also lead to more innovation, as different localities develop interesting and appropriate solutions to local problems and because large monolithic structures are understandably risk-averse. Proponents suggest that the effectiveness of policy decision-making will improve because frontline workers have more information about needs and are therefore better placed to identify problems and devise effective remedies. Advocates of decentralisation also suggest that it offers better opportunities for community participation and greater accountability, as government officials are more likely to be scrutinised by citizens who are engaged with the process of policymaking and implementation.

Legitimacy in the eyes of the public is important if decision-makers at any organisational level are going to be able to implement reform.¹⁷⁹ A system is more likely to be viewed as legitimate if the public has some ability to provide input into the decision-making process. A highly centralised health system that lacks clear democratic processes may risk suffering diminishing support, especially if potentially unpopular changes, such as reconfigurations of services, need to be implemented. Decentralisation is seen as a potential solution as it brings decision-making closer to the local population and thus enhances satisfaction and acceptance in the community.¹⁸⁰

THE DIFFICULTIES OF DECENTRALISATION

Decentralisation has been embraced by policymakers as an effective way of improving healthcare across Europe. However, the outcomes of decentralisation have not always been evaluated fully with proper consideration given to health gain, efficiency, quality

179 J. G. March and J. P. Olsen, *Rediscovering Institutions* (New York: The Free Press, 1989).

180 D. Stone, *Policy Paradox: The Art of Political Decision-Making* (New York: W. W. Norton, 1998).

of care and consumer choice. Decision-makers have on occasion assumed that decentralisation will inevitably bring about positive results, and so it has been trumpeted as an end in itself, rather than as a way of achieving explicitly defined outcomes.¹⁸¹

Decentralisation should not be seen as a panacea: it must be understood that decentralisation can throw up a number of democratic, political and economic problems and difficulties. The democratic argument against decentralisation emphasises the degree of inequity that can accompany variation in service provision; different standards of service are provided in different localities with the result being that some citizens, often lower-income or vulnerable groups, may receive poorer services. Evidence from Finland, Norway and Denmark shows that local control over health sector decision-making has led to increased disparities in services provided, and it has been those individuals from lower socio-economic groups who have been adversely affected.¹⁸²

There is also concern that a localised system is more vulnerable to political manipulation by particular stakeholders or interest groups. This is why all increases in power for local commissioners must be accompanied by strengthened local accountability mechanisms to ensure that quality is upheld in every locality and to prevent manipulation of the system from occurring. Further thought is given to this issue in chapter 6.

Politically, there is a sense, especially in North European countries with tax-funded health systems, that national politicians are blamed when the health service fails to meet expectations (even if the decision-making has been largely decentralised). Understandably,

181 K. Vrangbaek, "Key Factors in Assessing Decentralization and Recentralization in Health Systems", in R. B. Saltman, V. Bankauskaite and K. Vrangbaek (eds), *Decentralization in Health Care: Strategies and Outcomes* (Buckinghamshire: Open University Press, 2007), 68.

182 R. B. Saltman, "Decentralisation, Re-Centralisation and the Future of European Health Policy", *European Journal of Public Health* 18:2 (2008).

politicians tend to conclude that if they are going to be blamed for what they cannot control, they may as well ensure that they have the necessary controls so that they have some chance of correcting any problems. It is also reported that deconcentration can lead to confusion, with one level of government not knowing what the other is doing.¹⁸³ Currently in England, only a tiny minority of the population actually knows what a local primary care trust is.¹⁸⁴ If local commissioners are to be given greater control over local services and are going to be held to account by their local population, this will need to change. In chapter 7 it is argued that much more effort must be made by PCTs to publicise their existence, explain what they do, and engage with their local population if local control and accountability are to form a viable model.

The economic case against decentralisation focuses on the inefficiency that results from a loss of economies of scale, and on the likelihood of duplication, fragmentation and high transaction costs of having multiple small providers. It is also argued that small-scale units may have a limited capacity to handle complex problems and that local finance bases are likely to be insufficient to fund expensive future care needs.¹⁸⁵

However, as set out in chapter 3, the SMF Health Project does not recommend that NHS finances should be raised locally. Furthermore, as discussed in chapter 6, strong local commissioning can drive down costs and improve quality at the same time. Groups of local commissioners, working together in partnership, can gain the benefits of economies of scale, while also maintaining the positive aspects of locally commissioned services held to account

183 D. J. Hunter, M. Viononen and W. C. Wlodarczyk, "Optimal Balance of Centralized and Decentralized Management", in R. B. Saltman, J. Figueras and C. Sakellariades *Critical Challenges for Health Care Reform in Europe* (Buckingham: Open University Press, 1998).

184 LGA Health Commission, "LGA Health Commission Opinion Polling – Results", <http://healthcommission.lga.gov.uk/lga/core/page.do?pagelid=579283>.

185 M. De Vries, "The Rise and Fall of Decentralization: A Comparative Analysis of Arguments and Practices in European Countries", *European Journal of Political Research* 38:2 (2000).

by local people. And although there are certainly drawbacks to a more localised system, there is no possibility that the NHS will return to a centralised model of command and control – reform is too far advanced for a rollback to be considered.

This chapter has thus far considered the theory behind decentralisation. The next section turns to focus on the real world, and evaluates the rise and fall of decentralisation in health policy across Europe over the past 60 years.

RISE OF DECENTRALISATION

A central trend of European health policy over the past 60 years has been the decentralisation of important aspects of decision-making authority to increasingly lower levels of government, as well as to private organisations. Decentralisation as a concept has been accepted by many policymakers in Europe, although notably not in the UK until very recently. However, in the second half of the twentieth century, non-governmental control became part of the “received wisdom” about what good health policy should include.¹⁸⁶

For example, the tax-funded health systems in the European Nordic countries have all experienced substantial health policy decentralisation over the past few decades. In Sweden, Norway, Finland and Denmark, most of the administrative and managerial responsibilities, along with much of the policy and fiscal decision-making control, has been decentralised within the public sector.¹⁸⁷

The tax-funded health systems of Southern Europe have also experienced this trend, with the majority of managerial and political (but not key fiscal) responsibilities being devolved from national to regional governments.

186 Saltman, “Decentralisation, Re-Centralisation and the Future of European Health Policy”.

187 Ibid.

Countries with social health insurance systems in continental Europe – such as Germany and the Netherlands – have not been exempt from this decentralising pattern either. Most administrative and managerial decisions, as well as many fiscal (but not key political) decisions, have for a long time been delegated to private not-for-profit bodies.

The state-based social insurance systems that have emerged since 1990 in many Central European countries have also decentralised to a certain extent. Countries such as Hungary, Estonia and Poland, reacting against the previously highly centralised model, have utilised various forms of decentralisation. For example, ownership of hospitals has moved from national to regional and local governments.¹⁸⁸

RECENTRALISATION

For 50 years after the Second World War, decentralisation was standard practice across European health policy. Over the past decade, however, attitudes have been starting to change and policymakers are reassessing the merits of decentralisation. Since 2000, the role of the state in the health sector has begun to strengthen measurably in many countries. State institutions are beginning to change course and take back responsibility for decision-making in many European healthcare systems. Countries, especially those that have engaged in more radical decentralisation of healthcare policy, are reclaiming control over key elements of the system – typically, funding and setting professional standards.¹⁸⁹

Norway is a prime example: responsibility for hospitals has swung back and forth from central control, to local control and back. Initially, political responsibility for hospitals in Norway was in the hands of the national government. Then in 1969, control was decentralised from

188 *Ibid.*

189 Vrangbaek, "Key Factors in Assessing Decentralization and Recentralization in Health Systems", 68.

state to regional level. However, the regional authorities failed to keep hospital expenses within their agreed budget, which led to recurring demands from regional governments for more state funds. Finally, in January 2002, the Norwegian state recentralised both ownership and policymaking for all Norwegian hospitals.¹⁹⁰

A similar pattern of regional consolidation and a strengthening of the state role has occurred in Denmark, the Netherlands and Poland, and is under way in Sweden and Finland.¹⁹¹ So does this mean that if the NHS embraces radical decentralisation it is swimming against the tide of European policy? To a certain extent, the answer is yes. But two points should be noted.

First, it is commonly agreed that the UK health system has reached the limits of improvement through centralised control.¹⁹² To deal with the financial crisis in healthcare requires radical thinking, and to move against the drift of policy in Europe may be no bad thing. A significantly localised model of healthcare delivery may prove to be the only possible future for public health services. Localised services that meet local needs will be more efficient than those imposed through central planning, just as a market economy is more efficient than state planning.

Second, the English health system is much more centralised than most of its European neighbours.¹⁹³ As a result, if decentralisation occurs in England while the rest of Europe recentralises health policy, this can actually be seen as a convergence, rather than a divergence, of policymaking.

190 J. R. Johnsen, *Health Systems in Transition: Norway* (Copenhagen: European Observatory on Health Systems and Policies, 2006).

191 Saltman, "Decentralisation, Re-Centralisation and the Future of European Health Policy".

192 See, e.g., Ara Darzi, *High Quality Care for All: NHS Next Stage Review Final Report* (London: HMSO, 2008); The Conservative Party, *Delivering Some of the Best Health in Europe: Outcomes Not Targets* (London: Conservative Party, 2008); The Liberal Democrats, *Empowerment, Fairness and Quality in Healthcare: Policies for an Effective NHS* (London: Liberal Democrats, 2008).

193 Vrangbaek, "Key Factors in Assessing Decentralization and Recentralization in Health Systems", 68.

FINDING THE RIGHT BALANCE

So what can be taken from the European health policy experience of decentralisation, followed more recently by recentralisation? The first thing to note is that although it might appear that health policy across Europe has lurched from one extreme to the other, in reality this is not the case. The term “decentralised” and the categories set out by Rondinelli as well as by Saltman and Bankauskaite are all abstract concepts: they help us to understand what is going on, but in reality no country has an entirely devolved, deconcentrated or delegated health system. Just as there is no system that is completely centralised with all decisions made at the highest possible level of management, so too there is no country with a wholly decentralised system where all decisions are taken at the lowest operational level.

In actuality, decentralisation in most European countries has been focused on specific areas of decision-making. Policymaking has become a shared exercise; local level decision-makers have responsibility for a wide range of service-related decisions, while the national level retains core strategic levers as well as regulatory responsibilities. Successful decentralisation involves balancing policymaking activities between national and regional or municipal bodies.

Fiscal decision-making is often shared between national and regional governments as opposed to being fully centralised or decentralised. This is partly because control over finances is politically important to national governments and so they are reluctant to surrender it fully to lower-level bodies. For example, county councils in Sweden raise 70% of their health sector revenue from county-level taxes, while the remaining 30% comes largely from state sources.¹⁹⁴

194 Saltman and Bankauskaite, “Conceptualizing Decentralisation in European Health Systems: A Functional Perspective”.

Concerns over equity also ensure that fiscal decentralisation is balanced between national and regional levels. Countries tend to have significant variations in wealth between regions, so most fiscally decentralised systems include some sort of equalisation payments to allocate extra resources to lower level governments that are less well off.

Striking a balance between national and local accountability structures is also important. Smaller units with decision-making closer to the public are often seen as more transparent and easier to hold accountable. The public find it easier to understand and control processes at local levels rather than in large centralised bureaucracies.¹⁹⁵ However, on the other hand, there is a risk of duplication of effort if quality assurance and data-collection systems are based at the local level. It may also be more difficult to compare performance across decentralised units, making critical assessment harder to achieve. Therefore, a combination of “decentralized decision units that are embedded in and supported by centralised standards and evaluation of performance may be the solution to this dilemma”.¹⁹⁶ The issue of robust accountability in a localised health system is given greater consideration in chapter 7.

LESSON FOR THE NHS

There is no clear message for health policymakers in England; it is possible to construct a strong intellectual argument both for and against decentralisation. However, from the evidence that is available, there seem to be some useful points that should be borne in mind when considering whether to pursue a strategy of decentralisation in the health sector.

195 Vrangbaek, “Key Factors in Assessing Decentralization and Recentralization in Health Systems”, 72.

196 Ibid.

First, decentralisation should be regarded as a policy mechanism to achieve a specific objective, not as an end in itself. It must also be understood that decentralisation is not a panacea to solve all structural and policy dilemmas. To be successful, a health system needs a mix of decentralised and centralised areas, so policymakers should concern themselves with the balance between the two, a balance that will need to be continuously adjusted to respond to competing pressures throughout the system. There will always be trade-offs, for example between “democracy”, “efficiency” and “participation”, which are ultimately political considerations, rather than simply questions about policy.¹⁹⁷ A decentralisation strategy is based upon the “values, objectives, and preferences of the decision-makers, which will necessarily be context-dependent.”¹⁹⁸

A country’s history, its bureaucratic infrastructure, its political institutions, its civil society and the value base within that society will all influence the appropriateness of various structural choices in particular circumstances.¹⁹⁹ In the case of the health service in England, the NHS has been subject to a decade of centralised control which has succeeded in raising activity levels, but which has failed to improve productivity and has left staff disillusioned. In this context, decentralisation is the best option for improving the quality, productivity and responsiveness of the health service.

Decentralisation is also the best way to drive change while maintaining public support for the health service at a time of fiscal constraint. As discussed above, legitimacy in the eyes of the public is important if decision-makers are going to be able to implement

197 R. B. Saltman and K. Vrangbaek, “Drawing Lessons for Policy-Making”, in Saltman, Bankauskaite and Vrangbaek (eds), *Decentralization in Health Care: Strategies and Outcomes* (Buckinghamshire: Open University Press, 2007), 79.

198 Saltman and Vrangbaek, “Drawing Lessons for Policy-Making”, 80.

199 Vrangbaek, “Key Factors in Assessing Decentralization and Recentralization in Health Systems”, 69.

reform.²⁰⁰ A system is more likely to be viewed as legitimate if the public has some ability to provide input into the decision-making process. As such, decentralisation, which brings decision-making closer to the local population, will help enhance satisfaction and acceptance in the community, which will be crucial to the future success of the health service at a time when difficult decisions about resource allocation will need to be made.²⁰¹

Finally, as set out above, a balance needs to be struck in which decision-makers at the local level have responsibility for a wide range of service-related decisions, while the national level retains core strategic responsibilities as well as regulatory responsibilities. Local commissioners must be granted the power and freedom to innovate and take risks, but within a system that includes robust national regulation.

WHAT TYPE OF DECENTRALISATION?

As the preceding argument demonstrates, there is no pure form of decentralisation. However, Saltman's three functional dimensions of decentralisation provide a framework to help determine where decentralisation should and should not occur in the NHS.

Recommendation 14: Political and fiscal decentralisation is not desirable, but administrative decentralisation should be extended.

Political decentralisation

The health system will not respond successfully to its crisis of finance by delegating current national responsibilities to local

200 March and Olsen, *Rediscovering Institutions*.

201 Stone, *Policy Paradox: The Art of Political Decision-Making*.

government. Not only does this fail to reduce the burden of downwardly imposed targets and standards on local health providers, but it would require a structural shift in the health system to equip local government to take on responsibility for healthcare. This is not a desirable option, and local government is unlikely to play a substantially increased role in the management of health services in the next decade.

Fiscal decentralisation

The preceding chapters have shown that whatever system of supplementary funding might be introduced in response to the recession, there is still a necessary role for central government in raising money and distributing resources. In part, this is a pragmatic decision – any new form of financing would be difficult and costly to implement. Tax funding, while imperfect, has the advantage of being cheap to collect and distribute. Centralised funding also enables a collective decision about the fair distribution of resource across the country. A regional or local approach here would make it very much more difficult to ensure equal access for equal need as poorer areas, particularly urban centres, would find themselves at a particular financial disadvantage.

Administrative decentralisation

As discussed above, administrative decentralisation ensures that decision-makers are closer to, and in more frequent contact with, the population. As a result, they should be more aware of population needs and preferences and the public should have more opportunities to participate in decision-making and to voice their opinions.²⁰²

Administrative decentralisation also provides the opportunity for decentralised units (in the case of the NHS local PCTs) to offer differentiated services, thus allowing services to be tailored

202 Vrangbaek, "Key Factors in Assessing Decentralization and Recentralization in Health Systems", 65.

to meet the needs of the specific population. Such differentiation also allows local experimentation to take place which can result in innovative solutions that are responsive and efficient at a local level.²⁰³

Decision-making at a local level also promotes the use of knowledge and experience accumulated by local staff and strengthens feelings of responsibility among employees.²⁰⁴ It is also argued that accountability and responsiveness may increase by creating a shorter distance between users and decision-makers.

As such, in place of top-down rules that tightly restrict the day-to-day activities of lower level functionaries, commissioners and providers should be subject to the lowest possible levels of central control, with a radically reduced role for national government that will largely be focused on raising money and distributing it according to widely accepted definitions of what is fair.

Local priorities should be reflected in a process of decision-making that allows real variation. National guidance from the Department of Health should be substantially reduced, enabling local commissioners to work autonomously with local populations to develop appropriate policy for their area. This includes decisions about what services should be available, and how money should be spent. Regulation will ensure that these approaches are fair, and that they result in the delivery of high quality services.

203 P. E. Mourtsen and J. Svara, *Leadership at the Apex: Politicians and Administrators in Western Local Governments* (Pittsburgh: University of Pittsburgh Press, 2002).

204 O. E. Hughes, *Public Management and Administration: An Introduction* (New York: Palgrave, 2003).



CONCLUSION

In the light of these lessons about decentralisation, this report sets out a vision for a health service that is based to a much greater extent at a local level. Powerful, autonomous local commissioners, free from central control, shape the local health system to suit the needs and the wishes of the local population, who hold the commissioners to account.

Such an approach will lead to care that suits local need and will result in the development of a more efficient and innovative service. But concurrently, the local thrust of the system will be balanced by strong national regulation and a clearly defined role for central government that will continue to raise money for the NHS through central taxation, make resource allocation decisions, set limited national standards and be responsible for defining NHS values.

CHAPTER SIX: COMMISSIONING HEALTHCARE

The government sees commissioning as key to improving quality and efficiency in the NHS. The Department of Health has invested a lot of time and effort into developing the “world class commissioning programme” in an attempt to raise the standards of PCT commissioning as a route to improving services as a whole. At the heart of a social market approach to healthcare is the idea that a pluralistic and diverse approach to the delivery of services is the best way to stimulate innovation and to ensure that those services suit the needs of local people, thus improving both quality and efficiency. However, it is clear that many PCTs are struggling to manage the commissioning process.²⁰⁵ Past experience in the NHS, as well as international attempts at commissioning, suggest that excellent commissioning is very difficult to achieve. Some health experts argue that the commissioning experiment will ultimately prove to be fruitless.²⁰⁶

This chapter sets out a brief explanation of what commissioning is and how the practice has evolved in the NHS, before considering the lessons that can be taken from international attempts at healthcare commissioning. The second half of the chapter focuses on the world class commissioning programme before considering what reforms should be introduced to improve healthcare commissioning in England over the next 10–15 years.

Getting commissioning right will be key to squeezing out as much performance in the health service as possible over the coming years, in a context of what looks certain to be a much tighter funding settlement post-2011, coupled with rising health costs. There is no appetite in the health sector for any more

205 C. Ham, *Health Care Commissioning in the International Context: Lessons From Experience and Evidence* (Birmingham: University of Birmingham, 2008).

206 J. Deffenbaugh and C. Ham, “Is World Class Commissioning the Answer?”, *Health Service Journal* (29 May 2008).

extensive structural change, so it is essential to get the systems that are in place working as well as possible.

Public sector spending will be significantly reined in after the next general election. In the 2009 budget the Chancellor announced £9 billion in new spending cuts on top of the £5 billion identified in the pre-budget report in November, adding up to a £14 billion annual reduction in public spending from 2013. Financial commentators have suggested that the Chancellor has not gone far enough and that cuts of around £20 billion will be needed to reduce public sector borrowing more rapidly.²⁰⁷ Most recently the NHS Confederation has gone further still, warning that the NHS could face a shortfall in funding of £15 billion over the next decade.²⁰⁸ Whatever the exact figure, it is clear that there will be much less money to play with over the next ten years. The NHS budget is protected until 2011, but after that the service is going to have to prepare for much more frugal times.

In this context, commissioners have a vital role to play in shaping a health service that is high in quality and also efficient. It is not certain that commissioners will be up to the task; it will be extremely difficult for them to drive up quality, squeeze out efficiency savings, improve productivity, prioritise treatments and services, deal with continually changing health policy, and keep the service afloat in a time of financial strain, coupled with increasing demographic and technological demands placed upon the service.

PCT commissioners are relatively new and inexperienced, and are still quite weak in comparison to some hospital trusts. Nevertheless, it is these local commissioning organisations that

207 K. Griffiths, "Public Sector Spending Slashed by £9bn in Budget 2009", *The Daily Telegraph* (22 April 2009).

208 NHS Confederation, *Dealing with the downturn* (London: NHS Confederation, 2009).

are best placed to guide the NHS forward over the next decade – precisely because they are local.

Local commissioners are best placed to:

- assess the needs of their local population and, with input from patients and the public, determine what services to provide;
- work with local providers to secure value for money for the NHS;
- think innovatively and creatively about how to stimulate the provision of cost-efficient and effective quality services; and
- strike up a two-way conversation with their local population about the shape of local services and about prioritisation and decommissioning decisions.

It is intelligent healthcare commissioning that has the potential to create more value for the users of the health service, the wider public and the public purse.

After all, what are the alternatives? Central performance management has driven up activity levels but at great expense – both in terms of resources and in terms of the morale of staff. Such tight control from Whitehall is no longer an option when cuts are going to have to be made and justified at a local level, and innovative answers are going to have to be developed to meet pressing local need. The development of integrated care organisations that both commission and provide services across the healthcare environment has been suggested as an alternative to PCT-level commissioning, but introducing such a system would require a destabilising structural upheaval that the health service cannot cope with at this point. As such it seems sensible to throw our efforts into the difficult task of developing strong, intelligent, strategic local commissioners.

WHAT IS COMMISSIONING?

The concept of NHS organisations purchasing health services is not new. Since the introduction of the internal market in 1991, it has been understood that, as well as providing services itself, the NHS also negotiates agreements to purchase healthcare from other provider organisations.

Commissioning, however, is a newer concept, which is less well understood. Purchasing is an important part of the commissioning process, but commissioning entails more than simply buying services. At a minimum, commissioning is the technical or administrative process of matching authorised service provision, as defined by the Department of Health and the National Institute for Health and Clinical Excellence (NICE), with the known health needs of a defined population. This model “assumes a technocratic process of allocation that balances a predetermined budget with politically and clinically defined requirements”.²⁰⁹

However, commissioning is increasingly being viewed as more than this, encompassing prioritisation decisions based on the health needs of a defined population, while taking into account mandated care and local and national health priorities. This view of commissioning creates the opportunity for a process of differentially valuing various forms of healthcare framed by politically and clinically defined requirements.²¹⁰

Although an accepted definition of commissioning in the NHS remains elusive, it is the wider, more ambitious view of commissioning that is being promoted under the latest NHS Operating Framework²¹¹ and the recent world class commissioning competencies.²¹² The SMF

209 J. Q. Titter, *Submission to the LGA Health Commission January 2008* (2008).

210 *Ibid.*

211 Department of Health, *The NHS in England: The Operating Framework for 2009/10* (London: HMSO, 2008).

212 Department of Health, *World Class Commissioning: Competencies* (London: HMSO, 2007).

Health project held two expert health commissioning roundtables and conducted an extensive interview process with healthcare commissioners. This process revealed that, while different definitions of commissioning are used, there is a growing agreement that the commissioning process involves a number of central components:

- assessing health and social care needs of the target population;
- priority setting and allocation of resources to meet those needs in line with local and national targets;
- contracting with providers or purchasing services to meet those needs and targets;
- monitoring and evaluating outcomes;
- maximizing the use of data;
- assessing variations in clinical practice; and
- improving health outcomes and cost effectiveness.

With this ambitious definition in mind, what follows considers the context in which healthcare commissioners in England will have to operate over the next decade and asks whether there is potential for better value for money to be delivered if they succeed in achieving their goals.

COMMISSIONING IN CONTEXT: VALUE FOR MONEY AS PUBLIC SECTOR SPENDING SHRINKS

Good-quality commissioning

Good-quality commissioning aims to save significant sums of money and provide a better service for patients. And we know that this is not just a theoretical concept, as good commissioning is already making a significant difference: high-performing PCTs are achieving much better results and saving a huge amount of money, as compared to their lower-performing counterparts.

The NHS Institute for Innovation and Improvement has published data that highlights the gulf between high- and low-

performing PCTs for a number of different criteria. For example, the way in which PCTs manage emergency admissions makes a difference to the patient experience and to the amount of resources spent. Many patients present at A&E with problems that could have been avoided if they had been managed better in the community. This is distressing for patients, and wastes A&E time and NHS money.

NHS Institute data reveals that within West Midlands Strategic Health Authority (SHA), for example, the top-performing PCT achieved a rate of emergency admission in the third quarter of 2008 that was 13% below the expected level, while the lowest-performing PCT's emergency admissions rate was 53% above the expected level. The data shows that if the lower-performing PCT was to bring its performance up to achieve a population standardised rate of admission in line with the top quartile performance, it would save more than £6 million a year.²¹³

Huge savings can also be achieved depending on the way in which PCTs manage outpatient appointments. Many patients, for example, could be treated effectively and more cheaply outside hospital altogether, and follow-up of some patients could be conducted over the telephone. The NHS Institute data reveals that in the West Midlands SHA, the top-performing PCT could have saved £53,000 a year if its referral rates had been in line with the quartile of PCTs with the lowest standardised rate of referrals, while the lowest-performing PCT in the SHA could have saved £1.3 million a year.²¹⁴

Similarly, increasing low-cost prescribing by encouraging the use of generic drugs, for instance, can save PCTs a huge amount of

213 NHS Institute for Innovation and Improvement, "Managing Variation in Emergency Admissions", http://www.productivity.nhs.uk/Form_GetReport.aspx?period=2008-Q3&report=p22&orgCode=5PG.

214 NHS Institute for Innovation and Improvement, "Managing Variation in Outpatient Referrals", http://www.productivity.nhs.uk/Form_GetReport.aspx?period=2008-Q3&report=p24&orgCode=5PG.

money at no cost to the patient. The volume of statin prescribing has increased significantly during recent years and there are large cost differentials between the different statin drugs. By ensuring that clinicians follow national clinical guidelines, PCTs can keep prescribing costs down. A 28-day course of a branded statin is on average about six times more costly than an appropriate generic statin. If PCTs with below 78% use (achieved by the top quartile of trusts) of lower-cost statins increased this to 78%, more than £64 million would be saved in a year.²¹⁵

The NHS Institute data shows that in West Midlands SHA the lowest-performing PCT could save more than £1 million a year if it achieved a 78% rate of low-cost statin prescribing, while the highest-performing PCT in the region was already achieving the 78% level.²¹⁶

These are just three examples of the ways in which good-performing PCTs in West Midlands SHA are saving millions of pounds a year, as compared to their counterparts within the same SHA. This pattern is true in every SHA across the country, which shows that although cost savings will be difficult to achieve, they are not impossible. Commissioning organisations can be strengthened by giving them more power and freedom to innovate and focus on outcome-based commissioning, while commissioning skills can be enhanced through education and training and through spreading best practice and encouraging PCTs to work together to build skills.

There is no guarantee that commissioning will ever become “world class”, and it is clear that developing the strength and skills of commissioners will be a difficult and slow process. But a dramatic structural overhaul of the health service is unwelcome and would be damaging. Instead, a concerted attempt to improve commissioning appears to be the best hope for achieving a high-

215 NHS Institute for Innovation and Improvement, “Increasing Low Cost Prescribing for Lipid Modification”, http://www.productivity.nhs.uk/Form_GetReport.aspx?period=2008-Q3&report=p43&orgCode=5PG.

216 Ibid.

quality, effective, efficient health service which meets the needs of local people and responds to their demands, in the context of reductions in the growth of public sector funding that will have to occur over the next decade.

If the NHS is to succeed in its aim of achieving world class commissioning, it must look beyond its own shores to see how other countries have approached the task of strategically commissioning healthcare. Therefore, the chapter now turns to international attempts at healthcare commissioning to consider what lessons the NHS can learn.

LESSON FROM INTERNATIONAL EXPERIENCE

International attempts at healthcare commissioning offer some useful lessons and insights for the English system.

Information

In 1993, New Zealand separated commissioning and provider roles in its health system, and this remained in place until 1999. A study of the experience found that a lack of good information on costs, volumes and quality hampered the commissioning process.²¹⁷ However, the study noted that the commissioning process encouraged an increased focus on improving efficiency and quality of care.

Size and skills

The USA, with a well-established market in healthcare, also provides guidance for the more fledgling healthcare market in this country. Donald W. Light summarised a number of lessons that the NHS should learn from the American experience. He stressed that commissioning organisations need to be large and strong and that commissioning teams need to be intelligent, well trained and technically supported.²¹⁸

217 T. Ashton, J. Cumming and J. McLean, "Contracting for Health Services in a Public Health System: The New Zealand Experience", *Health Policy* 69:1 (2004).

218 D. Light, *Effective Commissioning* (London: Office of Health Economics, 1998).

Patient focus

A further study of commissioning in the US healthcare sector during the period of managed care found that the health insurance industry focused its strategies on understanding and influencing physicians, with only secondary attention given to understanding and influencing patients. The industry has subsequently had to reposition itself as an agent of the patient rather than of the employer and to focus its activities on informing and supporting consumer healthcare choices.²¹⁹ Although the health service in England is different from the system of managed care in the USA, what these findings highlight is the need for commissioners in the NHS to keep the patients they are serving at the front of their mind at all times. Commissioners must remember that it is patients and the public that they serve, not doctors, clinicians or provider organisations. Commissioners must engage with, understand and inform the populations they serve, anticipate their healthcare demands and work out how they can best be met, while simultaneously working with providers to control costs and improve performance.²²⁰

Integration

The international experience makes it plain that healthcare commissioning is difficult to do well. Chris Ham examined healthcare systems across Europe, New Zealand and the US and failed to find an example of “any working models of health care systems where commissioning is working effectively across the whole system”.²²¹ Ham pointed to the complex nature of healthcare and the need for commissioners to have a high level of technical and managerial skills as the main reasons why it is so hard to commission health services successfully.

219 J. C. Robinson, “Reinvention of Health Insurance in the Consumer Era”, *JAMA* 291 (2004).

220 Ham, *Health Care Commissioning in the International Context*, 5.

221 C. Ham, *Commissioning in the English NHS: The Case for Integration* (London: The Nuffield Trust, 2007), 8.

Ham suggests that an integrated system which combines commissioning and provision within the same organisation would be more successful than doggedly persisting with an internal market in health. He points to systems such as Kaiser Permanente (KP) in the USA, which seem to perform well in comparison with other systems.²²²

KP is an integrated managed care organisation which operates in nine US states with 8.7 million health plan members and 156,000 employees.²²³ It has received a lot of attention in England over the past few years; the DH became impressed with some aspects of the Kaiser operation, and there were suggestions that the NHS should adopt some of its policies. It was argued that the KP model delivers a cost-efficient and integrated healthcare service that lacks the traditional distinction between primary and secondary care and provides well-established pathways of care for many diseases. It was suggested that the management costs of the system were at least as efficient as the NHS and that it achieved fewer hospital admissions per head of population.²²⁴

However, KP, unlike the NHS, does not deliver universal coverage. It is not obliged to take all-comers and can cream off the least risky patients who make low use of health services. This practice is reinforced by healthier consumers self-selecting into the lower-cost plans offered by managed care.²²⁵

As such, making direct comparisons between KP and the NHS is difficult. There is no indisputable evidence that a KP-type model would provide better or cheaper care than is currently achieved in the NHS, and a number of commentators have actually argued that the NHS is more efficient and provides higher-quality care.²²⁶

222 Ibid., 9.

223 "Fast Facts About Kaiser Permanente", <http://xnet.kp.org/newscenter/aboutkp/fastfacts.html>.

224 C. M. Shapiro and A. McCall Smith, "Lessons for the NHS From Kaiser Permanente", *BMJ* 327 (2003).

225 C. Donaldson and D. Ruta, "Should the NHS Follow the American Way?", *BMJ* 331 (2005).

226 A. Talbot-Smith et al., "Questioning the Claims From Kaiser", *British Journal of General Practice* 415 (2004).

In addition, the KP model combines commissioning and provision within one organisation. Introducing this into the NHS would require a rejection of the purchaser/provider split and would entail significant structural change.

The Department of Health has invested heavily in a new world class commissioning programme²²⁷ which would have to be entirely overhauled if a KP model were to be introduced. The potential benefits of such an overhaul are not certain enough to justify the huge disruption, especially at a time when healthcare professionals are desperate to avoid yet more structural upheaval and the health service faces significantly tighter funding increases over the next decade. Integrated care is discussed in more detail later in this chapter.

Fundamentally restructuring the NHS once again, particularly in a time of pressure on public finances, is not the right approach to improving the quality and efficiency of healthcare in England.

Recommendation 15: The purchaser/provider split should be maintained and attention should be focused on improving commissioning performance within existing structures.

The chapter now considers how commissioning came to become central to the future of NHS, culminating, as it has done, in the development of the world class commissioning programme.

227 Pockets of good commissioning exist, for example, Heywood, Middleton and Rochdale PCT, Sport England and the Big Lottery Fund have joined together to regenerate local sports facilities.

RISE OF COMMISSIONING IN THE NHS

Policymakers have been espousing the merits of purchasing within the NHS for the past 20 years. The 1990 NHS and Community Care Act introduced the “internal market” in an attempt to make the NHS more efficient and less producer-dominated, by separating the roles of the purchaser and the provider of healthcare (the “purchaser–provider split”). At the same time, GP fundholding was established to allow groups of GPs to take direct control over budgets for purchasing hospital and other services. The “purchasers” (health authorities and GP fundholders) used their budgets to buy health services (mostly secondary care) from “providers” (such as acute hospitals, organisations providing healthcare for the mentally ill, and ambulance services).

Health authorities and GP fundholders were granted the freedom to alter established purchasing patterns in order better to reflect the needs of their populations. However, they struggled to influence powerful providers defending historical patterns of service provision. Evidence suggests that despite the attempt to beef-up the purchasing arm of the NHS, patterns of contracting remained largely unchanged.²²⁸

The Labour government elected in 1997 immediately set about reforming the internal market that had been set up by the Conservatives, although the fundamental division between purchasers – now termed “commissioners” – and providers remained more or less intact. GP fundholding was abolished, largely because of an aversion to markets in public services that has since been overcome. Responsibility for purchasing healthcare was taken away from health authorities and devolved to smaller, newly created primary care groups (PCGs) made up of local GPs and other clinicians.

228 M. Dusheiko et al., *Trends in Health Care Commissioning in the English NHS: An Empirical Analysis* (York: University of York, 2006), 1–2.

Supply-side reform also occurred with the introduction of NHS foundation trusts and independent sector treatment centres. At the same time, the way in which NHS hospitals in England were paid for the work they were doing was fundamentally changed. A system termed “Payment by Results” (PbR) was introduced under which hospitals are reimbursed for the activity they carry out using a tariff of fixed prices that reflect national average costs: payments to providers follow the patients they treat. This was meant to make it easier for commissioners to switch providers or reconfigure services.

However, as was the case with the Conservative reforms of the early 1990s, the small PCGs struggled to negotiate on equal terms with the large providers. As a result, more recent policy has attempted to strengthen primary care organisations in part by merging PCGs to form larger, stronger entities. From the outset, the 481 PCGs were supposed to evolve into 303 primary care trusts (PCTs) after a probationary period in which they demonstrated their ability to manage budgets and services. But in May 2006 the government announced plans to reduce the number of PCTs to 152 to enable them to commission care more effectively and economically. In addition, a variant of fundholding, known as practice-based commissioning (PBC), was reintroduced, with GP practices able to opt to hold budgets for secondary care.

Reintroducing commissioning capacity at GP level is at odds with the government’s attempt to increase the size of commissioning organisations. However, it was argued that different services should be commissioned at different levels (local, regional or national) and that PBC would in fact strengthen commissioning by putting commissioning power in the hands of frontline clinicians. This would lead to “high quality services for patients in local and convenient settings” because “GPs, nurses and other primary care professionals are in the prime position to translate patient needs into redesigned services that best deliver what local people

want".²²⁹ Practice-based commissioning is discussed in more detail later in this chapter.

This attempt by the Department of Health to strengthen the commissioning arm of the NHS does not appear to have been much more successful than the Conservative effort ten years earlier. A study by Judith Smith et al. in 2004 found "little substantive research evidence to demonstrate that any commissioning approach has made a significant or strategic impact on secondary care services".²³⁰ The study concluded that this was due in part to the fact that commissioning organisations were not powerful or sophisticated enough to exert their will on health providers because they lacked the organisational stability enjoyed by many providers.

This conclusion is supported by research undertaken by the Centre for Health Economics at York University, which found that in the period between 1997/8 and 2002/3 the use of providers for elective care was highly concentrated and became more so over time.²³¹ The quality and effectiveness of commissioning cannot be assessed solely in terms of how concentrated the purchasing patterns are. Such concentration may reflect the fact that PCTs were developing long-term relationships with local providers, or that patients were reluctant to travel to more distant providers. But whatever the cause, in this five-year period, at a time when purchasers were actively encouraged by the Department of Health to use a wider range of providers, the reverse occurred.²³²

More recently, PCTs have been subject to another wave of reform, most notably with the introduction of the world class commissioning programme.

229 Department of Health, "About Practice Based Commissioning", http://www.dh.gov.uk/en/Managingyourorganisation/Commissioning/Practice-basedcommissioning/DH_4138698.

230 J. Smith et al., *A Review of the Effectiveness of Primary Care-Led Commissioning and Its Place in the NHS* (London: The Health Foundation, 2004), 2.

231 Dusheiko et al., *Trends in Health Care Commissioning in the English NHS*.

232 Ibid.

WORLD CLASS COMMISSIONING

World class commissioning has been trumpeted by the Department of Health as a key initiative to transform PCTs into commissioning organisations that will drive up the quality of healthcare across the NHS. Quality is the new maxim of NHS reform²³³ and the development of world class commissioning is seen as a central lever to deliver it.

The world class commissioning programme, launched in December 2007, aims to “transform the way health and care services are commissioned”, delivering a “more strategic and long-term approach to commissioning services, with a clear focus on delivering improved health outcomes”.²³⁴

World class commissioning is a statement of intent made up of four key elements:

- a vision for world class commissioning;
- a set of world class commissioning competencies;
- a support and development framework;
- an assurance system.

The vision, which outlines what world class commissioning means (delivering better health and wellbeing, care and value), is backed up by 11 core competencies set out by the Department of Health that outline the knowledge, skills, behaviour and characteristics that a world class commissioning organisation will need to develop.²³⁵

233 A. Darzi, *High Quality Care For All: NHS Next Stage Review Final Report* (London: HMSO, 2008).

234 Department of Health, “WorldClassCommissioning”, <http://www.dh.gov.uk/en/managingyourorganisation/commissioning/worldclasscommissioning/index.htm>.

235 The 11 core competencies are: Locally lead the NHS; work with community partners; engage with public and patients; collaborate with clinicians; manage knowledge and assess needs; prioritise investment; stimulate the market; promote improvement and innovation; secure procurement skills; manage the local system; make sound financial investment.

SHAs have responsibility for supporting PCTs in achieving world class commissioning by encouraging them to share services and good practice, develop internal resources or buy in external expertise, for example through the Framework for procuring External Support for Commissioners (FESC). FESC enables PCTs to partner with independent providers that can undertake aspects of the commissioning function while remaining accountable to the PCT board throughout.

Most crucial of all to the success or failure of world class commissioning is the new assurance framework which will hold PCTs to account and reward performance and development. The assurance framework is a nationally consistent system managed by SHAs which will measure performance in three central areas: health outcomes, competencies and governance. The three elements will be assessed using a combination of self-assessment and self-certification by PCTs, combined with the results of evidence gathering and data analysis which will provide the input for a panel day, which is the focal point in the commissioning assurance.²³⁶ The panel will make an assessment of the PCT across outcomes, competencies and governance, and will provide developmental advice to PCTs to support ongoing improvement.

For each PCT, a scorecard will be created to demonstrate their performance relative to the national average for each outcome and their rate of improvement relative to the national improvement rate. PCTs will also be shown their performance adjusted for health deprivation. For each of the 11 competencies, PCTs will be rated on levels 1–4 (where level 4 is world class). The governance element of the system focuses on whether the PCT board has a meaningful strategic plan for commissioning, supported by a robust financial plan.

236 The panel will be made up of five individuals: the director from the local SHA; PEC chair or medical director from another PCT; director of Adult Services or director of Children's Services from another PCT; executive director from an international organisation or another industry; PCT chief executive from another SHA area.

Where an SHA has cause for concern about a PCT's performance, the PCT may be publicly designated as either "underperforming", or "seriously underperforming" or "challenged". If a PCT is designated as challenged, it would be subjected to an external review of governance and board capability. Outputs from this would inform the SHA of potential changes at board level. The SHA would sign off a "turnaround plan" and, after a maximum of 12 months, the SHA would submit a report to the NHS chief executive and make recommendations either to remove the challenged designation or to place the organisation "under direction". Placing a PCT under direction would involve action to take control of the board, and could include replacing the board, outsourcing some or all of the PCT functions or having another PCT take over.²³⁷

INITIAL RESPONSE TO WORLD CLASS COMMISSIONING

As mentioned above, this is not the first time that the Department of Health has attempted to re-energise healthcare commissioning and questions remain about whether this latest initiative will be any more successful than previous reforms. However, there does appear to be some optimism that the world class commissioning programme could deliver this time. It is still very much in its infancy, so at this stage it is difficult to determine its likely success. Nevertheless, the initial response from PCT staff appears to be reasonably positive. Commissioning is now seen as critical to the NHS's success in a way that was not previously the case, and momentum seems to be building behind the programme.

The process to develop the world class commissioning strategy involved stakeholders from across the health system, which means that a lot of people are engaged with the process. The programme has been praised for setting out a clear vision and aspirations

237 A. Laban, *NHS Performance Regime* (Yorkshire and Humber: NHS Yorkshire and Humber Strategic Health Authority, 2008).

for change. The core components of the assurance system were designed and tested with the PCTs in the NHS North West region and participating PCTs reported that the panel day was “constructive, positively challenging and valuable”.²³⁸

Assessing PCTs

At the heart of the world class commissioning programme is the assurance system for PCTs. This is intended to inform central government and local stakeholders about commissioner performance, and make it possible to compare results from different areas of the country.

Some concerns were expressed, before the publication of the first round of results from the assurance framework, that almost no PCTs would score levels three or four for any of their competencies, meaning that there would be little gradation in scores and that PCTs operating at different levels would end up with very similar results. It was argued that, if this were the case, the rating system would fail as an assessment of relative performance.²³⁹

However, the publication of the first round of results has taken place, and although no PCT achieved level four for any of the 11 competencies, level three was awarded 37 times, surpassing expectations that PCTs would remain stuck at levels one and two. Mark Britnell, then Director General of Commissioning at the DH, declared that the first round of world class commissioning had gone “very well indeed”.²⁴⁰

Despite the general satisfaction with how the programme has worked, some managers have warned that the scheme is at risk of ‘gaming’ (this occurs when the rules of a system are used for purposes outside what they were intended for). SHAs have stressed the importance of PCTs achieving year-on-year improvements

238 A. Cowper, “World Class Commissioning: Quality Assurance”, *HSJ* (2008).

239 H. Crump, “Data Shortfalls Hinder World Class Commissioning Efforts”, *HSJ* (2008).

240 H. Crump, “PCTs Exceed Expectations in Year One”, *HSJ* (2009).

of their competency scores. As such, it has been suggested that some PCTs deliberately attempted to score at a low level in the first year so that improvements are easier to attain in coming years. A senior PCT executive interviewed by the SMF Health Project team indicated that such gaming of the assurance system was occurring in his PCT. If such practices are widespread, it will devalue the assurance framework's grading system.

Another concern with the framework is that it rewards steady PCTs that do not take risks. PCT Network director David Stout said: "There's an issue where if you're ambitious but can't articulate very clearly how you're going to achieve your ambition, the system will mark you down." It is important that the system does not create overly cautious, risk-averse PCTs that focus on scoring well on world class commissioning assurance tests rather than commissioning the best healthcare for their population. Innovation may also be stifled as PCTs focus solely on the 11 centrally determined competencies, thus undermining a major benefit of the devolved approach.

There is also a possibility that the assurance process will uncover more about the different approaches to the framework adopted by the SHAs than the actual performance of PCT commissioners. The NHS Alliance is concerned that the framework could become a means for SHAs to exert undue influence and impose their own agenda.²⁴¹ Chair Michael Dixon questioned whether the process will distinguish between those that commission well and those that do not, "or will it be based on PCTs commissioning in the way the SHA thinks they should?"²⁴²

John Appleby, Chief Economist at the King's Fund, agrees, pointing out that SHAs will be key decision-makers in awarding scores and providing an assessment of PCT performance, and so will

241 H. Crump, "SHAs Urged Not to Abuse Their Power", *HSJ* (2008).

242 *Ibid.*

have the potential to manage the outcome to suit their preferred approach to performance management.²⁴³ This could make comparison of PCT performance across the country questionable, as some SHAs may hold different interpretations of the scoring criteria from others. It may also introduce a degree of subjectivity into the system, which would weaken its credibility.

There are also question-marks about whether the new system will actually lead to significant changes in commissioning patterns – a goal that has so far remained out of reach. A survey by *Health Service Journal* found that two out of three PCTs failed to decommission any services in 2007.²⁴⁴ Decommissioning is not the only way to improve services, and cancelling a contract is unlikely to be a commissioner's initial response to poor outcomes. Instead, commissioners would be expected to work with providers to agree standards that will improve quality and efficiency. However, world class commissioners are supposed to stimulate the market, manage the local health system and make sound investments, which will inevitably require some services to be decommissioned, and currently PCTs are failing to do this. This failure is underlined by the fact that PCTs performed worst at competency seven: stimulating the market. While 17 PCTs achieved level two, and no PCTs reached level three or four, 135 PCTs only managed to reach level one, the lowest mark available.²⁴⁵

While the world class commissioning programme offers a useful definition of commissioning, and is rightly considered a crucial mechanism to improve the quality and value for money of the NHS, there are clear issues with the way in which PCTs report on their performance and how they are assessed by external agencies. As well as this, there are problems of organisational underperformance that will be present in any complex public service. The world class commissioning

243 Ibid.

244 H. Crump, "PCTs Failing to Decommission Services", *H SJ* (2008).

245 Crump, "PCTs Exceed Expectations in Year One".

programme must develop in the next few years to truly empower PCTs to commission services effectively in their local area. This requires not only a different approach to regulation, but also an in-depth focus on the strategic performance of commissioning organisations.

A successful PCT assurance system must:

- provide detailed, comparable information about PCT performance for public consumption;
- drive up PCT performance;
- support quality and ambition;
- encourage innovation;
- support decommissioning and encourage efficiency.

HOW TO IMPROVE COMMISSIONING IN THE FUTURE

The SMF Health Project has identified many of the trends and challenges that the health system in England will face over the next 10–15 years, set out in detail in the project’s five background papers.²⁴⁶ Commissioning is central to driving up performance in the NHS and has the potential to create a health system that reflects the needs of the local population in an innovative way. However, for this goal to be achieved, some changes to the current approach to commissioning are needed. The next section of this chapter sets out a number of recommendations that aim to ensure that commissioning is successful in the future.

SKILLS

If commissioning is to succeed in driving up quality in the NHS, the capability, capacity and profile of individuals who work for

246 SMF Health Project background papers: Paper1 – *An Overview of Health Systems Reform and the NHS*; Paper 2 – *Demography and Technology: External pressures for Change*; Paper 3 – *Commissioning Healthcare*; Paper 4 – *Providers of Healthcare*; Paper 5 – *Patients in the Health System*. The background papers can be downloaded from the SMF website: www.smf.co.uk

commissioning organisations, and the organisations themselves, need to be strengthened. The world class commissioning framework sets out 11 useful commissioning competencies. However, a nationally dictated set of skills and competencies will not meet all requirements; PCTs will need different skill sets to meet different needs. As such commissioning skills should be developed at a local, regional and national level. This is happening already to a certain extent; the Department of Health's world class commissioning team stresses that development may be self-managed by PCTs, directed by SHAs or led by the department.²⁴⁷

West Kent PCT is an example of best practice in this respect. At a national level, West Kent is involved in working collaboratively with other PCTs on new development programmes, designed to support boards in readiness for change. Regionally, West Kent is in the process of reaching an agreement with Brighton and Sussex University Medical School to run an MSc in health commissioning. Locally, West Kent is creating a PCT-run commissioning graduate development programme which will be complementary to, but not part of, the national management trainee scheme.²⁴⁸ This is intended to supply the PCT with the skills it needs for the future, and is surely a more profitable use of resources than striving to demonstrate adherence to a list of centrally determined priorities.

Recommendation 16: PCTs must continually assess the skills and competencies that they require to successfully commission at a local level, and then strive to develop those capabilities.

247 A. Cowper, "Supporting World Class Commissioning", *HSJ* (2008).

248 Cowper, "Supporting World Class Commissioning".

Commissioning skills are not just about managing data and drawing up contracts; equally important is a cultural shift away from a rigid focus on current systems to think instead about new ways of achieving improvement through, for instance, engagement with all the people who are effected by the system – managers, clinicians and community members. A change in commissioning culture that understands the power of people’s values and the motivational force of engagement is just as important as system change.

INVESTMENT IN SKILLS

Significant investment in commissioning skills is required. Commissioners need to be expert at a number of different skills – risk analysis, health economics, procurement and data management. Currently only around 1.4% of the NHS budget is devoted to the mechanics of commissioning, whereas this figure is believed to be about 5–6% in other health systems in the developed world.²⁴⁹ PCTs don’t have huge management resources and, because of a political drive to cut down NHS bureaucracy, a cap on numbers of personnel exists. To function properly, PCTs must be allowed to develop themselves as organisations rather than bowing to political pressure that demonises bureaucrats. Health system performance will be improved with an increased emphasis on management skills in commissioning. Better management will also improve the capacity of PCTs to deal with information flows in the health system that can be overwhelming. Commissioners need to play a much more active role in promoting quality in healthcare, and information about provider performance is central to this. However, there are real fears that PCTs are simply not very good at dealing with information in an effective way. Good local commissioning will only be achieved if PCTs are enabled to develop their management skills and capacity without top-down control of the numbers of staff they are permitted to employ. This is not about

249 J. Appleby, "How to Get Commissioning Working Better: Skills, Data, Subsidiarity and Culture", http://www.commissioninghealth.com/index_files/v2n2Appleby.htm.

creating large new bureaucracies, but about putting commissioners on a level playing field with mature acute providers.

Recommendation 17: The cap on PCT personnel numbers should be removed granting PCTs responsibility for determining their own staffing levels.

PROFESSIONAL STANDARDS

As commissioning is becoming increasingly complex and central to the way public sector services are delivered, there is a growing case for a more formal recognition of commissioning as a professional discipline. Commissioners, both as individuals and organisations, would benefit from the development of mechanisms for increasing their influence, developing their skills and capabilities, and raising their profile. This could be achieved through a form of membership organisation or professional body which could develop a set of professional standards for commissioners. There are already organisations, such as the Institute of Commissioning Professionals, that aim to improve professional standards. Additionally, the medical profession is well supported by a number of royal colleges that both represent the collective interest of their members, and also play a central role in training and professional standards.

However, for a number of reasons such a formalised approach may not be the best option. First, in most cases commissioning is an organisational responsibility, not an individual task. It is not possible for an individual to possess all the competencies required for effective commissioning, and there is concern that the ability for an individual to become a professional commissioner would undermine the notion of public sector organisations as commissioners.

In a similar vein, because of the organisational nature of PCT commissioning, there would be a question as to who from the PCT should become accredited. Would it only be the director of commissioning? Or would the chief executive have to be accredited, or would all the senior managers need to be professional commissioners? And if it was only PCT managers who became professional commissioners, it might create the idea that commissioning is a "management" function that does not concern other professionals. This would be at odds with the current DH policy of practice-based commissioning, which encourages GPs to view commissioning as a central part of their existing professional role, not a new profession they need to enter.

Finally, the context-specific nature of commissioning competency means that different individuals and organisations will need to develop different skills in order to be competent. Defining a standardised qualification or accreditation criteria that was applicable and stretching for all would be hard to achieve, and could detract from the important task of addressing specific local development needs.

Recommendation 18: A formal set of individual commissioning competencies should not be developed for NHS commissioners.

While a role is not envisaged for standardised commissioning qualifications, the voice of commissioners should be strengthened to enable them to stand up to provider organisations, recruit high quality staff and stamp their authority on the health service. Currently, the PCT Network, which was launched in December 2006, now has 95% of the trusts as members and represents their interests. The Network was established to improve the health system by raising the profile of issues affecting PCTs and strengthen the influence of PCT members. The Network aims to strengthen commissioning by putting in place a support and development programme for PCTs around world class

commissioning competencies. It also has a role influencing the regulatory landscape positively for its members, enhancing the reputation of PCTs and identifying examples of PCT successes.²⁵⁰ The Network puts on seminars, conferences and forums to promote networking and learning and publishes papers and information on primary care issues.

The PCT Network has made a strong start in its short existence. According to Mark Britnell, it “is a highly effective membership organisation that makes its point clearly and firmly”.²⁵¹ However, a number of changes could be made to give the organisation more clout and make it a more effective vehicle for improving the quality and strengthening the standing of healthcare commissioners in England.

First, it may be beneficial for the body representing commissioners to be totally independent. At present, the PCT Network is part of the NHS Confederation – a trade association representing all types of NHS organisations with a number of networks focusing on specific parts of the NHS. A commissioning body would have more freedom if it was not part of a larger organisation but stood alone with the sole responsibility of furthering the interests of healthcare commissioners in England.

Second, the PCT Network is, in effect, a trade body for those commissioners who work in PCTs. However, in the future it should broaden out to include all healthcare commissioners in the health system, moving from being a PCT Network to become a Healthcare Commissioner Network. In a similar vein, at present the network covers both commissioning and provider elements of PCTs’ roles, but PCTs are increasingly separating out these roles. In the future, the Commissioner Network should focus exclusively on the commissioner role, with provider interests supported elsewhere.

250 Primary Care Trust Network, “About the PCTN”, <http://www.nhsconfed.org/Networks/PrimaryCareTrust/AboutThePrimaryCareTrustNetwork/Pages/AboutPCTN.aspx>.

251 Primary Care Trust Network, “Become a Member”, <http://www.nhsconfed.org/Networks/PrimaryCareTrust/Pages/BecomeAMemberPCTN.aspx>.

Third, although a commissioning body would not develop a set of professional commissioners skills, there is no reason why it could not take on a number of roles that royal colleges currently carry out for their members. This could certainly include an educational element. A commissioning body could provide:

- distance learning;
- network accredited courses;
- study days;
- short courses;
- workshops; and
- assist commissioners in undertaking training courses or other educational activities run by other establishments;

It could also:

- establish regional faculties to effectively support commissioners across the country;
- actively encourage talented people to become healthcare commissioners;
- publish work by members and others to improve healthcare commissioning by spreading innovative ideas and approaches and engendering discussion;
- diffuse information on all matters affecting healthcare commissioning and establish, print, publish, issue and circulate papers, journals, magazines, books, periodicals and other publications;
- publish guidelines and best practice statements;
- undertake research to better understand the art of healthcare commissioning, and encourage members and others to do likewise;
- hold meetings, conferences, seminars and instructional courses;
- cooperate and form partnerships with other bodies to further the aims of the Network;
- provide information to the general public, media and external official bodies.

Recommendation 19: The current PCT Network should develop to take on a role similar to a Royal College, as a way of strengthening commissioners in the NHS.

NICE

NICE provides commissioners with crucial support and information. The Institute produces web-based commissioning guides that provide topic-specific information to help ensure that effective, evidence-based care is commissioned.

Each commissioning guide offers practical advice on issues such as local needs assessment and opportunities for clinical service redesign. The guides set benchmarks to help commissioners determine the level of service needed locally.

Within each guide, an interactive commissioning tool enables commissioners to estimate the cost of local commissioning decisions. The tool can help commissioners to:

- identify local service requirements;
- review current levels of commissioned activity;
- identify future change in capacity required using the indicative benchmark provided;
- model future commissioning intentions and associated costs over three years;
- calculate potential set-up and recurrent costs over three years.²⁵²

In addition, the NICE appraisal process provides essential information about the clinical and cost-effectiveness of health

252 National Institute for Health and Clinical Excellence, "NICE Support for Commissioning", <http://www.nice.org.uk/media/6BD/98/NICESupportForCommissioning2008.pdf>.

technologies. This will become increasingly important as commissioners attempt to squeeze out efficiency savings in the years ahead.

Health minister Ara Darzi has set out an expanded role for NICE, which is now expected to make more rapid appraisals of new drugs and set national quality standards.²⁵³ This is to be welcomed, but it is important that NICE appraisals do not end up focusing exclusively on new pharmaceuticals at the expense of existing devices and procedures. If commissioners are going to drive out ineffective practice, they will rely on NICE to assess old technologies, as well as new ones, so that they can commission the most cost-effective treatment.

The expansion of NICE's role will require additional resources and, at a time of fiscal consolidation, finding extra money for a quango will be difficult. NICE's £30 million annual budget has already come under attack in the media.²⁵⁴ However, investing in NICE is money well spent, as it will lead to savings in later years. In addition, the world-class reputation that NICE has required is starting to pay dividends. NICE has begun to offer consultancy services to foreign governments, such as in Ghana, Colombia, Jordan and Turkey, which could bring in an important revenue. The Institute is also beginning to offer scientific advice to companies seeking to tap into NICE's experience in health technology assessments.²⁵⁵ Again, this could prove to be very lucrative.

Recommendation 20: The capacity of NICE to appraise existing procedures, as well as new ones, needs to be strengthened.

253 Darzi, *High Quality Care for All*.

254 R. Robinson, "New Look NICE", <http://www.fleishman-hillard.co.uk/uploads/documents/NewLook.pdf>.

255 Robinson, "New Look NICE".

Recommendation 21: The commercial capacity of NICE to offer consultancy to governments and private sector companies should be expanded.

INTEGRATION

Following the primary care strategy of the Darzi review, integrated care organisation pilots are currently under way. Colleagues in primary, secondary and tertiary care can come together to offer a joined-up set of services provided under the umbrella of an integrated care contract.

Some commentators are calling for the establishment of integrated care organisations along the lines of the American-managed care provider Kaiser Permanente that combine commissioning and provision and compete for patients. It is argued that the introduction of such a system would lead to patient-centred, joined-up care provided in the community rather than in hospitals, which would be better for the patient and cheaper to provide.

There is no doubt that the current system in England is far too focused on acute, hospital-based care and there is insufficient collaboration between healthcare sectors. For too long, ministers and civil servants have focused their attention on the acute sector, contributing to an organisational culture where hospitals are given undue attention. In an era of sophisticated speciality medicine, patients need to be diagnosed and treated in multispeciality health centres where primary care teams work in partnership with specialty nurses and doctors, laboratory and imaging technicians and the pharmacy team.²⁵⁶

However, as discussed above, introducing integrated care organisations along the lines of Kaiser Permanente would require

256 D. Light and M. Dixon, "Making the NHS More Like Kaiser Permanente", *BMJ* 328 (2009).

significant structural change and the establishment of a different funding mechanism for healthcare in England. The potential benefits of such a transformation do not outweigh the massive costs of upheaval that such a radical change would require.

Instead, the action plan originating from the Darzi review is attempting to stimulate integrated care under the current system, which is a worthwhile goal. However, it is important that integrated services are allowed to develop organically at a local level to meet local need, rather than the DH dictating how integration should develop and what integrated care models should look like. The focus of the integrated care pilots must be on the outcomes delivered rather than on the structure of the organisation delivering the care. In some cases, clinicians from across the health service will merge together into one organisation to offer integrated services to a PCT; in other cases colleagues will look instead to improve their information systems and governance structures to enable them to work together more seamlessly.²⁵⁷

There are already pockets of very effective integrated care across the NHS. In Bolton, for example, there is a locally managed diabetes network that strives to provide patient-centred, integrated care that is delivered in the appropriate place at the appropriate time by the appropriately trained professional. The plan is that Bolton will have a fully integrated service that irons out gaps or duplication, and ensures a smooth referral from primary care to specialist advice.²⁵⁸ This shows that where there is a shared long-term vision, effective integration can be achieved.

Recommendation 22: PCTs and local providers must be given the freedom to develop integrated care organisations at a local level to meet local need.

257 "NHS Next Stage Review: The Whole Package", *HSJ* (2008).

258 C. Ham, *Integrating NHS Care: Lessons From the Front Line* (London: The Nuffield Trust, 2008).

ABOLISH NATIONAL CONTRACTS

The growth of integrated multidisciplinary organisations that provide care across sectors will lead to the development of new professional roles and the need for contracts to reflect new ways of working. Britnell recently suggested that the “the logical conclusion of the success of integrated care organisations is that they will lead to the abolition of the national [GP and consultant] contracts”.²⁵⁹

It seems sensible for PCTs to be able to set pay and working conditions as part of contractual negotiations with providers. This would lead to the emergence of innovative services and new clinical roles that meet local need and emerging demand, and could also lead to better value for money.

In addition, a number of experts have suggested that the general medical services contract prevents PCTs from dealing effectively with poor-performing practices. Peter Reader, chair of the NHS Alliance professional executive committee network and medical director at Islington PCT, reveals that because of the nature of the GP contract, practices in some areas are able to create a “smokescreen” of paperwork behind which to hide poor performance.²⁶⁰ PCTs will instead draw up local contracts with the freedom to define new roles to meet specific local needs, set pay and conditions to attract the right staff, and use the contract as a robust way to deal with poor performing practices.

Recommendation 23: National contracts for GPs, consultants and other medical staff should be abolished, and renegotiated at a local level when they come up for renewal.

259 R. Finch, “Commissioning Chief Predicts End of Traditional Doctors’ Contracts”, *BMJ* 337 (2008).

260 C. Santry, “Care Quality Commission: a Chance to Peep Under the Primary Care Carpet”, *HSJ* (2008).

It has been argued that abolishing national contracts will lead to big increases in GP and consultant pay as the DH's bargaining power will be lost and doctors will be able to drive up their salaries by playing local organisations off against each other. However, this argument loses its power in the wake of the latest national GP and consultant contracts, both of which led to significant increases in pay. The recent GP contract led to an average increase in GP earnings of 22.8% in its first year taking an average annual GP salary up to £100,170. An investigation by the National Audit Office published in early 2008 concluded that the contract had cost substantially more than the DH had budgeted for – nearly £1.8 billion in the first three years.²⁶¹ Similarly, in the first three years of the new consultant contract, consultants received an extra 27% in pay, increasing their average annual pay from £87,000 to £110,000 by 2005–6. Over the same period the number of hours worked by full-time consultants for the NHS decreased by an average of 1.4 hours per week from 51.6 to 50.2 hours. This rise in pay was greater than the DH had anticipated: by the end of March 2006, the department had spent £715 million on the new consultant contract, 27% more than the original estimate of £565 million.²⁶² The DH has failed to negotiate a good deal for the tax-payer when it comes to GP and consultant contracts, so local PCTs and provider organisations should be free to set wage scales themselves.

JOINT WORKING

In the future localisation must become the watchword of the health service, with devolved responsibilities a major driver of improvement.

However, PCTs are geographically too small and lightly staffed to be able successfully to carry out certain important

261 National Audit Office, *NHS Pay Modernisation: New Contracts for General Practice Services in England* (London: National Audit Office, 2008), 6.

262 S. Williams and J. Buchan, *Assessing the New NHS Consultant Contract: A Something for Something Deal?* (London: The King's Fund, 2006).

tasks. The answer to this problem is not a further round of disruptive mergers that would dilute many of the positive aspects of a localised service. Instead, the goal must be to increase the capacity, expertise and influence of PCTs without undermining the values of locality, or wasting public money on duplicated functions where they are not needed.

An important factor in achieving this goal involves PCTs working together in partnership. Individual PCTs are relatively small and do not have enough commissioning clout when dealing with large acute hospitals. This is particularly true in London; for example, it takes six PCTs to account for just 60% of Imperial College Healthcare NHS Trust's NHS income. A PCT acting alone has little purchasing power over such a large provider.

PCTs also currently struggle to fill gaps in crucial areas of expertise such as health economics and predictive modelling.²⁶³ These skills would be expensive for a single PCT to recruit or procure, so greater collaboration with neighbouring PCTs is necessary.

Partnerships between PCTs are beginning to occur. For example, Hammersmith and Fulham, Kensington and Chelsea, and Westminster PCTs have joined together to create a "commissioning alliance". The three PCTs share similar demographics, health priorities and investment strategies, and commission the majority of hospital care from the same two hospital trusts (Imperial College Healthcare NHS Trust and Chelsea and Westminster Healthcare NHS Foundation Trust), so close collaboration makes sense. The three PCTs understand that they can bring the greatest improvements to the health of residents across the three boroughs by creating a single team

263 S. Whiting, "Primary Care Trust Proposals for Strengthening Commissioning in Hammersmith and Fulham", http://www.lbhf.gov.uk/Images/HASCSRevisedreport05112008_tcm21-108713.pdf. (3)

equipped with the skills and capacity to improve the quality of commissioning decisions and reduce duplication of analytical, contracting and quality assessment processes.²⁶⁴

The commissioning alliance is initially focusing on acute hospital commissioning, along with contract and performance management of pharmacists, dentists and opticians. However, it is hoped that further joint commission will be developed in the future.²⁶⁵

This initiative has brought together three neighbouring PCTs, but in some cases a wider basis will be needed to commission certain services, such as trauma or paediatric surgery, across a larger area. PCTs are beginning to put in place networks to achieve these wider partnerships. Eight London PCTs across the north-west of the capital, for example, have joined forces to create a project team to lead the development of a sector-wide strategy. They have established a joint committee with decision-making powers to oversee consultation and the implementation of changes to services on offer that affect them all.²⁶⁶

Finally, collaboration across an entire region is also important, especially if SHAs are to be phased out. Currently, SHAs are responsible for developing plans for improving health services in their own area and making sure that local health services are of a high quality and are performing well. SHAs provide a strategic overview of the local population and have a regional level input into how those services are configured. This role must be taken on by PCTs working together across the region to set up strong organisations to provide regional support, data, commissioning and overview.

264 Ibid., 5.

265 Ibid.

266 Ibid.

Some progress has been made forming region-wide PCT networks. The 31 PCTs in London are in the process of developing an expert support and shared services organisation (Hub) that will help them to improve the quality of healthcare provision across the region. And it is not just London PCTs that are starting to forge strong working partnerships. In Manchester the Association of Greater Manchester primary care trusts (AGMPCT) brings together all its ten PCTs to work in partnership on issues of common concern, while the Birmingham Primary Care Shared Services Agency (BPCSSA) was established in April 2002 to provide core non-clinical services to PCTs across Birmingham. The organisation aims to encourage and promote:

- efficiency: by enabling increased economies of scale and through avoiding duplication of services;
- expertise: reducing city-wide competition for scarce resources and by building areas of expertise that the PCTs can draw upon;
- partnership: by encouraging and enabling the Birmingham PCTs to work together and share knowledge;
- focus: through the SSA concentrating solely on improving non-clinical support services while the PCTs concentrate solely on improving patient care.²⁶⁷

PCTs are tentatively starting to work together in partnership, but much more needs to be done to develop local, regional and national networks to stimulate joint commissioning, the pooling of resources, the sharing of expertise, intelligence and information, and the spread of best practice. At the moment, the world class commissioning framework does not provide enough incentive to persuade PCTs to work together. This must be changed if joint working is to become a reality.

267 Birmingham Primary Care Shared Services Agency, "BPCSSA: Introduction", <http://www.bpcssa.nhs.uk/AboutUs/index.htm>.

Recommendation 24: Competency two of the World Class Commissioning Assurance Framework should be reworded to require PCTs to work collaboratively with local and regional PCTs and prevent needless duplication.

FESC

As the commissioning framework was being developed, the Department of Health concluded that, on their own, many PCTs did not have the capability at all levels to carry out the entire commissioning role. Therefore, in 2005 it published *Commissioning a Patient-led NHS*, in which it was made clear that PCT functions could be “provided by external agencies, partners and consortia working on their behalf”. It was determined that the private sector has commissioning skills that are lacking in the NHS and that need to be tapped into.

As part of the process of encouraging PCTs to seek private sector support rather than attempting to grow their own expertise, the government launched the Framework for procuring External Support for Commissioners (FESC) in October 2007. The framework was designed to provide PCTs with easy access to a set of expert suppliers to support them in undertaking their commissioning functions. FESC provides a list of 14 “prequalified independent sector organisations” that have been approved by the Department of Health, from which PCTs can purchase a range of skills and expertise in areas such as data analysis, contract management and public engagement.²⁶⁸ The aim was that the framework would assure the quality of private sector companies working with PCTs, and would save time in undertaking procurement activities by

268 The 14 organisations are: Aetna Health Services; AXA PPP Healthcare Administration Services; BUPA Membership Commissioning; CHKS, trading as Partners In Commissioning; Dr Foster Intelligence; Health Dialog Services; Humana Europe; KPMG; McKesson Information Solutions; McKinsey & Company; Navigant Consulting; Tribal Consulting; UnitedHealth Europe; WG Consulting Healthcare.

providing PCTs with easy access to optimum value-for money solutions, while reducing the legal and cost implications that can be encountered when seeking to procure external support.

Launching FESC, the then Minister for Health, Ivan Lewis, stressed that it would “allow PCTs to benefit from a bank of knowledge already built up through the DH procurement process”. FESC would mean that PCTs would be able to work with organisations that are “already known and trusted” to free up PCTs to “concentrate their efforts and expertise on providing patient care”.²⁶⁹ The Department also made it clear that FESC is just one of the tools available to help commissioners fill any gaps in expertise and that PCTs were not obliged to use the framework.

The immediate response to FESC from PCT managers was lukewarm. HSJ surveyed 93 chief executives, as well as commissioning directors, finance directors and others from a total of 74 PCTs about their views on FESC in November 2007. The survey found that 80% of those questioned thought there were ways other than FESC to help the commissioning process at PCT level, such as developing internal capability through training and education and more national information and support on best practice. Nearly half thought that the framework would prove to be only “a little” successful within their organisations.²⁷⁰

This pessimism has been vindicated: currently, only four PCTs have used FESC to secure contracts with private sector organisations. The main reason for the low uptake is the FESC has turned out to be a very slow and bureaucratic process. It was intended to provide PCTs with a fast-track route to procuring accredited providers; it was billed as a way of receiving a quick injection of private sector expertise, but this has not been the case. The average time for completing the framework has

269 BBC News, “Private Firms to Aid NHS Trusts”, <http://news.bbc.co.uk/1/hi/health/7029809.stm>.

270 H. Mooney, “HSJ Commissioning Supplement: an in-Depth Look at FESC”, *HSJ* (2007).

been a tedious 26 weeks, with the Department of Health being accused of slowing the process down by requiring constant changes to FESC bids. The DH has declared that it plans to shorten the FESC with the possibility of devolving responsibility of overseeing the process to SHAs.

It is certainly true that the private sector has a lot to offer PCTs in their difficult task of commissioning health services in a strategic way for their local community. However, PCTs should be trusted to purchase such support from whichever private sector organisations they think offer them the services that they need. Why limit PCTs to just 14 organisations, thus stifling choice and competition? Why put in place a framework that takes 26 weeks to negotiate, thus slowing down progress while driving up costs? Additionally, PCTs work with many different private companies that are not part of the FESC framework – for everything from office cleaning to health visiting. Why should there be a centrally imposed set of companies pre-approved to carry out a defined set of tasks? This is an unwarranted interference in the development of a genuine market in commissioning support.

Part of the reason for the failure of FESC is that some PCTs are still unwilling to engage with the private sector. There is some ingrained conservatism in the NHS, and using the private sector remains an anathema to some. However, FESC will not change this (if anything, managers will simply resent being cajoled into using the DH's chosen private sector organisations) and PCTs should ultimately be judged on their outcomes and held to account for their choices.

Recommendation 25: FESC should be abolished

PUBLIC ENGAGEMENT

Involving the public in the design and commissioning of health services is an important element in ensuring effective

local accountability. Accountability does not only mean formal mechanisms such as democratic election, regulatory scrutiny and audit, but must also ensure that the public and patients are engaged with the authorities that run or commission services.

The system for patient and public involvement in the NHS, after many years of stability, has undergone substantial change over the past decade. Community Health Councils (CHCs), established in 1974, were abolished by the Health and Social Care Act 2001 and were replaced by three bodies: the Patient Advice and Liaison Service, designed to provide help and advice from within trusts; the Independent Complaints Advisory Service, set up to pursue formal complaints; and the Commission for Patient and Public Involvement in Health, an arms-length body introduced to coordinate patient and public involvement forums (PPIFs), to represent patients and citizens.

In 2004, PPIFs were abolished (less than six months after many had begun to operate) to be replaced by patient local involvement networks (LINKs). These networks are no longer attached to individual NHS trusts, as the forums were, but instead operate over a larger geographical area which tends to be coterminous with a local authority or PCT boundary.

The rationale behind LINKs is that they will provide trusts with a means to access the views of a much more representative sample of the local population than the PPIFs did.²⁷¹ In theory, LINKs will offer a range of different ways for local people to have a say, both through links with local voluntary sector organisations, and by using a range of techniques for engaging the public, such as focus groups and surveys.

Evaluation of LINKs pilots by the NHS National Centre for Involvement found that it was too early to report significant change in public involvement or in the response of the NHS

271 R. Thorlby, R. Lewis and J. Dixon, *Should Primary Care Trusts Be Made More Locally Accountable?* (London: The King's Fund, 2008), 33.

organisations.²⁷² Time will tell whether LINKs become an important mechanism in helping NHS organisations to access a wide variety of patient and public views, and whether they manage successfully to communicate bottom-up views on health from patients and the local public. However, to aid the process, the relationship between LINKs and overview and scrutiny committees should be strengthened to ensure that the public is involved in the scrutiny process. Currently, a LINK has the power to refer an issue to its local OSC but the OSC has no duty to respond. This should be changed to ensure that users have more influence over services.

Recommendation 26: OSCs should be required to produce a public response to any referral made by a LINK.

Benefits of patient and public involvement

The success of LINKs is still uncertain, but what is clear is that patients are keen to be engaged.²⁷³ They value being involved in decisions, having their preferences respected and being presented with clear, comprehensible information.²⁷⁴ Involvement increases patients' satisfaction and confidence, and reduces their anxiety. It can also lead to improved trust and better relationships between patients and healthcare professionals.²⁷⁵ Involving patients in shared decision-making about their care and treatment and in how to manage their own condition can improve the appropriateness of care, improve health outcomes, reduce risk factors and prevent ill-health.²⁷⁶

272 NHS National Centre for Involvement, "Learning From the Early Adopter Programme: Interim Report", <http://www.nhscentreforinvolvement.nhs.uk/docs/EAP5%20interim%20report%20Final.pdf>.

273 D. Furness and B. Gough, *Local Control and Local Variation in the NHS: What Do the Public Think?* (London: Social Market Foundation, 2009).

274 Picker Institute, "Why Patients Should Share in Decision-Making", http://www.pickereurope.org/Filestore/Policy/position_papers/Picker_Policy_3_Why_patients_should_be_involved.pdf.

275 C. Farrell, *Patient and Public Involvement: The Evidence for Policy Implementation* (London: HMSO, 2004).

276 Picker Institute, "Why Patients Should Share in Decision-Making".

Evidence also shows that patient involvement can lead to more cost-effective outcomes, moderate demand, improve safety and reduce complaints and litigation.²⁷⁷ This was emphasised in the Wanless review of the future of the NHS, which stated that the health service would be most sustainable where patients and the public were “fully engaged”.²⁷⁸

If patients feel engaged with the health service, they are also more likely to trust healthcare professionals and support the NHS. This will be particularly important in the coming years as the NHS experiences a tightening of its budget. Difficult decisions are going to have to be made about which services to fund and how services should be delivered. People will accept those decisions more readily if they feel that they have been involved in the decision-making process. Finally, most health professionals tend to view patient involvement positively, seeing it as a rewarding process for both parties.²⁷⁹

Legal obligation

As well as being valuable, patient and public involvement is also a legal obligation. Since 2003 healthcare professionals have had a statutory duty to consult the public regarding any major service change, and, more recently, legislation has required PCTs to work with local government in assessing population service needs.

The world class commissioning programme also stresses the importance of involving the public. The vision for world class commissioning sees PCTs as “visible leaders of their local NHS. ... They act as an advocate for the people within their community, and their objectives and priorities resonate with the local population. ... There is local ownership and accountability for these decisions, which are made with a strong mandate from their local population and other

277 Ibid.

278 D. Wanless, *Securing Good Health for the Whole Population: Final Report* (London: HMSO, 2004).

279 Farrell, *Patient and Public Involvement*.

partners.²⁸⁰ In reality, no PCT is close to achieving this vision. SMF Health Project interviews with PCT staff revealed that PCTs are aware of the importance of public engagement but are struggling either to implement systematic programmes of engagement or to carry out sophisticated market research in order to understand the views of their local population. The Picker Institute supports these findings, stressing that most PCTs are using a limited range of techniques, and that they are more focused on consulting about service redesign decisions that they have already decided are desirable. The Institute found that “few PCTs are using more intensive, deliberative techniques; involving the public in early priority setting; or involving people in monitoring and reviewing the performance of service providers”.²⁸¹ Most senior managers are still not taking public engagement seriously enough and are failing adequately to resource it.²⁸²

The NHS’s continuing failure to give patients enough say on local health services was further underlined in a recent report by the Healthcare Commission. The study of 130 healthcare organisations and 170 user groups in England revealed that patients do not feel they have enough input into what services are provided or how they are delivered. The Commission’s report states: “Few trusts could demonstrate that people’s views routinely influence their decision-making.”²⁸³ The report found that some PCTs are undertaking “excellent practice” in certain areas, particularly in consulting the public on large reorganisations of services. However, it revealed that PCTs are still not routinely considering patients’ opinions about GP practices or requiring hospitals or surgeries to take account of the public as part of their contracts.²⁸⁴ As such, it should come as no surprise that in the first round of the world class

280 Department of Health, “World Class Commissioning”.

281 Picker Institute, *Accountability – Public Views and What to Do About Them* (Oxford: Picker Institute Europe, 2008), 6.

282 Ibid.

283 The National Centre for Involvement, “Watchdog Calls On Healthcare Services To Do More To Act On The Views Of Patients And The Public”, <http://www.nhscentreforinvolvement.nhs.uk/index.cfm?action=PRE&PressID=300>.

284 Ibid.

commissioning assurance tests not a single PCT scored level three or four on competency three (engaging with public and patients) and 51 PCTs did not manage to score higher than level one.

In an opinion poll for the Local Government Association Health Commission carried out in 2008, more than half the respondents did not know what a PCT was or what they did. Almost three-quarters of those questioned could not name their local PCT, and fewer than 10% had been involved in any patient group or forum concerned with local NHS services.²⁸⁵ PCTs cannot be held to account by the public if the public does not know they exist. These results highlight the inadequacy of most PCTs' public engagement strategies and the gulf that exists between the rhetoric of the world class commissioning vision and reality.

Having said this, it is also important to remain realistic when considering the scope of public engagement in healthcare commissioning. While a large majority of people think that the public should be consulted on decisions that shape the NHS, most people do not want to become full-time health service planners. Ipsos MORI carried out a set of polling and discussion groups for the SMF Health Project. The polling showed that 74% of respondents thought that the public should either be consulted on decisions shaping the NHS, or should be much more actively involved, while only 20% thought that such decisions should be made solely by qualified health professionals and not the general public. However, when this theme was explored more deeply in the discussion groups, it turned out that although most of the participants thought the general public should be involved in decision-making, the individual participants did not themselves want to be involved in decision-making. As one participant put it when asked if they would personally get involved: "Oh God no, it's too much work."²⁸⁶

285 LGA Health Commission, *Who's Accountable for Health? LGA Health Commission Final Report* (London: Local Government Association, 2008), 28.

286 Ipsos MORI, discussion group, for the SMF Health Project, 2009.

A number of research studies have found that this pattern is reflected across the public sector: around 75% of respondents say the public should be more involved in the planning or delivery of local services; however, only about 25% say that they personally would get involved, and in reality only about 1 or 2% actually do get involved.²⁸⁷

A study by the Audit Commission on public trust in local services concluded that there was “no great unmet desire on the part of the public to involve themselves in the planning or delivery of key public services. Only around one in five would like to get involved in helping their council or NHS hospital to plan and deliver services (17 per cent and 22 per cent respectively).”²⁸⁸

However, although the public might not want to be involved in every decision about their local health service, they do want to feel that they are being listened to and consulted about how the services they use are run. The Local Government Association (LGA) Health Commission argues that people want to be able to have their say and make an input when strategic plans are being made. They found, for example, that patients have strong views about how, where and when GP services are provided.²⁸⁹

This finding was echoed in the SMF Health Project patient discussion groups: all four groups thought that the public should be involved in decisions about how their local GP practice decided on funding priorities. They came to the general conclusion that the public need to be consulted or involved when:

- a decision affects a lot of people a lot of the time;
- there is a feeling that the NHS is currently getting the decision wrong;

287 Author interview with Jonathan Nicholls, Ipsos-MORI.

288 Audit Commission, *Corporate Governance: Improvement and Trust in Local Public Services* (London: Audit Commission, 2003), 37

289 LGA Health Commission, *Who's Accountable for Health?*, 4

- the public has genuine knowledge about what services are needed, for example the range of services that should be provided at their GP practice;
- the solution needs public buy-in, for example combating child obesity.

Conversely, the discussion groups concluded that they would be happy not to be involved in decision-making if:

- they felt the NHS was currently getting the decision right;
- the decisions should be objective and clinical.

The participants were also concerned that public involvement could lead to subjective, rather than objective, decision-making, and could fall victim to interest groups. Hence, unless well managed, the participants were concerned that public involvement could jeopardise fairness.

In addition, the participants stressed that while they do not want to be involved in every decision about how the health service is run, they do demand transparency about how decisions are made. Information, clarity and transparency can counteract cynicism around decision-making. As one participant put it: "If you don't feel involved in something, it's like somebody's making every decision on your behalf. It feels like a military state."²⁹⁰ All the participants found it easier to accept tough decisions if they were privy to the rationale behind them.

The Picker Institute also found in their own discussion groups that the public are keen to be involved in decisions about local health services if certain conditions are met. They found that people are willing to see consultation as a route to involvement and potentially a key part of accountability. However, participants stressed that consultations must be meaningful:

290 Ipsos MORI, discussion group, for the SMF Health Project, 2009.

- the decision should not already have been made;
- the public must be able to influence the decision;
- the results of the consultation and the action taken (or not taken) must be communicated back to them.²⁹¹

The Picker Institute argued that people feel that these three conditions are rarely fulfilled, which leads to a cynicism about the validity of consultation. The Institute suggested that this cynicism may be one of the factors that creates a gap between expressions of willingness to be involved, and actual participation.²⁹²

PCTs should be free to develop public engagement strategies that best suit their local circumstances. Having said that, it is crucial that they take the practice of public engagement seriously. This is particularly important as patients cannot “exit” their PCT by choosing another PCT to commission services on their behalf. PCTs therefore have a duty to listen and respond to their local population and to involve them in planning or delivery of local services where there is an appetite for such involvement.

The Department of Health’s latest guidance for PCTs on local decision-making about medicines states that they should take “reasonable steps to provide an explanation to the public on the need for PCT prioritisation”.²⁹³ This guidance should be substantially strengthened. Although PCTs should be free to develop their own engagement programmes, they must also be held to account for implementing those programmes and be able to show the impact that the programme has on the way the PCT operates. It is not acceptable for PCTs simply to take “reasonable” steps to provide an explanation of their actions to the public – such information must be seen as an essential

291 Picker Institute, *Accountability – Public Views and What to Do About Them*, 5.

292 Ibid.

293 Department of Health, *Defining Guiding Principles for Processes Supporting Local Decision Making About Medicines*, National Prescribing Centre (London: HMSO, 2009).

minimum, and any PCT failing to provide such information should be held accountable for such a failure.

Recommendation 27:

To improve public engagement PCTs must:

- Develop a statement of the aims and purposes of patient and public involvement in their local area and set out a two-year programme to demonstrate how these aims will be achieved.
- Commission research to identify effective strategies for engaging patients and local people.
- Ensure senior managers take public engagement seriously, providing it with adequate staffing and resources.
- Dramatically improve their public profile, ensuring that members of the public know that they exist and understand what they do.
- Change their names to indicate that they are the NHS body for that area. For example, NHS Hull rather than Hull PCT.
- Launch local information campaigns to clarify how the health system works at the local level and how individuals and groups can become involved. The campaigns should inform the local population about how different parts of the health service interact and about the different accountability mechanisms.
- Work hard to recognise when, where and how members of the public want to be involved and ensure that as wide a range of them are involved as possible.
- Ensure that even when the public is happy to leave decision-making up to the PCT, the public is still kept informed about how and why decisions are made and have a means to give feedback, which is responded to.

But this will not happen spontaneously: a national framework is needed to kick start the process and ensure that PCTs take patient and public involvement and engagement seriously.

Recommendation 28: The Department of Health should develop a national framework to measure and evaluate the effectiveness of PCTs' public engagement programmes. The results of the evaluation would feed into the world class commissioning assurance framework.

PRACTICE-BASED COMMISSIONING

Practice-based commissioning (PBC) seeks to grant GPs more decision-making power over how NHS resources are spent and enable them to deliver new services, or commission others to do so. The thinking behind this policy is that putting commissioning power in the hands of frontline clinicians will lead to "high quality services for patients in local and convenient settings" because "GPs, nurses and other primary care professionals are in the prime position to translate patient needs into redesigned services that best deliver what local people want".²⁹⁴

The Department of Health has set out that the aims of practice-based commissioning are to:

- encourage clinical engagement in service redesign and development;
- bring about better, more convenient, services for patients;
- enable better use of resources.²⁹⁵

²⁹⁴ Department of Health, "About Practice Based Commissioning".

²⁹⁵ Ibid.

Under PBC, GP practices are given virtual budgets (known as indicative budgets) with which to purchase health services for their patients.²⁹⁶ The indicative status of the budget means that the local PCT remains legally responsible for the money and is accountable for any overspends. The GP practice is able to submit business cases to the PCT, proposing changes to commissioning or the establishment of new services.

History

Giving GPs more power over resources and allowing them to commission services is not a new idea. In the 1990s, the Conservatives introduced similar policies in the form of GP fundholding. Fundholding was abolished by the Labour government in 1997, because of initial trepidation about using competition to drive change in the NHS. There was also concern that fundholding created extra bureaucracy and benefited some areas more than others, thus exacerbating inequality in access to care for patients.²⁹⁷

Nevertheless, despite the hostility towards fundholding, the 1997 White Paper, *The New NHS: Modern, Dependable*, did acknowledge that the experience of GP fundholding had delivered some benefits to patients, for instance by broadening the range of services available in GP surgeries. In fact the White Paper went as far as to predict that over time “indicative budgets [will be devolved] to individual practices” for a full range of services. Six years later, by which time any doubts about choice and competition as drivers of change had been swept aside, the policy re-emerged when the government announcement in December 2004 that all practices would be involved in practice-based commissioning by 2008.²⁹⁸

296 Practice-based commissioning budgets are separate from the funds that GP practices receive under their existing contracts for their core work (General Medical Services and Personal Medical Services).

297 Department of Health, *The New NHS: Modern, Dependable* (London: HMSO, 1997).

298 Department of Health, *Practice Based Commissioning: Promoting Clinical Engagement* (London: HMSO, 2004).

Impact of practice-based commissioning

The Department of Health has published examples of the sorts of change that can be made to services under PBC.²⁹⁹ These include examples of reducing avoidable emergency admissions through better management of people with chronic conditions, referral management centres run by PBC groups in order to control the number of elective referrals, and GPs performing minor surgery in their offices.

This suggests that PBC does have the potential to lead to effective service redesign. However, for this to occur, GPs have to engage in the process. A number of financial incentives have been made available to encourage GPs to sign up to the scheme. From 2005 to the end of the financial year 2007/08, a centrally funded incentive scheme was available which paid GPs directly for their involvement in PBC. A similarly structured local financial incentive is now offered by some PCTs to encourage GPs to fulfil or invest in a particular commissioning activity.³⁰⁰ GPs are also entitled to retain up to 70% of the indicative budget that has been saved at the end of the financial year to invest back into the GP practice.³⁰¹

However, despite these incentives, take-up has been poor. In 2007 the Department of Health published a survey of 1,200 GP practices across England, which revealed that although nearly two-thirds of practices said they were “supportive” of PBC as a policy, 60% said they had not commissioned any new services as a result of the policy.³⁰² The survey also found that 37% of respondents believed that it was “too early to tell” whether PBC had improved patient care, 31% “disagreed” that PBC had made improvements and only 13% felt that it had.

299 Department of Health, *Practice Based Commissioning (PBC): Implementation Progress Report* (London: HMSO, 2007).

300 N. Curry and R. Thorlby, *Practice-Based Commissioning: King's Fund Briefing November 2007* (London: The King's Fund, 2007).

301 Department of Health, *Practice Based Commissioning: Achieving Universal Coverage*. (London: HMSO, 2006).

302 Department of Health, *Practice Based Commissioning: GP Practice Survey* (London: HMSO, 2007).

A 2007 Audit Commission report examined the results of PBC. It highlighted some positive examples of service redesign and stressed that general practices had a better understanding of the financial consequences of their decisions and engaged more in managing their patients' use of secondary care. However, these achievements had been secured at a cost of at least £98 million in 2006/07. The report concluded that GPs tended to be more interested in directly providing services on a small scale and in a few clinical areas than getting involved in commissioning.³⁰³

A more recent report by the King's Fund found that GPs have still failed to engage fully with PBC. The report reveals that the majority of GPs, while supportive of the principles of the PBC, prefer to observe passively and let others lead.³⁰⁴ The Department of Health has been forced to accept that, so far, the policy is not working satisfactorily. The NHS Next Stage Review acknowledged that "there is a widespread view that, with some exceptions, [PBC] has not yet lived up to its potential".³⁰⁵

Why has practice-based commissioning stalled?

Evidence shows that a minority of entrepreneurial and innovative GP practices across England have used the policy of PBC to improve services considerably.³⁰⁶ This suggests that the policy has the potential to be successful, but so far it is failing. There appear to be a number of reasons why this is so. The first is simply that there may be a limited number of entrepreneurial and managerially talented GPs who want to get involved in commissioning services. This assumption is backed up by the Audit Commission report and also by the past experience of

303 Audit Commission, *Putting Commissioning Into Practice: Implementing Practice Based Commissioning Through Good Financial Management* (London: Audit Commission, 2007).

304 N. Curry et al., *Practice-Based Commissioning: Reinvent, Replace or Abandon?* (London: The King's Fund, 2008), viii.

305 Department of Health, *NHS Next Stage Review: Our Vision for Primary and Community Care* (London: HMSO, 2008), 51.

306 Curry et al., *Practice-Based Commissioning: Reinvent, Replace or Abandon?*, 13.

GP fundholding.³⁰⁷ The government has attempted to overcome this by using incentive payments to encourage GPs to support PBC. But so far it seems that the incentives have not been strong enough to deliver more than token involvement. This may in part be due to the fact that the incentives to undertake PBC are undermined by the stronger incentives contained within the GPs' General Medical Services contract.

The King's Fund highlights a number of other reasons why PBC has failed to take off. These include disagreements between GPs and PCTs over their roles and responsibilities in commissioning; a lack of commissioning skills amongst GPs; a lack of reliable, timely data; and concern amongst PCT senior managers that the levers are not available to allow them adequately to hold GPs to account. In addition, poor-quality relations between GPs and the government have discouraged GPs from fully engaging with PBC, while a perceived deterioration in the level of priority given to PBC by the Department of Health has resulted in some GPs and PCT staff spending less time and energy on the policy.³⁰⁸

One way of strengthening the financial incentives for GPs to fully engage in PBC and the budgetary accountability would be for practice-based commissioners to receive real devolved budgets rather than the current indicative budget. However, this would throw up some problems, not least the question of conflict of interest. PBC creates an implicit incentive for GPs to invest in and commission local services that they themselves provide. This creates a direct conflict of interest, which would become even more acute if PBCs held real budgets. New governance arrangements would need to be established to ensure that patient choice and the quality of GP referrals were not compromised.

307 Audit Commission, *Putting Commissioning Into Practice*; N. Goodwin, "GP Fundholding", in J. Le Grand, N. Mays and J. A. Mulligan (eds), *Learning From the NHS Internal Market: A Review of the Evidence* (London: The King's Fund, 1998).

308 Curry et al., *Practice-Based Commissioning: Reinvigorate, Replace or Abandon?*, x.

Evidence also shows that that practice based commissioners have tended to commission services based in primary and community care settings and, according to the King's Fund, have failed to address fully "the more strategic commissioning activities related to whole patient pathways".³⁰⁹ As a result, the scope of what could be purchased by budget-holding practice-based commissioners would need to be defined at the PCT level, which to some degree negates the point of PBC, as it takes the purchasing decisions away from the GP and places it back with the PCT.

The future of PBC

PBC is currently not operating effectively: progress has been slow and in some areas the policy is grinding to a halt.³¹⁰ Tens of millions of pounds have been spent trying to encourage GPs to commission services, but on the whole there is not a great appetite amongst the profession for PBC. More money could be invested in an attempt to re-energise the policy, but one has to ask whether it would be money well spent trying to incentivise GPs to get involved in an activity that many are either not interested in doing or do not have the skills to do well.

Even if GPs' disregard for the policy could be overcome, fundamental issues around conflicts of interest and governance suggest that significant redesign of the policy would be needed. It also seems perverse that while the government is encouraging PCTs to give up their provider functions to establish a clear separation between commissioners and providers, the policy of PBC seeks to establish that GPs are providers and commissioners of services.

There is no doubt that clinicians need to be closely involved in the commissioning process: clinicians have a crucial part to play in helping commissioners draw up strategic plans and design and commission services that build on the current clinical evidence

309 *Ibid.*, 53.

310 *Ibid.*, x

base, maximise local care pathways, and use resources effectively. But PBC is not the only way to achieve this. Instead of focusing on PBC, more effort could be made to ensure that GPs and other clinicians play a central role in providing clinical input into PCT commissioning decisions. Structures must be put in place to widen clinician involvement in PCT commissioning so that not only GPs but also hospital clinicians and other healthcare professionals are included.³¹¹ Collaboration between commissioners and providers must also be encouraged during contractual negotiations.³¹²

There is concern that the traditional GP practice can be inward-looking, replicating what has been delivered in the past and failing to adapt as lifestyles and patterns of ill-health evolve. Practice-based commissioning is seen as a way of changing this, delivering interrelated, high-quality and responsive care, and releasing resources from traditional hospital services. However, apart from in a minority of cases, PBC has not led to a change in service delivery. As discussed, PBC incentivises practices to commission services from their own practice and has led PBC consortiums to commission traditional services based in primary and community care settings rather than to think more strategically and commission activities related to whole patient pathways.

The best way to stimulate an outward-looking, joined-up, integrated service would be for PCTs to have the freedom to commission services from a range of providers, either working together or competing with each other. As opposed to PBC, which actually hampers choice and competition, commissioners should have the freedom to purchase care from the providers offering the best package. A thriving provider market would stimulate GPs and other health professionals across the sector to join together into integrated care organisations, to offer PCTs the chance to commission joined-up services. It is competition that

311 A. Liddel and N. Timmins, *Making It Happen: Next Steps in NHS Reform* (London: The King's Fund, 2008).

312 J. Smith and N. Goodwin, *Towards Managed Primary Care: The Role and Experience of Primary Care Organisations* (Aldershot: Ashgate, 2006).

will encourage providers to improve patient journeys and pathways, making them faster, safer, of higher quality and more resilient.

Should PBC be abandoned?

To date, NHS managers have tended to be unwilling to comment on PBC, but it seems that some managers' patience with the policy is starting to crack. Alison Tonge, director of health system development at NHS North West, has suggested that practice-based commissioning could be split in two, with PCT commissioners given a duty to engage clinicians as part of a care pathway and system design team. Hull PCT chief executive, Chris Long, has suggested that GPs, local authorities and the public should be brought together under a "locality director" who would report to the PCT chief executive.³¹³ Could these public statements of discontent mark the beginning of the end for PBC?

Abandoning PBC would be a blow to those GPs who have invested a lot of time, energy and resources into developing organisational structures for the system to work. So rather than the Department of Health simply scrapping the policy, where PBC is succeeding it should be allowed to continue, but the government should stop spending on incentivising its adoption in practices that have shown little interest thus far.

Recommendation 29: The focus of policy should be on strengthening PCT commissioners, ensuring clinicians are closely involved in PCT commissioning decisions, and stimulating a thriving provider market. This will allow current PBC consortia to evolve into integrated care organisations focused on providing joined-up services, rather than attempting to both commission and provide services.

313 Helen Crump, "Managers Call for GP Commissioning Reforms", HSJ (2009).

CONCLUSION

This chapter has demonstrated that commissioning is the key driver of quality in the health system. It is, in fact, the best hope of maintaining high-quality universal healthcare in a financial crisis. There are massive potential efficiencies to be gleaned from commissioning, but equally it is very difficult to extrapolate this out to model the potential cost savings should commissioning function at a high level. Nevertheless, the recommendations set out above are testament to the potential that exists, and the many different approaches to improvement that can be adopted by policymakers.

The overarching theme of this chapter has been that commissioners need to be strengthened by the removal of central control, and by taking on new responsibilities that will offer them the opportunity to influence providers and generate a real market for care. Only this offers the chance of savings that will maintain public health services in a universal form.



CHAPTER SEVEN: ACCOUNTABILITY IN A LOCAL SYSTEM

Chapter 6, above, set out the case for a health system at the heart of which sit local commissioners, driving improvements by means of strong relationships with providers, and shaping health services to suit the needs of local people through engagement with the public. Although central government should remain as the revenue-raiser and resource-distributor, the bodies tasked with driving change and improving the efficiency and quality of healthcare will be local PCTs.

The accountability structures in the health system will have to change to reflect this shift in responsibility and power. Currently, accountability mechanisms face upwards. PCTs and providers are ultimately accountable to the Secretary of State for Health, Parliament and national regulators. However, with the ever-increasing complexity of the health service, and with local PCTs holding more power and responsibility, it will be crucial for accountability to flow down to local people as well as up to central government.

This chapter considers how the accountability structures in the health service have evolved since the inception of the NHS in 1948 and highlights the changing nature of accountability in the NHS over the past 60 years. It focuses on what accountability means in the health system and on the different types of accountability in the NHS, underlining the multiple forms that accountability mechanisms can take. The chapter concludes by considering how powerful local commissioners should be held to account at a local level.

EVOLUTION OF ACCOUNTABILITY MECHANISMS

The accountability structures and institutions of today's NHS have their roots, to some extent at least, in the negotiations that preceded the formation of the NHS in 1948. The Labour MP and Cabinet Minister

Herbert Morrison supported local government control, but he was overruled by Nye Bevan's preference for a single national hospital service.

Bevan argued for national rather than local accountability, but not for national control over service delivery. Partly in order to secure the participation of doctors in the NHS, Bevan promised to provide them with "all the facilities, resources, apparatus and help I can, and then leave you alone as professional men and women to use your skills and judgement without hindrance".³¹⁴

As a result, right up until the 1980s, accountability in the NHS consisted largely of a system of professional self-regulation. It was not until 1982 that annual accountability mechanisms were introduced. But even with this development, the Griffiths Report criticised the accountability structures of the NHS in 1983, arguing that it was impossible to tell who was in charge of any given NHS hospital. The recommendations set out in the Griffiths Report were implemented from 1985 with the aim of improving the general management of the health system. Nevertheless, the confusion over who was accountable for what continued, resulting in a Department of Health White Paper, published in 1989, which declared that for the first time "a clear and effective chain of management command running from districts ... to the Secretary of State" was to be introduced.³¹⁵

In the past 20 years there have been further attempts to reshape the accountability structures of the NHS, first through internal markets, then through a reinforced hierarchy centred on national targets, and finally through the reintroduction of market mechanisms based on a mixed economy of supply.³¹⁶

314 Quoted in C. Webster, *The National Health Service: A Political History* (Oxford: Oxford University Press, 2008).

315 Department of Health, *Working for Patients* (London: HMSO, 1989).

316 LGA Health Commission, *Accountability for Health: A Scoping Paper for the LGA Health Commission* (London: Local Government Association, 2008).

Over the past decade, accountability has been focused upwards with the emphasis placed on meeting centrally set targets.³¹⁷ However, over the last few years a growing reaction against this central control has been building, with calls to end political interference and create an independent NHS and to strengthen local accountability mechanisms.³¹⁸

WHAT IS ACCOUNTABILITY IN THE HEALTH SYSTEM?

Put simply, accountability in the public sector aims to ensure that those who deliver public services are answerable to those who either finance them or use them.³¹⁹ The OECD defines accountability as “the obligation of those entrusted with particular responsibilities to present an account of, and answer for, their execution”.³²⁰

Ashworth and Skelcher identify four components of accountability:

- taking into account – through consultation with citizens and stakeholders;
- giving an account – explaining actions that have been taken;
- holding to account – citizens hold the government to account at the ballot box, for example;
- redress – the right for compensation of some kind, or to remedy or set right the situation, when services have not been delivered to an appropriate standard.³²¹

317 R. Thorlby, R. Lewis and J. Dixon, *Should Primary Care Trusts Be Made More Locally Accountable?* (London: The King’s Fund, 2008).

318 See, for example, The Conservative Party, *NHS Autonomy and Accountability: Proposals for Legislation* (London: The Conservative Party, 2007); B. Edwards, *An Independent NHS: A Review of the Options* (London: Nuffield Trust, 2007); A. Dixon and A. Alvarez-Rosete, *Governing the NHS: Alternative to an Independent Board* (London: The King’s Fund, 2007); BMA, *An NHS Constitution for England* (London: British Medical Association, 2008).

319 P. Day and R. Klein, *Accountabilities* (London: Tavistock, 1987).

320 OECD, *Modernising Government: The Way Forward* (Paris: Organisation for Economic Cooperation and Development, 2005).

321 R. Ashworth and C. Skelcher (The Office of the Deputy Prime Minister), *Meta-Evaluation of the Local Government Modernisation Agenda: Progress Report on Accountability in Local Government* (London: HMSO, 2005).

So in some respects accountability is about ensuring that institutions are transparent and made to justify their actions. But accountability also goes further than this: it must include the power to dismiss decision-makers or challenge decisions. There is no point in simply being accountable either upwards to government or downwards to people unless a change is implied – accountability mechanisms must have the power to change behaviour.

TYPES OF ACCOUNTABILITY IN THE NHS

The Local Government Association (LGA) Health Commission distinguishes five types of accountability in the NHS:

1. *Professional accountability* – based on a professional body setting the standards of practice that service users can expect, with professionals answerable to their peers for their performance against these standards.
2. *Audit* – performance assessment carried out to ascertain the validity and reliability of information and to provide an assessment of a system's internal control for the purpose of accountability.
3. *Democratic control* – in the UK, this has conventionally meant elected representatives holding professional officers to account and having the power to enforce decisions.
4. *Stakeholding* – the building of partnership to ensure accountability, with one institution providing a check on its partner organisation or branch of government.
5. *Market mechanisms* – politically managed markets, designed to ensure equity and social justice, are a means of delivering individual-level accountability.³²²

Accountability can be achieved in different ways, via different mechanisms to meet different goals. How much weight is given to

322 LGA Health Commission, *Accountability for Health: A Scoping Paper for the LGA Health Commission*.

any one of these types of accountability will depend on the type of health service that is being designed and the type of accountability that is desired. In a decentralised health system there is a key role for a national audit – making sure that local commissioners are putting out high-quality information into the public domain. There may also be a role for democratic control of some kind, particularly to justify local variation of services.

At what level is accountability currently located?

Accountability can be located at either a central or a local level: it can be directed upwards to a higher authority (which must itself be held to account by the public through national democratic structures) and downwards to local people or service users (achieved through local government or another form of local governance arrangement).

Central accountability

On the whole, accountability in the NHS is located centrally with government and national regulators. This is in a large part because of the funding arrangements of the NHS: centrally raised taxes have always resulted in national government responsibility for, and control over, the expenditure of these funds.³²³

Professional accountability, carried out by the professional bodies such as the General Medical Council, has been the main way in which the health service in England has been held to account for the past 60 years. However, a number of high-profile cases of substandard care and abusive behaviour by doctors have led to calls for a more robust system of accountability.³²⁴

As a result, the role of audit has become increasingly important. Since 2000, the performance of NHS institutions has been assessed

323 Thorby et al., *Should Primary Care Trusts Be Made More Locally Accountable?*, 13.

324 For example, the behaviour of Harold Shipman, Clifford Ayling, Rodney Ledward and the problems at the Bristol Royal Infirmary.

against publicly available standards and targets, first by the Commission for Health Improvement (CHI), then by the Healthcare Commission, and since April 2009 by the Care Quality Commission (CQC). The CQC is the new independent regulator of health and social care in England which replaced the Healthcare Commission, the Commission for Social Care Inspection and the Mental Health Act Commission. Financial scrutiny is carried out by the Audit Commission.³²⁵

National accountability has also been strengthened by the introduction of National Service Frameworks, NICE and clinical governance processes. All these developments aim to reduce variations in practice across the NHS, making local NHS bodies accountable for meeting national standards and guidelines. The role of regulation in the health system is discussed in more detail in chapter 8.

Local accountability

The system of audit, carried out by national regulators, has ensured managerial accountability upwards but it has been less effective in ensuring accountability downwards to the local population.³²⁶ There appears to be a growing consensus, both in some parts of government (to a certain extent) and within the health community, that it is time to move on from the process of upward accountability characterised by top-down national targets towards systems of local accountability.³²⁷

What is meant by local accountability?

Local accountability is a somewhat unclear term; it is possible to confuse local accountability with public involvement.

325 The regulation of the health service in England is dealt with in more detail in chapter 8.

326 Thorlby et al., *Should Primary Care Trusts Be Made More Locally Accountable?*

327 See, for example, A. Darzi, *High Quality Care for All: NHS Next Stage Review Final Report* (London: HMSO, 2008); The Conservative Party, *Delivering Some of the Best Health in Europe: Outcomes Not Targets* (London: The Conservative Party, 2008); The Liberal Democrats, *Empowerment, Fairness and Quality in Healthcare: Policies for an Effective NHS* (London: The Liberal Democrats, 2008).

Public involvement can strengthen accountability, but simply introducing some form of public involvement into health services via a mechanism such as a citizen's jury does not automatically ensure accountability. There needs to be a synthesis of public involvement and accountability exercised at a local level for true local accountability to be achieved.³²⁸

Democratic accountability

One way to achieve this synthesis is through the ballot box. General elections act as a form of direct, democratic accountability in the NHS. However, the belief that national elected representatives hold all public servants to account, including those at a local level, has become less convincing over time as the NHS has become more complicated and as more responsibility has been devolved outwards to national, unelected arm's-length bodies. Also, general elections occur infrequently, are rather remote and are not focused solely on the government's handling of the health service, but on their running of the country as a whole.

It is possible to argue that democratic influences are not entirely absent at a sub-national level as a significant part of an MP's constituency business is taken up with health service matters. However, in reality MPs lack any real means of enforcement.³²⁹ Consequently, a number of suggestions have been made about how the NHS can be made more democratically accountable. The next section considers how commissioners can be held to account at a local level, and examines a number of democratic options.

PCT accountability

As PCTs gain more control over the shape of the NHS in the future, it is going to become increasingly important that they are effectively held to account at a local level. Currently, PCTs are formally held

328 Thorby et al., *Should Primary Care Trusts Be Made More Locally Accountable?*.

329 C. Johnson, *Scrutinising for Health: Health Scrutiny Evaluative Research Project* (London: Centre for Public Scrutiny, 2007).

to account through the world class commissioning assurance framework (discussed in detail in chapter 6), which is managed by Strategic Health Authorities, which are themselves accountable to the Secretary of State for Health. PCT performance is also assessed by the Care Quality Commission, which monitors the quality and safety of PCTs' service delivery as well as their activity levels, and by the Audit Commission, which measures value for money and probity (both of these bodies are themselves accountable to Parliament).

This form of accountability is essentially "upwards" to central government and Parliament rather than "downwards" to the public that they serve. There is a growing consensus that more accountability should be devolved locally and that clinicians, local NHS staff and the public need to be more involved in decision-making. Lord Darzi's review of the health service, *Our NHS, Our Future*, emphasises the importance of direct engagement with patients, the public and their representatives while the 2008/09 NHS Operating Framework has promised "a decisive move towards greater local autonomy".³³⁰

PCTs now receive 80% of the NHS budget and are starting to gain more freedom to commission local services. The current arrangements, however, which rely for the most part on centralised mechanisms of oversight, do not adequately ensure that local decision-makers are held to account.³³¹

In the current system, characterised by national standards and targets, there are significant local variations in the quality and the nature of services provided by different PCTs that are not fully

330 D. Nicholson (Department of Health and NHS Finance Performance and Operations), *The NHS in England: The Operating Framework for 2008/09* (London: HSMO, 2007).

331 LGA Health Commission, *Who's Accountable for Health? LGA Health Commission Final Report* (London: Local Government Association, 2008), 4

explained by differences in the patient population.³³² This is hardly surprising as even in a highly centralised system decisions are continually being made at a local level.

In the future, as local commissioners are granted greater discretion, the local variability that already exists will increase further. For this scenario to be accepted by the public, any variation in services must be seen to be legitimate, transparent and accountable at a local level.³³³ In short, the more local autonomy PCTs receive, the more important it is that clear and robust “downward” accountability mechanisms are in place.

Currently, the local accountability mechanisms are not sufficient to enable PCTs successfully to carry out all the responsibilities that commissioning entails with the support of their local population. For example, PCTs are currently failing to decommission services, partly because they do not hold a clear mandate for major service changes. Public protests are the norm when changes to local services are proposed³³⁴ and PCTs do not have the democratic legitimacy to withstand such popular pressure.

It is becoming increasingly clear that an “accountability gap” exists which needs to be filled. This lack of accountability needs to be addressed both because of the intrinsic value of public accountability in maintaining the integrity of the system, and also for the pragmatic reason that public buy-in and ownership is crucial, especially in a constrained fiscal environment with increasingly high public expectations.

The lack of local public accountability of PCTs has been made even more apparent since the creation of NHS foundation trusts which

332 J. Appleby and S. Gregory, *NHS Spending – Local Variations in Priorities: An Update* (London: The King's Fund, 2008).

333 LGA Health Commission, *Who's Accountable for Health? LGA Health Commission Final Report*, 21

334 BBC News, “Actress Backs Hospital Campaign”, <http://news.bbc.co.uk/1/hi/england/6378189.stm>.

are “owned” by their members who are drawn from the public, staff, patients and carers. Members elect governors who, together with a number of appointed governors, have a distinct role to play in the overall governance of the trust. This local public accountability on the provider side has emphasised the “democratic deficit” of PCTs. Essentially, policymakers have directed their efforts at the wrong side of the purchaser/provider split: it is more important that commissioners are held accountable by local people, rather than hospital trusts.

The government, in an effort to remedy the local accountability deficit, has put in place a range of mechanisms to improve local decision-making and support local accountability and public involvement. These include directors of public health who are jointly appointed by the NHS and local government, local council health overview and scrutiny committees (OSCs), local strategic partnerships and local area agreements, comprehensive area assessments, and local involvement networks (LINKs). Various arrangements have also been made by the NHS and local government to support joint commissioning of services. Finally, there is now a strengthened duty on PCTs to involve and consult the public.

OVERVIEW AND SCRUTINY COMMITTEES

Over the last few years there has been an attempt to strengthen the tie between the NHS and local authorities. OSCs have been established which give local councillors the opportunity to formally question, scrutinise and influence the decisions of local NHS bodies. OSCs have powers to summon NHS staff and request information.³³⁵ The Department of Health states that OSCs “bring democratic accountability into healthcare decisions and make the NHS more publicly accountable and responsive to local communities”.³³⁶

335 R. Thorlby and R. Lewis, *How to Score Public Accountability Points* (London: The King's Fund, 2008).

336 The Department of Health, “Local Authority Overview and Scrutiny Committees (OSCs)”, http://www.dh.gov.uk/en/Managingyourorganisation/PatientAndPublicinvolvement/DH_4093409.

Although the development of OSCs represents a step towards greater local accountability, questions remain about their degree of influence and effectiveness. Department of Health guidance states that PCT executives and key stakeholders are “encouraged to implement” OSC recommendations,³³⁷ but PCTs are not obligated to do so. The most recent evaluation of OSCs found that they have only made a small impact in terms of changes to PCT services and plans.³³⁸ It is also the case that the legitimacy of OSCs rests on the democratic mandate of local government, which could be undermined by continued low turnout at local elections.

Despite these shortfalls, there is a feeling that OSCs represent a fruitful platform on which to build. The King’s Fund states that the role of OSCs could be enhanced and the responsibility of ward councillors extended.³³⁹ The Conservative Party agrees, arguing that OSCs should be given greater powers and scope to investigate and report on NHS services.³⁴⁰

Current proposals for OSCs do not go far enough. The SMF Health Project recommends that they be given significantly enhanced powers to hold PCTs to account.

Recommendation 30:

- **OSCs should have the power to report issues of concern, relating to a PCT, directly to the PCT regulator.**
- **The regulator should be required to make a public response to the OSC.**
- **If the regulator’s response does not successfully**

337 The Department of Health, “Local Authority Overview and Scrutiny Committees (OSCs)”.

338 Johnson, *Scrutinising for Health: Health Scrutiny Evaluative Research Project*.

339 Thorlby et al., *Should Primary Care Trusts Be Made More Locally Accountable?*.

340 The Conservative Party, *Delivering Some of the Best Health in Europe: Outcomes Not Targets*.

address the issue of concern the OSC should have the power to trigger an external review of PCT performance.

- This review should have the power to remove the PCT board and put in place a turnaround team.
- After a maximum of 12 months from the introduction of the turnaround team a new board should be elected by the local population.

OTHER PARTNERSHIPS BETWEEN THE NHS AND LOCAL AUTHORITIES

A number of other partnership arrangements exist to enable the NHS to work with local government. NHS bodies and local authorities can now pool budgets and integrate staff from different organisations to work under a single management structure. Local authorities, meanwhile, have a duty to set up local strategic partnerships to draw together a range of bodies, including the NHS, to create strategies to improve the wellbeing of the local area. There are also requirements for PCTs and local authorities to cooperate through “joint strategic needs assessment”, and to assess needs and commission services together through local area agreements (LAAs).

However, the aim of many of these partnerships is not primarily to improve local accountability but to meet local needs and drive up service standards. Because of the democratically elected status of local government, the NHS may be seen as more locally accountable if it were to work closely with local authorities, but this is very much local accountability by proxy and does not provide the necessary legitimacy to allow PCTs to make tough decisions.

The system is moving in the right direction, but the reforms have evolved in a piecemeal way resulting in a confusing set of

arrangements that healthcare professionals, let alone the general public, find difficult to understand.³⁴¹ It remains unclear where decisions are made, how decisions can be influenced and who is responsible for what. An opinion poll for the LGA Health Commission revealed a widespread lack of understanding and a high level of confusion among the public about the structure and organisation of the NHS, including the role of PCTs. It also found that only half of those surveyed felt that their local PCT was currently answerable for the quality of its services.³⁴²

The new accountability mechanisms, such as OSCs, are essentially “external” mechanisms of local public accountability.³⁴³ New structures to deliver “internal” and participative local public accountability are needed.

STRENGTHENING LOCAL ACCOUNTABILITY: THE OPTIONS

Before leaping to suggest new systems of accountability it is first worth considering the wisdom in allowing the current system, which has only recently been developed, to bed in. Many healthcare professionals argue that the mechanisms now in place will provide satisfactory local accountability if they are given time to get up and running and for local people to understand how they work. An NHS Confederation online consultation with its members found that 80% of respondents were in favour of “retaining the existing system to enable it to at least be fully implemented before considering more change”.³⁴⁴ Another reorganisation of PCT structures so soon after establishing the new system in 2006 would be disruptive and should be avoided.

341 LGA Health Commission, *Who's Accountable for Health? LGA Health Commission Final Report*, 5

342 *Ibid.*

343 J. Smith, R. Lewis and T. Harrison, *Making Commissioning Effective in the Reformed NHS in England* (London: Health Policy Forum, 2006), 35.

344 The NHS Confederation, *Principles for Accountability: Putting the Public at the Heart of the NHS* (London: The NHS Confederation, 2008), 3.

Nevertheless, while major structural reorganisation must be avoided, it is essential for the credibility of the service that PCTs are properly held to account by the local public in a way that cannot be achieved under current arrangements.

Foundation PCTs

One option that would give the public more of a say would be to develop the concept of the foundation PCT, in which high-flying PCTs would be granted the same governance structure as foundation trusts.

Although this option seems appealing, as it would neatly replicate the foundation status available to NHS trusts, there are a number of problems. PCTs might well struggle to attract members, especially as most people are not clear what a PCT is. It is also unlikely that PCT membership would be representative of the community as a whole, while the experience of foundation trusts suggests that a large variation in the knowledge and skills base of governors elected by members can be expected. Also, a foundation PCT model would lead to a loss of direct control by the Department of Health over commissioning to go alongside the increasing loss of direct control of provision. Unsurprisingly, the government has not shown enthusiasm for the idea. Furthermore, identifying foundation PCTs would surely exacerbate variations in performance between the best and worst commissioners rather than drive service improvement across the board.

Elected PCTs

Alternatively, local public accountability of PCTs could be strengthened alongside current upward accountability to central government. For example, some or all of the PCT board could be elected by the local public. This would provide local democratic input but would not necessarily mean that PCTs have to sever ties to the Department of Health (the DH could set policy and manage locally elected boards). This is the system that was adopted in New

Zealand,³⁴⁵ and has been considered by the Scottish Executive.³⁴⁶ However, PCT elections would be expensive and would probably be undermined to some extent by low turnout, which would prevent the PCT from being representative of all sections of the community. There is also a danger of single issue politics and short-termism controlling a politicised local health system.

A variation of this approach would be to incorporate existing local democratic mechanisms into PCT governance. The most extreme example of this system would be to pass all NHS commissioning responsibilities on to local authorities which would then be held accountable to their electorates, as is the case in countries such as Denmark and Sweden.³⁴⁷ This option establishes a link between local elected members and the local health system without requiring additional local elections. There would be a democratic influence on the local health system but without the single issue politics that could emerge from a directly elected board.

However, such a system would not deliver specific accountability for health services, as local government elections would be fought on a number of different local issues, not just health. Also, as local authorities and PCTs do not share the same boundaries, this approach would result in further disruptive reorganisation, would swamp local councils' other work and could result in local party politics interfering in the running of the NHS.

Some critics also argue that it is inappropriate for local government to spend money that has been raised at a national level; health is a centrally funded public service and so, it is argued, it

345 T. Ashton, N. Mays and N. Devlin, "Continuity Through Change: The Rhetoric and Reality of Health Reform in New Zealand", *Social Sciences and Medicine* 61 (2005).

346 The Scottish Parliament, *Health Board Elections (Scotland) Bill* (Edinburgh: HMSO, 2006).

347 S. Thorton, "Democratic Control Is Essential", *BMJ* 333 (2006); J. Glasby, J. A. Smith and H. Dickinson, *Creating NHS Local: A New Relationship Between PCTs and Local Government* (Birmingham: Health Services Management Centre, 2006).

should not be the domain of local councillors. One response to this objection would be to allow local areas to raise revenue to spend on healthcare in their locality. However, this is not an option that the SMF Health Project endorses. There is little appetite for local funding of the health service from the public or from national politicians and setting up such a system would cause further major disruption to the health service. There would also be significant equity concerns under such a funding system, with more affluent areas potentially able to raise more funds than less well-off localities.³⁴⁸

The most powerful argument against simply incorporating existing local democratic mechanisms into PCT governance as the way to strengthen local accountability is that such an approach would not necessarily satisfy the public. Public perceptions of local government are generally not positive: work undertaken by the Department for Communities and Local Government revealed that most people do not know the identity of their local councillors, are cynical of their reasons for being in local politics and do not trust councils to deliver cost-effective services or honour the promises they make in the run-up to elections.³⁴⁹ Similar views were uncovered by the Audit Commission, which found that councils are perceived by the public to have poor-quality leaders and managers,³⁵⁰ while a Home Office study of police authorities, where councillors sit on the board, found public scepticism about whether this makes them more effective and accountable.³⁵¹ Finally, polling for the NHS Confederation revealed that only 6% of the public believe that decisions about medicines or treatments funded by the local NHS should be made by local councillors.³⁵²

348 For more on funding issues, see chapter 3.

349 LGA Health Commission, *Who's Accountable for Health?* LGA Health Commission Final Report.

350 2003 MORI survey for the Audit Commission, cited in Picker Institute, *Accountability – Public Views and What to Do About Them* (Oxford: Picker Institute Europe, 2008), 10.

351 The Home Office, "Public Perceptions of Police Accountability and Decision-Making", <http://www.homeoffice.gov.uk/rds/onlinepubs1.html>.

352 The NHS Confederation, *Principles for Accountability: Putting the Public at the Heart of the NHS*.

These findings suggest that involving local councillors in the running of PCTs would not solve the public perception that PCTs have a local accountability gap.

The public appear to believe that there is a democratic deficit at a local level in the health service and so want services to be more democratically run,³⁵³ but at the same time they have little trust in national or local politicians. They also want local accountability to be strengthened, but only want to be involved in decision-making when they can influence the process and when something is not working.

In summary, the SMF Health Project argues that:

- the lack of local PCT accountability will become increasingly unacceptable to the public as more power is devolved to PCTs and their commissioning duties become more widely understood;
- the ever greater variation in local services that is a desirable consequence of greater PCT autonomy and improved commissioning performance means that it will become essential to strengthen local PCT accountability in order to lend legitimacy to the decisions made by local health officials;
- further involvement of elected local councillors is not an adequate solution as the public do not have sufficient confidence in local government;
- introducing directly elected PCT boards would solve the “democratic deficit”, but could lead to single issue politics and short-termism controlling the local health system and would probably be undermined by low turnout.

None of these proposed ways to strengthen local PCT accountability are entirely satisfactory.

353 A. Chisholm et al., *Patient and Public Involvement in PCT Commissioning* (Oxford: Picker Institute Europe, 2007).

A NEW MODEL FOR PCT ACCOUNTABILITY

Currently, PCTs are held to account by SHAs through the world class commissioning assurance framework. It is still unclear exactly what will happen to failing PCTs, but Mark Britnell stated that they will be subjected to “directed development” from their strategic health authorities for “a year or two”, with the possibility of the private sector being brought in to “accelerate their improvement”.³⁵⁴ The SMF Health Project argues that it is at this point that greater public involvement needs to be introduced in order to strengthen local accountability. Ipsos MORI carried out polling and discussion groups for the SMF Health Project with members of the public. The results revealed that it is precisely when NHS functions are failing that the public are most keen to be involved in decision-making on the future of the failing service.

The current top-down intervention in which SHAs make the decision about when to step in and intervene in the running of a PCT needs to be accompanied by some manner of citizen trigger if accountability is to be meaningful. The public need a way of being able to make it clear when they are not happy with the performance of their PCT, and to force action to be taken.

The SMF Health project recommends that this should take the form of a citizens’ initiative to trigger a review of PCT competence. The White Paper *Our health, Our Care, Our Say* granted new powers to local communities to stimulate a “public petition” to initiate action by PCTs where the public believe that some or all local services are deficient.³⁵⁵ However, the White Paper simply states that PCTs will have to “respond” to these public petitions, but goes no further than this. This concept should be given teeth in the same way that Recommendation 30, above, gives more

354 H. Crump, “PCTs Exceed Expectations in Year One”, HSJ (2009).

355 Department of Health, *Our Health, Our Care, Our Say: A New Direction for Community Services* (Lonsdon: HMSO, 2006), 160.

power to OSCs. The general public should be able to make it clear when they are not happy with the performance of their PCT, and to force action to be taken. This level of control and accountability will be necessary if PCTs are to have the necessary legitimacy to make difficult decisions over the next decade.

Recommendation 31:

- A public petition of an agreed proportion of the local population should have the power to trigger an external review of PCT performance.
- This review should have the power to remove the PCT board and put in place a turnaround team.
- After a maximum of 12 months from the introduction of the turnaround team, a new board should be elected by the local population.

CONCLUSION

The model of accountability described in this chapter would fill an important gap in the health system. Currently, accountability is focused upwards towards the SHA and the Secretary of State. But in a system where more autonomy is granted to local commissioners, it becomes ever more important to make sure that PCTs are accountable to local people. The proposals put forward in this chapter would give real power to OSCs and the public in general to bring regulatory attention to problems in the local health system. It is hoped that not only would this encourage greater legitimacy in commissioning decisions, but would also support the role of the regulator in avoiding catastrophic failures in the health system.

While it is certain that local people should have more power over their commissioners, it is not so clear that local democracy

is the answer to questions of accountability. SMF Health Project public opinion research found that people want to be involved in health service decision-making when things go wrong. Therefore, the project has concluded that there should be elections for new PCT boards only when there has been a clear failure of the incumbents. This offers the best chance of stability in management for the PCT as well as allowing local people to get involved when there are real problems to address in a particular area. In this way, commissioners can be accountable for the decisions they make as the health service moves away from a centralised top-down system of governance.

CHAPTER EIGHT: REGULATING A LOCAL SYSTEM

Throughout this report arguments in favour of a radically localised health system have been championed. The report has set out a vision for a system in which local commissioners, in combination with clinicians and with involvement from patients and the public, shape local health services that are innovative, high quality, efficient and meet the needs of local people.

However, as discussed in chapter 5, a radically localised system does not mean a system without national regulation. In fact, it is essential that a system in which power is held at a local level is “embedded in and supported by centralised standards and evaluation of performance”.³⁵⁶ Effective national regulation is crucial to ensuring that safety standards across the system are upheld and that the public has confidence in both providers and commissioners. National regulators also play an invaluable role in the collection and publication of detailed, comparable data on the performance of commissioners and providers.

In healthcare, as in other areas, “regulation” often has a negative connotation, viewed as centrally imposed interference that restricts innovation and stifles enterprise. At the same time, however, the public expect direct and extensive oversight to ensure that quality and safety are maintained. The regulatory framework of the health system in England has to balance these two desires and attempt to provide a robust system that protects patient safety without becoming too burdensome. This chapter provides a review of the current regulatory system and examines how it has evolved over the past decade. It highlights the regulatory principles that should guide policy in this area to support a shift from central to local control of the health service.

356 K. Vrangbaek, “Key Factors in Assessing Decentralization and Recentralization in Health Systems,” in R. B. Saltman, V. Bankauskaite and K. Vrangbaek (eds), *Decentralization in Health Care: Strategies and Outcomes* (Buckinghamshire: Open University Press, 2007), 72.

The chapter sets out a brief theoretical explanation of regulation before considering in detail principles that should inform the regulation of healthcare provider organisations and commissioners.

WHAT IS REGULATION?

Regulation involves the establishment of mechanisms that allow governments, directly or indirectly, to oversee and shape the behaviour of providers or funders of goods and services to ensure that governmental objectives, such as efficiency, safety and quality, are achieved.³⁵⁷

Regulation tends to be viewed principally as a remedy for market failure,³⁵⁸ but it is also used to achieve wider social goals, such as ensuring equity, diversity or social solidarity, and to hold corporate, professional and social interests to account.³⁵⁹

Quality regulation and economic regulation

A regulatory system has two main tasks: to provide quality regulation and to provide economic regulation. Quality regulation aims to protect consumers by ensuring that services and goods are safe and of high quality. It should also ensure fair access to services and manage the externalities and by-products of service provision. In healthcare this would include public health and overall public safety.³⁶⁰

Economic regulation generally has three key objectives: first, to develop a reliable delivery of services through regulating market entry and exit and ensuring that competent and efficient providers receive sustainable returns; second, to promote efficiency and accountability by monitoring the financial performance of

357 R. Lewis, A. Alvarez-Rosete and N. Mays, *How to Regulate Health Care in England? An International Perspective* (London: The King's Fund, 2006), 2.

358 A. Ogus, *Regulation: Legal Form and Economic Theory* (Oxford: Hart Publishing, 2004).

359 K. Walshe, "The Rise of Regulation in the NHS," *BMJ* 324 (2002).

360 Monitor, *Developing an Effective Market Regulatory Framework in Healthcare* (London: Monitor, 2005).

suppliers and by intervening if necessary; and, finally, to foster a fair operating environment by enforcing the rules of the game and preventing anti-competitive behaviour.³⁶¹

It is most common for both quality and economic regulation to be carried out either by two separate bodies or by multiple bodies across economic regulation and quality inspection for different industry segments. However, another option is for one body, a super regulator, to perform both economic and quality regulation.

Types of regulation

Regulation can be *ex ante*: anticipatory intervention that seeks to prevent adverse behaviour or outcomes from occurring – for example, the licensing of service providers before they enter the market. Alternatively regulation is *ex post*: action is taken after an offence has been detected to redress proven misconduct through a range of options, including fines, injunctions and bans.

Regulatory agencies can also adopt different styles of regulation; on the whole, they opt for one of two regulatory models: deterrence or compliance. The deterrence model works from the assumption that the organisation being regulated is an “amoral calculator”³⁶² that will act to maximise its own best interests in whatever environment it is in. As such, the organisation must be forced to behave responsibly by strict regulation enforcement. The compliance model takes the opposite view, assuming that the organisation being regulated is well meaning and will behave dutifully where possible. Regulators who take this line provide support and advice, and are more lenient in respect of mistakes that occur.³⁶³

361 Ibid.

362 R. A. Kagan, ‘The ‘Criminology of the Corporation’ and Regulatory Enforcement Strategies’, in K. Hawkins and J. M. Thomas (eds), *Enforcing Regulation* (Boston: Klunwer-Nijhoff Publishing, 1984), 67–96.

363 Walshe, ‘The Rise of Regulation in the NHS’.

Of course, in reality organisations aren't "good" or "bad" but have a wide variety of motivations and react in different ways to different circumstances. Some regulators attempt to take account of such variations by applying a range of different approaches, but are often forced by legislative or political pressures to use a particular regulatory style, regardless of its appropriateness.³⁶⁴ Traditionally, regulators in the NHS have adhered to the compliance model of regulation.³⁶⁵ However, more recently regulation of the public sector has become increasingly orientated towards deterrence, with this change in emphasis being favoured by politicians, the media and the public.³⁶⁶

Effective regulation

Effective regulation relies on a number of guiding principles. First, it is important for regulators to be responsive. If regulation is to be effective, then the agency carrying out the regulation must appreciate the diversity of organisations it regulates and be able to adapt to the way different organisations behave. A "one-size-fits-all" policy should be rejected in favour of a more flexible approach.

Walshe, writing in the *British Medical Journal*, argues that if this responsive approach is to work, the regulators need to have a range of graduated incentives and sanctions at their disposal: incentives and informal interventions on the first rung, formal supervision and inspection on the next rung, and closure of an organisation or removal of their license at the top, for the most serious cases. Regulators should be able to move freely up and down the hierarchy of methods to ensure the most effective regulation.³⁶⁷

364 Ibid.

365 P. Day and R. Klein, "The Regulation of Nursing Homes: A Comparative Perspective", *Millbank Q* 65 (1987).

366 Walshe, "The Rise of Regulation in the NHS".

367 Ibid.

A further feature of effective regulation is the ability of regulators to work with other stakeholders in the organisations they regulate, as opposed to viewing the relationship between them and the organisation as bilateral. This approach, known as tripartism, requires groups such as patients and staff to be involved in the process of carrying out regulation. Regulators tend to have very limited resources and can only ever oversee a small proportion of regulated activities. Tripartism enables them to extend their oversight by using stakeholders to inform the regulatory process, and sometimes, in the case of self-regulation, for example, to take on regulatory responsibilities themselves.

Involving patients in the regulatory process also guards against other stakeholders becoming dominant at the expense of patients. A regulator's relationship with different stakeholders needs to be managed carefully, as there will always be asymmetries in the extent to which different stakeholders can mobilise resources to influence the regulatory process. There is potential for 'capture' if the regulator fails to maintain an arm's-length independent relationship, becoming too closely identified either with the interests of the organisations it regulates (firm capture) or, alternatively, with those of the government (government capture). It is important to make sure that industry, professional or governmental interests are balanced by patient interests.

Finally, to be effective and respected, regulators must strive to balance independence and accountability. Regulatory agencies need to be independent to ensure their credibility and their impartiality, and to give them the freedom to take actions that could be unpopular with some stakeholders. But, at the same time, regulators must be held accountable for their actions and the effects of their regulation.³⁶⁸

368 Ibid.

REGULATION IN THE NHS

The rise of regulation

When the NHS was founded in 1948, the responsibility of providing a good-quality service was left to the healthcare professionals. In order to win the support of doctors for the new National Health Service, the government struck a deal with the professions whereby the government set the overall budget for the NHS and the professionals were free to spend it how they saw fit.³⁶⁹ By the 1980s, variations in care and concerns about equity across the health service, along with the prevalence of inefficient and ineffective practices, meant that this pact was in need of reform. In an effort to improve the performance of the NHS, the government decided to take an increasingly direct role. Through the use of primary and secondary legislation, directives from the centre and performance management at a local, regional and national level, it was hoped that the quality of healthcare provision could be standardised and improved.³⁷⁰

The shift in emphasis towards greater performance management of the NHS is part of a wider growth of the “regulatory state”³⁷¹ in the private and public sectors that has occurred in Britain over the past 20 years. The Conservative government, while publicly committed to deregulation, in fact introduced a host of new regulatory agencies between 1979 and 1997. Many of these regulators were created to oversee newly privatised industries, but the government also increasingly used regulation to manage the performance of public sector organisations.

The growth in regulation was in part the result of changes in the way public sector organisations were managed and structured. The Conservative government embraced the new public management

369 R. Klein, *The New Politics of the NHS* (London: Prentice Hall, 2000).

370 J. Dixon, *Regulating Health Care: The Way Forward* (London: The King's Fund, 2005), 8.

371 G. Majone, “The Rise of the Regulatory State in Europe”, *West European Politics* 14: 3 (1994).

philosophy, which extols the virtues of providing greater autonomy for public sector organisations, placing them at arm's length from the government, separating purchasing and providing functions and increasing competition. This approach did lead to greater autonomy for public sector organisations, but was accompanied by increased regulation.³⁷²

The development of regulatory agencies has also been spurred on by a shift in the way society holds public services to account. Previously, it was felt that accountability was satisfactorily achieved through elected central and local government. But over the past 20 years, with the rise of the consumer society, it has increasingly been felt that this is no longer adequate. There is now a desire across society for more direct and extensive oversight.³⁷³

Clinical performance of NHS hospitals

The drive to strengthen the regulation of healthcare was taken up by the Labour government that came to power in 1997. At this time, public confidence in the healthcare system – and especially in the healthcare professions – had been seriously undermined by several high-profile quality failures.³⁷⁴ In the period around and following the Bristol Royal Infirmary inquiry – a detailed investigation into the deaths of 29 babies undergoing heart surgery at an NHS hospital in Bristol – the media and public began to call for a more robust system for quality assurance and improvement, questioning whether the professions, left to regulate themselves, could assure a high quality of care.³⁷⁵ This pressure resulted in substantial reform of the regulatory system.

In 1999, the Commission for Health Improvement (CHI) was established to inspect the clinical activity of NHS trusts. It was the first

372 Lewis et al., *How to Regulate Health Care in England?*, 2.

373 Ibid.

374 For example, the cases of Harold Shipman, Clifford Ayling and Rodney Ledward.

375 BBC News, "The Bristol Inquiry", http://news.bbc.co.uk/1/hi/health/background_briefings/the_bristol_heart_babies/297370.stm.

organisation ever to assess the clinical performance of NHS hospitals in England. Although other statutory and non-statutory forms of external review had been used in parts of the NHS in the past (such as the Audit Commission and the National Audit Office), this was the first time that an agency with a broad remit for quality improvement had been created to review the activity of NHS trusts. The CHI reported directly to the Secretary of State for Health and was tasked with providing an “independent guarantee that local systems to monitor, assure, and improve clinical quality are in place.”³⁷⁶ The CHI had wide powers to monitor how clinical governance was implemented and to carry out investigations into the management, provision or quality of healthcare provided by trusts. It was planned that every trust would be reviewed and reported on by the CHI within four years of its establishment.

However, despite the powers that the CHI enjoyed, its authority was not as complete as some had hoped it would be. It did not possess the power to impose sanctions or incentives to force or encourage healthcare organisations to take account of its views, apart from the publication of its reports, and it could only advise the Secretary of State if it thought action was needed.³⁷⁷ In addition, the powers the CHI did hold were limited to NHS organisations and property, and excluded healthcare providers in the private sector and most general practice premises, as they tend to be owned by the GPs themselves, not the NHS. The government emphasised the independence of the Commission, but in fact the Secretary of State had complete power to direct the way in which it exercised any of its functions.

Subsequently, in April 2004, following completion of the Kennedy Review into the Bristol Royal Infirmary cardiac deaths, the CHI was replaced by the Commission for Healthcare Audit and Inspection, which became known as the Healthcare Commission.³⁷⁸

376 K. Walshe, “Improvement Through Inspection? The Development of the New Commission for Health Improvement in England and Wales”, *Quality in Health Care* 8 (1999).

377 Ibid.

378 J. R. Haslam, “What Is the Healthcare Commission Trying to Achieve?”, *Soc Med* 100 (2007).



The Healthcare Commission

The Healthcare Commission had more power than its predecessor. It could replace managerial staff in poorly performing NHS organisations and even force the merger or break-up of trusts as a last resort. It provided guidance to the NHS, reviewed formal complaints against the NHS, carried out patient satisfaction surveys and presented an annual “state of healthcare” report to Parliament.

It was also responsible for inspecting and regulating private sector providers against national requirements, a task that the CHI did not undertake. However, its approach to regulating private sector providers was somewhat different from its approach to NHS providers. The Commission was required to inspect all independent providers once a year against the national minimum standards for independent healthcare. These standards were similar to the core standards that applied to the NHS, but were more detailed and difficult to achieve. If independent providers failed to comply with the requirements, the Commission could intervene and ultimately prosecute or de-register the provider.³⁷⁹

The establishment of the Healthcare Commission was initially viewed as an important development in the drive to improve quality across the NHS, but it soon began to receive mixed reviews. It was criticised for placing too heavy a bureaucratic burden on the organisations that it inspected, and for taking a reactive approach to quality improvement.³⁸⁰ These problems were highlighted in a Healthcare Commission survey of 220 NHS trusts in 2006–7, which uncovered frustration amongst trusts about a perceived duplication of Healthcare Commission roles with other regulators, as well as concerns about follow-up inspections and questions about the comparability of scores across trusts. However, despite

379 The Department of Health, *The Future Regulation of Health and Adult Social Care in England* (London: HMSO, 2006), 31.

380 S. Leatherman and K. Sutherland, *The Quest for Quality: Refining the NHS Reforms* (London: The Nuffield Trust, 2008), 35.

these qualms, the survey revealed that 93% of trusts found that the annual health check did have a positive impact on patient care.³⁸¹

It is difficult objectively to assess the impact of the Healthcare Commission compared to other interventions to improve quality. Improvement in overall ratings was mainly achieved in the better-performing trusts, with a significant increase in the number of trusts rated “excellent” for both quality of services and use of resources, while the number of trusts rated “weak” remained static. High-performing trusts were mainly foundation trusts, so it is hard to know whether their improvements were due to the regulatory impact of the Healthcare Commission or to other organisational changes, such as greater autonomy enjoyed by foundation trusts.³⁸²

Foundation trusts

The Healthcare Commission did not directly regulate foundation trusts; instead, this task was carried out by Monitor, an independent regulator established in January 2004. Monitor is responsible for licensing new foundation trusts, for monitoring their performance and for intervening in their management if the trust significantly breaches the terms of its authorisation.

Performance of foundation trusts was assessed against healthcare standards by the Healthcare Commission, which then sent reports to Monitor which had the power to intervene in the running of a foundation trust in the event of failing performance. Monitor’s statutory powers of intervention included imposing changes on the composition of the trust board and requiring that it complied with an imposed action plan.³⁸³

381 Ibid.

382 Ibid., 35–6.

383 Monitor, *Monitor’s Rules of Procedure* (London: Monitor, 2006).

FURTHER REFORM OF HEALTHCARE REGULATION

Despite the establishment of the Healthcare Commission and Monitor, there continued to be calls for further changes to the system. One concern was the burden that the regulatory system placed on providers.³⁸⁴ The demands of the Healthcare Commission, coupled with continuing financial reviews by the Audit Commission and requests for information about trust activity from numerous other organisations, led to what some described as “inspectorial overload”.³⁸⁵

Another concern with the regulatory framework was that it had become fragmented over time.³⁸⁶ As mentioned above, there were different regulatory procedures, standards and enforcement measures for NHS and independent sector providers, and the system also retained the barriers between health and social care. As more decisions were being devolved to the local level and more choice given to patients and the public, it was felt that the distinctions would become more and more archaic.³⁸⁷

In response to these concerns, the Department of Health, in 2005, began a review of regulation in health and social care that resulted in the Health and Social Care Act 2008, receiving Royal assent on 22 July 2008.³⁸⁸ The Act contained significant measures to modernise the regulation of health and social care. Most crucially, it set out the establishment of the Care Quality

384 R. C. Heron, “Better Coordination of the Inspection, Review and Audit of Healthcare Organisations”, http://www.concordat.org.uk/_db/_documents/Better_coordination_of_the_inspection,_review_and_audit_of_healthcare_organisations.pdf.

385 Walshe, “The Rise of Regulation in the NHS”.

386 C. Hughes, “Evidence Submitted by The Hearing Aid Council (Audio 42)”, <http://www.publications.parliament.uk/pa/cm200607/cmselect/cmhealth/392/392we26.htm>.

387 The King’s Fund, “Response to the Department of Health Consultation on the Future of Regulation of Health and Adult Social Care in England”, http://www.kingsfund.org.uk/applications/site_search/?term=consultation+response+regulation&searchreferer_id=2.2

388 Department of Health, *The Future Regulation of Health and Adult Social Care in England: A Consultation on the Framework for the Registration of Health and Adult Social Care Providers* (London: HMSO, 2008).

Commission, a new integrated regulator for health and adult social care.

Care Quality Commission

On 1 April 2009 the Care Quality Commission (CQC) took over from the Healthcare Commission, the Commission for Social Care Inspection and the Mental Health Act Commission. The new Commission, for the first time, provides regulation across both health and adult social care, reflecting the growing integration of those services.

The CQC is responsible for:³⁸⁹

Safety and quality assurance

- registering providers of health and adult social care;
- monitoring and assessing providers against a set of registration requirements;
- escalating serious service failures, using discretionary sanctions that ultimately lead to enforced closure of a service or of the provider through de-registration, if patients or users of services are seriously at risk;
- conducting further inspections or investigations where there are significant risks to the required levels of safety and quality;
- publishing information and reports using information gathered through carrying out its functions.

Commissioner assurance and performance assessment of providers

- ensuring good-quality information is available to support patient and service user choice;

389 *Health and Social Care Act 2008* (London: HMSO, 2008).

- publishing an independent assessment of both providers and commissioners for the purpose of public accountability;
- providing an annual report to Parliament on the state of health and adult social care and the operation of the Mental Health Act;
- carrying out general service reviews, studies and research on issues that arise from carrying out its functions.

Minimising the burden of regulation and inspection

- adhering to the principles of good regulation and carrying out its functions in a way that minimises the burden of regulation and is proportionate, targeted, accountable, consistent and transparent.

The introduction of the CQC is a clear signal of the trend towards consolidation of regulatory functions as a mechanism to achieve quality. Innovations in the CQC model are considered below, and later in this chapter consideration is given to whether an external regulator such as the CQC is best placed to improve quality.

REGISTRATION

From April 2010, all providers of health and adult social care regulated activities, including NHS, local authority, private and third sector providers, will have to be registered with the CQC.³⁹⁰ Before the introduction of the CQC, any non-NHS provider of health and social care had to register with either the Healthcare Commission or the Commission for Social Care Inspection in order to provide services legally. However, there was no registration system for NHS bodies, which were instead assessed against the Standards for Better Health by the Healthcare Commission.

390 Care Quality Commission, "Summary of Guidance About Compliance", http://www.cqc.org.uk/_db/_documents/LP_consultation.rtf.

The new initiative is an attempt to develop a coherent system of registration across health and adult social care based on one set of generic “registration requirements”, which all providers have to meet. Providers have to demonstrate that they can meet the essential levels of safety and quality required for registration and will need to continue to meet them to maintain their registration.

Registration requirements

The robustness of the system of registration will depend on the registration requirements. A single set of registration requirements is proposed for all providers which will concentrate on essential levels of safety and quality.³⁹¹ They will be separate from the revised set of improvement standards to be developed for the NHS to benchmark good practice. Baroness Young, chair of the CQC, has declared that registration “will involve meeting a wider range of standards”³⁹² than under the old regulation regime, and the Department of Health has set out 18 broad standards that will apply to health and social care services. These will replace the current core standards for better health, which apply to NHS trusts, and the national minimum standards and regulations, which apply to social care and independent sector health providers.³⁹³

391 Director of Adult Social Services, “Report to Cabinet Members for Health, Social Care and Partnerships”, <http://www.solihull.gov.uk/akssolihull/images/att15145.doc>.

392 Care Quality Commission, “New Regulator for Health, Mental Health and Adult Social Care”, http://www.cqc.org.uk/newsandevents/pressreleases.cfm?cit_id=34816&FAArea1=customWidgets.content_view_1&usecache=false.

393 Proposed topics for registration requirements: making sure people get the care and treatment that meet their needs safely and effectively; safeguarding people when they are vulnerable; managing cleanliness, hygiene and infection control; managing medicines safely; making sure people get the nourishment they need; making sure people get care and treatment in safe, suitable places which support their independence, privacy and personal dignity; using equipment that is safe and suitable for people’s care and treatment and supports their independence, privacy and personal dignity; involving people in making informed decisions about their care and treatment; getting people’s ongoing agreement to care and treatment; responding to people’s comments and complaints; supporting people to be independent; respecting people and their families and carers; having arrangements for risk management, quality assurance and clinical governance; keeping records of the provision of care and treatment; checking that workers are safe and competent to give people the care and treatment they need; having enough competent staff to give people the care and treatment they need; supporting workers to give people the care and treatment they need; and working effectively with other services.

The registration requirements aim to ensure that care provided is safe, effective, fair and personalised. The requirements are generic, but the criteria used to assess compliance, which will be developed by the CQC, will be tailored to the type of service being registered, taking into account the differences between, for example, a hospital and a care home.³⁹⁴

Primary care

Initially it was unclear whether primary care providers would have to register with the CQC. Primary care professionals are already individually registered by their professional governing bodies and are subject to the Quality and Outcomes Framework (QOF) and PCT contracting arrangements. It was thought that CQC registration may be unnecessary.

However, although the QOF does gather data on some aspects of the quality of general practice, it is far from exhaustive and does not cover all areas of primary care.³⁹⁵ The QOF is also failing adequately to detect the considerable variation in the quality of GP services that is recognised both in the profession and among PCT managers.³⁹⁶ Commissioners are expected to commission for best practice but are hampered by a lack of adequate information that benchmarks different practices nationally.

In addition, the current primary care regulatory arrangements focus mainly on the competence of the individual professional, as opposed to the practice. Given the increasing range of services offered in primary care, including minor operations and other services traditionally provided in hospitals, it was argued that primary care organisations should be subject to the same standards as secondary care providers.

394 Director of Adult Social Services, "Report to Cabinet Members for Health, Social Care and Partnerships".

395 The Department of Health, "Quality and Outcomes Framework (QOF)", http://www.dh.gov.uk/en/Healthcare/Primarycare/Primarycarecontracting/QOF/DH_099079.

396 H. Mooney, "GP Quality: the Final Frontier for Inspectors", HSI (2009).

As such, the Department of Health decided, after additional consultation, that NHS primary medical and dental services must register with the CQC by 2010/11 (a year later than other NHS providers). This development means that, for the first time, around 8,500 GP practices and 9,000 dental practices will be required to register with the mainstream regulator.³⁹⁷

The Department of Health has stated that the new system will “strengthen PCTs’ core responsibility for managing primary care contracts, provide broader information about primary care services to the public, and tackle unacceptably poor or unsafe performance”.³⁹⁸ The CQC will have the authority to fine or shut down substandard GP practices.

REGULATION AND QUALITY

The nature of the relationship between quality and regulation is a key question. Regulators have a central role in ensuring safety, but there is a general lack of clarity about the role of regulators as a driver of improved quality relative to the local commissioner or the provider itself. Some commentators, such as NHS Alliance chair Michael Dixon, have suggested that the registration of primary care services would ensure a minimum level of quality and safety, but would be less effective at generating continuing improvements.³⁹⁹ Similar sentiments have been expressed, for example, by the King’s Fund, about the new regulatory system’s ability to ensure quality across the whole service.⁴⁰⁰

This argument is linked to a wider question about whether inspection is the best way of ensuring quality. The CQC does not want to be thought of as a traditional inspectorate. Baroness

397 C. Santy, “Care Quality Commission to Regulate Primary Care”, *HSJ* (2009).

398 Department of Health, cited in *ibid*.

399 C. Santry, “Care Quality Commission: A Chance to Peep Under the Primary Care Carpet”, *HSJ* (2008).

400 The King’s Fund, “Response to the Department of Health Consultation on the Future of Regulation of Health and Adult Social Care in England”, 8.

Young is adamant that the CQC will be a modern, proportionate and responsive regulator, which will work with the providers and commissioners of services to encourage improvement. But nevertheless, the CQC will carry out inspection. Baroness Young has stressed that the CQC will not be an easy touch: the regulator will inspect and monitor health and social care providers and is equipped with a range of tough new enforcement powers which they “won’t be afraid to use ... when it is appropriate”.⁴⁰¹

Inspection tells organisations what problems exist, but does not necessarily help them to solve those problems. There is a danger that problems are identified but then little changes as a result. External review and inspection is the correct method for ensuring safety, but may not be particularly suitable for securing continuous quality improvement. Quality improvement is an organisational challenge internal to the healthcare provider, so although an external perspective on performance and quality can be valuable, alone it cannot change anything. To bring about improvements, the organisation has to take on board the need for change and have the skills and resources itself to make change happen. External inspection processes can also seem threatening and lead to defensiveness and self-justification, which makes improvement more difficult to achieve.⁴⁰²

Other mechanisms will therefore have to be relied upon to ensure quality improvement. Financial incentives may play a part – for example, payment for outcomes rather than activity could be introduced. Competition for patients might lead to improvements in quality, while routine reporting of comparative performance data on performance indicators will also be important.⁴⁰³ However,

401 Care Quality Commission, “Care Quality Commission Launches”, http://www.cqc.org.uk/newsandevents/newsstories.cfm?cit_id=34817&FAArea1=customWidgets.content_view_1&usecache=false.

402 Walshe, “Improvement Through Inspection?”.

403 The King’s Fund, “Response to the Department of Health Consultation on the Future of Regulation of Health and Adult Social Care in England”, 7.

relying solely on choice, competition and the availability of performance information to drive up quality has not been particularly successful to date. There is no substantive evidence, even in a highly competitive market system like that in the US, that patient choice will significantly drive quality improvement,⁴⁰⁴ while some international evidence suggests that patients are unlikely to use quality information when making their choices.⁴⁰⁵

The other mechanism that is being relied upon to drive up quality is commissioning.

Local commissioners responsible for the quality of provider organisations

Commissioners increasingly have responsibility for the quality of NHS services. Although the new regulator, the CQC, does have a statutory responsibility for the quality and safety of NHS services, the Department of Health has emphasised that “key ‘regulatory’ functions ... will be picked up elsewhere”, most noticeably “by commissioners”.⁴⁰⁶ The department states that although the CQC will have an important role in ensuring that all providers meet national standards, it is “excellent commissioning” that will drive up the quality of services and ensure that a range of local providers is available to offer choice of services to patients.

The CQC has a vitally important role to play in approving new providers, making sure that minimum standards are adhered to, guaranteeing safety and compiling nationally comparable data on provider performance. But it is PCTs that should be responsible for using this data to commission effectively and ensure the quality of the services that they commission. Commissioners are much

404 P. Shekelle et al., *Does Public Release of Performance Results Improve Quality of Care? A Systematic Review* (London: The Health Foundation, 2008).

405 E. C. Schneider and T. Lieberman, “Publicly Disclosed Information About the Quality of Health Care: Response of the US Public”, *Quality in Health Care* 10:2 (2001).

406 The Department of Health, *The Future Regulation of Health and Adult Social Care in England*, 6

better placed to drive up quality, as they are embedded in local areas and can see from day to day what works well and where there are problems.

External review and inspection is the correct method for ensuring safety but is not particularly suitable for ensuring continuous quality improvement, which is a long term, internal process. Commissioner organisations, which are based at the same local level as the provider and have a long-term, continuous relationship with the provider, are much better placed to help encourage, stimulate and support this internal improvement. They also have more flexible responses to failure. Commissioners can tweak contracts in multiple ways to stimulate improvement, which an external regulator cannot. Indeed, since the PCT “holds the purse strings”, it is the most effective organisation to demand improvement from the providers it works with.

Recommendation 32:

- **The quality of provider organisations should be assured and developed through PCT contracts.**
- **The Care Quality Commission should maintain responsibility for setting minimum safety and quality standards as part of the licensing arrangement, and collecting comparative data on providers across the health service.**

THE REGULATION OF COMMISSIONERS

The preceding section has established a need to involve PCTs in the regulation of local providers, alongside an assurance of safety and basic standards from the CQC. But how should PCTs themselves be regulated?

Currently, PCTs report to four different bodies on different aspects of their performance

- the Department of Health;
- the Audit Commission on financial performance;
- Strategic Health Authorities; and
- the Care Quality Commission.

There are two major problems with the structure as it stands. First, it provides unnecessary work for hard-pressed commissioners. They report to four different bodies, each of which has different requirements and different processes. SMF Health Project interviews with commissioners and seminar discussions identified frustration at the unnecessary work this generates.

The second problem is one of accountability. For patients, it is difficult to access information about PCT performance, as it is not held in a single repository. This situation must change as commissioners develop, and as we move away from a centralised system driven by national standards. It is imperative that patients and the public can easily access high-quality information about how their local commissioner is performing.

There should be a consolidation of PCT regulation, with a single body overseeing the performance of PCTs against minimal national targets, and providing information for the public with a particular focus on Patient Reported Outcome Measures (PROMS).

Recommendation 33: A single commissioning regulator and inspectorate should be introduced – the NHS Commission – to sit alongside the Care Quality Commission.

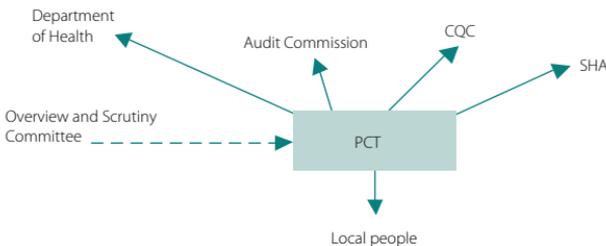
The earlier chapters have consistently stressed that the health system should not consider a massive structural overhaul at this time of financial crisis. However, if PCT regulation is consolidated under one independent body, this will remove from SHAs their responsibility for managing the world class commissioning assurance framework. Such a development would leave SHAs rather redundant. As such, it seems sensible that SHAs should be abolished, saving a significant amount of money – more than £3.5 billion a year.⁴⁰⁷ As stated in chapter 6, the strategic commissioning role that is currently undertaken by SHAs should be taken up by groups of PCTs working in partnership.

This is the only structural change that should be introduced in the next decade, but it would represent a useful change to improve commissioning performance and streamline the structure of the health system to promote efficiency.

Recommendation 34: The SHA should be abolished.

Figures 8.1 and 8.2 illustrate how the system of accountability and regulation will change under SMF Health Project proposals.

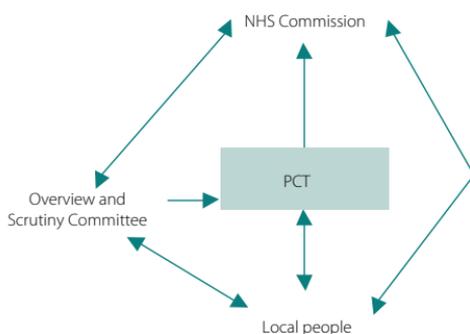
Figure 8.1: Current model of PCT accountability and regulation



407 "Hansard Written Answers for 12th March 2004, Column 1832W", <http://www.parliament.the-stationery-office.com/pa/cm200304/cmhansrd/vo040312/text/40312w22.htm>.

In this current model PCTs are accountable to several different national bodies. Local people do not have an established mechanism to hold their PCT to account, except through the very weak powers of the Overview and Scrutiny Committee.

Figure 8.2: New model of PCT accountability and regulation



In this proposed new model a single commissioning regulator works with PCTs, Overview and Scrutiny Committees and local people to improve performance.

CONCLUSION

The preceding discussion has traced the development of regulation in healthcare through its many different organisational manifestations in recent years. There is now a proper focus on the provision of information, particularly about primary care facilities, that will enable commissioners to make decisions about the quality of care in their area. However, it is clear that there are limits to the capacity of regulators to achieve the all-encompassing goals of ensuring safety and improving quality across all health providers. There should be a less ambitious goal for regulation – to make sure that health services are safe, rather than to drive up quality of care, and to collect and publish extensive comparable data on the performance of providers.



Through a more sophisticated use of information and their local purchasing power, it is commissioners who must play a bigger role in driving up quality, and weeding out poor providers of care.

CHAPTER 9: CONCLUSION

This report has set out a process of reform to help the health service in England deal with the catastrophic impact of the recession on the public finances. Whatever the political rhetoric, the NHS will not be immune from a spending squeeze that will be worse than any previously experienced by the vast majority of civil servants and public sector workers. There is an urgent need to obtain better value for money from health spending through greater efficiency and a proper focus on demand management. If the NHS cannot do more for less, then its future is in doubt. The long waiting lists and low quality care of the past must not return if the health service is to maintain public support in the years ahead.

The recommendations set out above recognise the need to take radical action but within politically realistic limits. The NHS has suffered in recent years from the sheer number of reorganisations it has undergone. There is no doubt that in some cases reorganising the health service has not helped it to perform better. The conclusions of the SMF Health Project acknowledge that while a revolution in structures is undesirable, a revolution in attitudes is essential. Policymakers in central government must become genuinely committed to devolving power to frontline commissioners. Those frontline commissioners must become the driving force of NHS improvement, taking on vested provider interests. And a dialogue with patients should be begun to help users recognise the desirability of a diverse, varied system that responds to the needs of local people, rather than aspiring to an unrealistic and inefficient idea of national uniformity.

The move towards a system of local control and local variation is essential if the NHS is to survive the crisis in public finances. The limits of centrally driven performance management have been reached. While there has been substantial improvement as a result of the reform and investment of the past few years, the ability of

central government to make the savings that will be needed is questionable. High quality local commissioning offers the best chance to deliver value for money, not performance management from the centre. It is time to try a new approach; one that harnesses the creativity and energy of local professionals. Additionally, the hard decisions that lie ahead can only be justified to local people by local health organisations, backed by local accountability mechanisms, not the Department of Health.

There will undoubtedly be political pain in the move from a centralised service to one where local commissioners drive improvement. However, public opinion research carried out as part of the SMF Health Project shows that people are realistic about the limits of NHS care, and open to the idea that resources should be distributed according to the needs of different areas. Political courage will be needed if a move away from the persistent idea that the NHS is the same everywhere is to be achieved. But the benefits of local choice must supersede concerns about postcode lotteries.

A diverse, varied service is one that fits with social market principles. Markets in healthcare provision can provide a pluralist, innovative and efficient system. Social goals of fairness and universal access can still be achieved through accountable commissioning organisations, and strong regulation. The benefits of a market approach to healthcare could be considerable, and can be achieved largely within existing NHS structures.

What does the future hold for the health system? It is a rocky road ahead. The year on year rise in health spending as a proportion of GDP cannot be continued indefinitely. It may be that the recession will present an opportunity to radically transform health services to save money in the long term. This transformation will require policymakers to consider options that have hitherto been politically unacceptable – including user charging.

In many different sectors of politics and society a new consensus is emerging that public services must be substantially reformed to deal with the challenges ahead. Old solutions that look to management by central government to make savings and improve outcomes for patients will not succeed in delivering value for money. Instead, a radical redistribution of power must take place. With strong commissioners, functioning provider markets and better accountability through national regulation and local accountability mechanisms, the NHS has every chance of a strong future. Without these much needed reforms, the future is bleak.



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