



SMF HEALTH PROJECT: BACKGROUND PAPER 1

An Overview of Health Systems Reform and the NHS

David Furness, Barney Gough, Dr Niall Maclean,
Lyndsay Mountford and Charitini Stavropoulou

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1 INTRODUCTION

AN INTRODUCTION TO THE SMF HEALTH PROJECT AND BACKGROUND PAPERS

This paper is the first of five which form the background to the ongoing work of the SMF Health Project. Our aim has been to lay a solid, empirically grounded foundation for the subsequent work of the SMF Health Project in identifying challenges which England's health system will face over the next 10–15 years, and in suggesting the ways in which it ought to change in order meet these challenges. Although our focus has been on England, we have sought to use UK-wide studies and comparative data from other countries wherever this was instructive.

Our methodology has been twofold. First, we have sought to conduct a thorough review of the published literature in the field. We have summarised the most salient findings, identified conflicting views where they arise and have highlighted gaps in the evidence. Second, we have undertaken interviews with experts and key stakeholders, to follow up on issues and themes that emerged from our literature review and which we believe would benefit from the input of those currently working at the cutting edge of the relevant subject areas. We plan to continue this outward-facing approach throughout the lifetime of the SMF Health Project.

This first paper is intended to provide an introductory overview of the main themes in the planning, financing, organisation and reform of health systems, and to provide a brief survey of the development of the NHS since its creation in 1948 in relation to some of these themes. In recent years, the NHS has been the subject of a very extensive reform programme by successive governments, particularly since the introduction of more market-oriented structures in 1991.¹ It has not been alone in this: all European health systems, and beyond, have experimented with reform, each in ways suited to the characteristics of their particular health system. These reform programmes have been

1 Department of Health, *Working for Patients* (London: HMSO, 1989).

extensively documented² as to their impact on the delivery of good-quality healthcare and healthcare processes, and some of the main themes are explored below.

Subsequent papers will consider aspects of NHS organisation and policy in more detail. Background Paper 2 explores the issue of long-term financing pressures which are likely to arise as a result of the ageing of the population and the growth of health technologies. The role of purchasers/commissioners and the structures, plans, performance targets and financing mechanisms used to support them are considered in Background Paper 3. Provider issues, including the changing nature of healthcare supply, the likely impact on healthcare supply of new technologies, and the challenges of coordinating care in an increasingly diverse and specialised provider environment, are the subject of Background Paper 4. Finally, the changing role and expectations of patients form the main topic of Background Paper 5. As they explore these topics in detail, the papers identify and propose a series of issues for further research which are brought together and summarised in a final research agenda.

2 There is now a vast literature on this subject. See, for example, the European Observatory on Health Systems and Policies: www.euro.who.int/observatory

2 OVERVIEW: HEALTH SYSTEM OBJECTIVES AND STRUCTURES

Whatever their structural characteristics – whether social insurance systems of the “Bismarckian” kind, or tax-based national health systems of the “Beveridge” type, whether locally devolved systems or highly centralised bureaucracies, well-functioning healthcare systems share similar features. Fundamentally, they tend to encompass very high levels of public financing, designed to deliver sufficient risk-pooling to provide their populations with equitable access to healthcare, based on need rather than the ability to pay. They aim to provide safe, high-quality healthcare, responsive to the needs of the patients they treat. Given that such systems are publicly financed, the aim is also to balance the desire to provide healthcare as efficiently as possible with the desire to limit demands on the public purse. Meeting these, often competing, objectives is the main challenge of modern healthcare systems, and the main questions about what, and how much, healthcare to provide in a publicly funded system, and how best to provide it, occur again and again.

Health systems, whether public or private, social insurance or tax-based models, are effectively insurance markets, and they suffer from the main failures of such markets, particularly the problem of moral hazard which arises from third-party payment. Consequently, there is always the risk of over-consumption of services by patients who do not face the full costs of their care. This problem can be exacerbated by information asymmetries between patients and doctors, which may give rise to supplier-induced demand: hence doctors may also prescribe for and treat patients above socially optimum levels. As a result, much healthcare policy is about trying to find a way through these difficult market failures, particularly in relation to finance and payment mechanisms, and about finding appropriate incentive structures with which to drive specific objectives and targets.



Two related questions are central to health-sector organisation and reform. One is about the nature and organisation of the relationships between the main stakeholders – namely, government, payers, clinicians and patients – and the definition of decision-making roles and relationships between them. The other is about the funding of healthcare and the subsequent methods of allocating (scarce) financial resources to healthcare delivery. The following chapter considers briefly some key aspects of these issues and identifies research topics which will be taken forward by the SMF Health Project.

3 CONCEPTS OF GOVERNANCE, REGULATION AND ACCOUNTABILITY

STRUCTURAL ARRANGEMENTS

International health systems have evolved as a result of very different cultural and economic pressures. In some countries the state has played a major part in both the financing and delivery of health services. In others, the state has taken a lesser part, leaving its health system to be run predominantly by self-regulating associations of insurers and providers. The OECD has classified international health systems according to the nature of their financing and the status of the public sector in the provision of services.³ It distinguishes funding systems as belonging to one of three categories:

- private health insurance, covering individuals and groups and setting premiums on the basis of their risk characteristics;
- social insurance systems, which are based on statutory sickness funds and are regulated by government, and which have a greater capacity to pool risk in the fund;
- tax financing.

The only other possible source of revenue is out-of-pocket payments by patients.

Arrangements for the supply of medical services can be thought of in terms of *reimbursement*, *contract* and *integrated* models. In reimbursement systems, providers are funded retrospectively for services, either directly by patients (who recover their costs wholly or in part from their insurers) or by the insurers (with patients receiving benefits in kind). An approach based on explicit contracts between payers and providers, whereby patients receive benefits-in-kind in return for their insurance payments, gives payers a degree of control over the level and distribution of funding (although practice varies considerably). However, in these systems, the degree to which patients have a choice of providers has an important bearing on how funds are

3 E. Docteur and H. Oxley, "Health care systems, lessons from the reform experience," *OECD Working Paper 9* (Paris: OECD, 2003).

distributed between providers and hence how supply arrangements develop. In integrated systems, the same organisation – usually central or local government – directly controls both the funding and the provision of services.

In practice, health systems tend to be a composite of these different characteristics, which give rise to a diverse mix of public, quasi-public, statutorily-regulated private, private non-profit and private profit-making bodies in international health systems. These different models imply very different structures and processes of overall authority and decision-making. The way in which the NHS has evolved structurally from an integrated to a contractual model of organisation is explored further below. The introduction into the NHS of patient choice of providers, how this is driving the use of services and the role of GPs in relation to commissioners (purchasers) of services is questioned further in Background Paper 3. The introduction into the NHS of private providers alongside NHS trusts and foundation trusts is considered in Background Paper 4.

DECENTRALISATION

A major theme in decisions about relationships between stakeholders is that of decentralisation. The WHO defines decentralisation 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 from higher to lower levels of government).”⁴ It distinguishes four main concepts of decentralisation:

1. *Deconcentration*, where administrative (but not political) responsibilities within the existing structure of central government are transferred to lower levels (e.g. to regional offices of central government ministries).
2. *Devolution*, where functions are carried out by a sub-national level of government which is substantially independent of the national government (e.g. regional or local government).

4 “European health care reform analysis of current strategies,” *WHO Regional Publications European Series* 72 (Copenhagen: WHO, 1997).

3. *Delegation*, namely the transfer to a sub-national authority of the responsibility for planning and implementing decisions without direct supervision by a higher authority.
4. *Privatisation*, which replaces direct authority over decision-making with privately capitalised firms (and which generally implies the greatest need for an accompanying regulatory apparatus).

The WHO points out that none of these four types of decentralization can be found in a "pure form". It uses the example of the replacement of the 14 regional health authorities in England in 1996 by regional offices of the NHS Executive as an apparent move towards decentralisation which, in fact, by strengthening the power of central government, actually recentralised the health service.⁵

The main advantage of decentralisation is seen to be the opportunity for more flexibility in tailoring solutions to local circumstances, compared with centralised authorities, which have been criticised for being cumbersome, remote, inefficient and insensitive to user preferences. On the other hand, the success of decentralisation depends heavily on the strength, competence and accountability of the devolved authorities. Borgenhammer has identified the following requirements for successful decentralisation:⁶

- sufficient local administrative and managerial capacity;
- ideological certainty in implementation of tasks;
- readiness to accept several interpretations of one problem;
- readiness to change organisational structures.

5 Ibid.

6 E. Borgenhammer, *Looking After Life: Organisation, Ethics, Quality* (Stockholm: SNS Förlag, 1993).

In addition, decentralising to too-local a level risks fragmenting provision into inefficient operating units. Key questions relating to decentralisation include:

- to which level should a particular function be decentralised?
- to whom should authority be decentralised? and
- what tasks should be decentralised?

These themes are explored further later in this paper in relation to possible future changes in the governance of the NHS, and in relation to commissioning and targets in Background Paper 3.

As the issue of decentralisation features so prominently in discussion about future governance arrangements for the NHS, the SMF Health Project will pursue this issue in more detail in the next stage of its research.

ACCOUNTABILITY AND REGULATION

The WHO has identified five possible forms of accountability in healthcare delivery, namely: ethical, professional, legal, political and financial. It distinguishes four main models of regulation:

1. The *technocratic* model, in which trained “experts” guide the system, by virtue of their specialised knowledge, and are given a dominant position in decision-making.
2. The *professional, self-regulatory* model has clinicians at the heart of decision-making and resource utilisation. In this model, in the absence of any real legal framework, limits and accountabilities are established by the medical profession itself, by means of codes of practice and ethics, education and training, and expectations of standards..

3. The *market* model affirms the autonomy of competing markets in accordance with supply and demand and implies minimal government intervention. However, there is extensive market failure in healthcare markets, due to externalities, third-party payments, asymmetries of information and supplier-induced demand. In practice, therefore, government regulation of quasi-markets in health is necessarily extensive.
4. The *democratic* model links the population, directly or indirectly, into the process of health services planning and delivery.⁷

These themes are all explored in more detail in the background papers in this series: later in this paper, in the discussion of the overall rise in regulation in the NHS since its founding, particularly in relation to clinical practice; in Background Paper 3, which considers the use of targets and the creation of formal institutions for promulgating guidelines and best practice; and in Paper 5, which looks at the rise of participative democratic ways of involving the public in health policy decision-making.

The question of how the NHS should be regulated and be made accountable in the future are also key issues, and the SMF will take these forward into the next stage of research.

EMPOWERMENT, RIGHTS AND CHOICE

Closely associated with accountability and regulation is the question of public and patient empowerment, which includes opportunities for the public and patients to have a bigger say in logistical matters (such as choice of doctor and hospital) and in clinical matters (such as participating in elective medical decision-making). It may extend to asking the public and communities about explicit rationing decisions (see below).

7 *European health care reform analysis of current strategies.*



European countries have taken very different stances on the participation of patients and the public in decision-making, ranging from the automatic inclusion of citizens in hospital boards (Finland), to the establishment of patient councils and tribunals (UK and Italy) to a definition of patients' rights in law (Finland and the Netherlands).

These important issues of patient empowerment and choice are extensively discussed in Background Paper 5, along with further research suggestions.

4 ENTITLEMENT AND RESOURCE ALLOCATION

RATIONING

The subject of entitlement to healthcare is closely related to rationing. It is also relevant to cost-containment and demand management. Both issues are considered further below, and are also dealt with in Background Papers 3 and 4, which explore commissioning in the NHS and the role of GPs as gatekeepers, respectively.

Implicit or explicit rationing?

Rationing refers to the very many types of decisions that have to be made about the allocation of scarce financial resources to healthcare. In its most visible form, it refers to questions about what medical services to fund from the public purse and the terms on which patients can access them. Some of these decisions, particularly those that relate to health services that have to be planned on a strategic (regional, or national) basis, are taken as a result of explicit, sometimes consultative, planning exercises. Traditionally, however, many micro-level decisions result from individual consultations between patients and clinicians, with few, if any, overarching guidelines (although the extent to which individual clinical practice is subject to protocols is now changing).⁸ Although an implicit approach allows for flexibility in the allocation of resources, it has been criticised for leading to conflicting, inefficient and ineffective rationing decisions. Critics also state that implicit systems fail to honour the principles of democratic accountability.⁹

Explicit prioritisation, on the other hand, occurs when priorities, particularly about what services to fund, are set in a clear and transparent way, in accordance with an acknowledged set of criteria. Advocates argue that prioritisation carried out in this manner improves decision-making and accountability. However, it is pointed out by some that explicit healthcare rationing is both politically and practically difficult, and is too inflexible to adapt to the different contexts in which health interventions are offered. There are no readily available “tool kits” for making decisions about service priorities, particularly where basic questions are being asked about what services to include or exclude from a basic package of care. In order to illustrate some of

8 National Health Committee, *Prioritising Health Services: A Background Paper for the National Health Committee* (Wellington: National Health Committee, 2004).

9 Ibid.

the difficulties and pitfalls of these exercises, a number of the most well-known examples of rationing models are described in the Annex at the end of this paper. The role of the National Institute for Health and Clinical Excellence (NICE) is evaluated further in Background Paper 3.

Internationally, health systems differ as to the degree of detail with which they specify what patients are entitled to receive by way of public healthcare, the amounts of care they can expect to receive, and the terms of their access to this care (for example, waiting times and levels of co-payments). They also vary as to whether these entitlement and access conditions are formally enshrined in statute. The NHS has no formal, statutory system of specified entitlements, as a succession of legal cases have demonstrated during its history,¹⁰ although we discuss below whether it is time for the NHS to adopt a core package of services.

FUNDING SERVICES

Cost-containment

As described above, funding for health systems may come from a number of sources: out-of-pocket payments by patients, private or statutory subscriptions to insurance schemes, or from general taxation. Since funding in public schemes represents a form of taxation, the ability to contain costs is an important feature of such systems, and was a leading consideration when healthcare reform schemes were introduced in the 1980s and 1990s. Cost-containment initiatives can operate on demand, principally by extending cost-sharing to patients, or through supply-side measures. Examples of supply-oriented cost-containment measures include gatekeeping arrangements for referral to secondary care, which is the most expensive component of healthcare use, expenditure ceilings and global budgets, reducing doctors' working hours, controlling

¹⁰ See, e.g. *Regina vs Cambridge Health Authority ex parte B (A minor)* 1995 EWCA Civ 43 (10 March 1995).

the introduction and use of expensive medical equipment and monitoring the use of resources by doctors (for example, by instituting controls on prescribing practices and pharmaceutical prices).

Cost-sharing schemes may include deductibles (equivalent to a fixed excess on an insurance policy), a co-payment or co-insurance.

Co-payments

The economic rationale for co-payment is to make patients more aware of the cost of the care they consume, thereby reducing demand. Whether this actually happens depends both on the sensitivity of demand for healthcare with respect to its price, and the extent of supplier-induced demand which may compensate for any change in behaviour by patients. For both these reasons, co-payments are generally regarded as a less effective way of containing costs than measures to restrict the supply of healthcare; they also have an impact on equity, unless there are compensating measures to address their impact on the less well-off.

Co-payments are also seen as a possible means of generating revenue. However, whether they do so will depend on the response of patients. If patients are deterred from seeking medical care because of charges, this will have no effect on revenue-generation. Despite the somewhat weak arguments in their favour, co-payments are used extensively in healthcare systems, particularly for sharing the cost of pharmaceuticals.¹¹

CONTRACTING FORMS, PAYMENT MECHANISMS AND INCENTIVE STRUCTURES

The recent move away from integrated models of service planning and delivery in West European countries has given rise to a new interest in contracting in its various forms. Insurance-based health systems have had contracts between third-party payers and health service providers for many years, although these have been mainly coordinating mechanisms. In tax-based systems, the introduction of contracting has been based more on an expectation that this would

11 The SMF has extensively researched co-payments in Jessica Asato (ed.), *Charging Ahead? Spreading the Costs of Modern Public Services* (London: SMF, 2006).

result in negotiations on price and quality of care. In competitive markets, contracts may be the outcome of informed choice between competing providers.

The flexibility and impact of contracting depends very much on the type of contract deployed. Block contracts are like a budget for a generally defined service, whereas cost and volume contracts relate more explicitly to the services to be provided (e.g., by specifying the number of patients to be treated in a particular speciality). A cost-per-case contract sets reimbursement for each item of service. Generally speaking, the better specified the contracting process, the more extensive are the information and transaction processes required to support it.

As is implied by this, payment mechanisms can also vary widely, and have potentially very different incentive affects depending on which is chosen. Primary care physicians can be remunerated on the basis of salary, fee-for-service (a form of retrospective payment) or capitation systems (a prospective payments method). The first method is clearly unrelated to clinical workload. The second remunerates work undertaken, while the third is related to the number of patients on a list. Consequently, retrospective, fee-for-service methods of payment tend to incentivise delivery of higher treatment intensity, while prospective, capitation-based methods contain better incentives to economise on care, although by the same token they may reduce the quality of care provided. Attempts to reduce these two perverse incentives in each reimbursement mechanism, so as to control total costs at the same time as preserving acceptable quality of care (the "transformation problem"), dominate discussion of healthcare policy priorities. Generally, most health systems adopt mixed systems, relying on selective fee-for-service contracting to deliver particular service priorities. However, the outcome of these has been found to be uncertain and difficult to predict.¹²

The acute hospital system typically accounts for a major component of health expenditure. Consequently, in a cost-constrained environment, there is legitimate interest in attempts to improve the efficiency of resource-use in the hospital sector. One area of particular interest concerns the way in which hospital services are paid for.

12 *European health care reform analysis of current strategies.*

Like individual physicians, hospitals can be reimbursed (prospectively or retrospectively) for the volume of actual services provided (for example, on a per diem rate, or by the type and severity of case treated). Or they can be reimbursed prospectively via global budgets for a given time period. These payments may result either from direct budgeting or from a contracting system. They have the same in-built incentives as the reimbursement methods used for individual physicians.

Classification of hospital financing mechanisms can be found in a number of sources. In "Hospital financing in selected member states of the European Union", Miriam Wiley identified three main groups of EU countries according to financing source:¹³

- decentralised, tax-financed health systems, predominantly the Nordic countries, including Denmark, Sweden and Finland;
- countries maintaining social insurance systems, namely Austria, Belgium, France, Germany and the Netherlands;
- countries with centralized, tax-financed health funding, including England, Ireland, Italy, Portugal and Spain.

Within these various models, Wiley identified two main hospital funding mechanisms, which she described as "prospective budgeting" and "service-based" approaches. Notwithstanding the differences in their main sources of overall financing, within the 13 countries she considered, 9 had adopted a form of prospective budgeting, and the remainder a "service-based" approach.

In a prospective budgeting system, total financing levels for service provision are determined in advance, for a pre-defined

13 Miriam Wiley, "Hospital financing in selected member states of the European Union," in Ed Leidl (ed.), *Health Care and its Financing in the Single European Market* (Amsterdam: IOS Press, 1998).

period. This applies irrespective of the financing source (tax or social insurance). What differentiates systems of prospective budgeting is the way they specify how hospital outputs are to be achieved, given the available level of financing. There is a range of systems in use:

1. A hospital is given a global budget, determined on a historical basis, with adjustments for relative price increases. Such a system is very effective at cost-containment, but adjustments need to be made to provide greater flexibility when pursuing broader health system objectives, such as activity or efficiency targets.
2. Prospective budgeting systems adjust for activity, for example by dividing the budget by the expected number of patients, to obtain a per diem payment, which may be supplemented by special fees or by rates based on casemix.
3. A casemix-adjusted payments system, usually based on Diagnosis-Related Groups (DRGs), or their equivalent. DRG-type classifications group patients according to the type and degree of treatment provided; hospitals are then remunerated more directly on the basis of the type of patients they actually treat. An activity-based payments system using DRGs was first developed in the US in 1983 to pay hospitals under the Medicare Programme. The first European experiment in this form of hospital budgeting was in Portugal, followed by Ireland, which set hospital budgets on an estimation of relative costs (which are assumed to proxy relative efficiency). In Italy, by contrast, reforms in 1995 shifted service payments to a tariff basis. For hospital services, tariffs based on DRGs were set on a prospective basis within predetermined budget constraints. In Belgium, a simple per diem price, derived by dividing the hospital budget by projected annual bed-days (assuming 80% occupancy), was supplemented in 1994 by the introduction of All Patient DRGs. These were integrated into the financing system in order to standardize length of stay comparisons by relative morbidity, as a result of which hospital budgets could be adjusted by significant amounts. Similarly, in 1996 France moved from a hospital-financing system of prospective global budgets, based on historical expenditures and designed to cover operating costs, to a system designed to depend

increasingly on DRG-based adjustments. In all, more than 20 healthcare systems in Europe, Australia, Asia and Africa have adopted similar, DRG-based hospital financing mechanisms.

In contrast to these systems of prospective budgeting, other European countries have relied on more open-ended approaches, which remunerate the actual services delivered. For example, Austria and Finland both financed hospital care on the basis of length of stay (until Finland moved to a more heterogeneous system in which cost and volume contracts came to be used). Hence, the total service cost and the time period may both be open-ended and may contain perverse incentives for efficiency (i.e. may incentivise longer lengths of stay). This is difficult for cost-containment, but does offer opportunities to encourage the delivery of particular types of care.

In England, the reforms advocated in the 1991 document, *Working for Patients*, marked a shift from budgeting for hospital services to the use of contracting.¹⁴ In theory, all contractual models – whether block contracts, cost and volume contracts, or cost-per-case contracts – were possible, although in practice most District Health Authorities (DHAs) relied on block contracts, which were like prospective budgets. More recently, however, England introduced a system of Payment by Results, a prospective payment system based on a health resource groups (HRG) casemix measurement, which are priced nationally according to a national tariff.

In view of the importance of hospital payments systems, the SMF will undertake further research into the implications of introducing Payment by Results.

14 Department of Health, *Working for Patients*, Cm. 555



5 MEASURING PERFORMANCE: EQUITY, QUALITY AND PRODUCTIVITY

Performance measures in health systems can take many forms. Later in this paper (chapter 6), we discuss the increasing trends towards explicit external regulation of healthcare delivery at all levels. Background Paper 3 also looks at the detailed performance target structure which has been in place in the English NHS in recent years, including responsiveness of the service as encapsulated in waiting time targets. It also looks at the arrangements in place for evaluating health technologies, particularly the guidelines of the National Institution for Health and Clinical Excellence (NICE). The following section is devoted to a discussion of high-level objectives of health systems, namely equity of access – equal treatment for equal need – delivery of high-quality healthcare and long-term productivity.

EQUITY IN HEALTHCARE SYSTEMS

The *raison d'être* of publicly funded healthcare systems is to ensure equitable distribution of healthcare. Equity has a number of different dimensions. First, it refers to the extent to which an entire population is eligible to receive publicly funded healthcare; with a few notable exceptions, most European and OECD countries have achieved a very high degree of (near to universal) population coverage. Second, equity also encompasses the concept of equitable distribution of available funding over geographical areas and social groups. Finally, there is the question of equitable access to healthcare services. When considering this, it is usual to distinguish between “vertical equity” – the differential utilisation of healthcare resources across individuals in different states of need (which is usually simply assumed to be satisfied) – and “horizontal equity”, namely equality of access to healthcare resources for those in equal need, regardless of income, race, place of residence, etc. (For those health systems which, for example, only aim to equalise access for the lower-income parts of their population, or which offer

options for topping up general public cover with complementary or supplementary private cover, this yardstick obviously does not apply to the same extent).

Work done by the OECD to investigate horizontal equity has looked at econometric evidence on a cross-country basis.¹⁵ Typically, poorer individuals will consume more healthcare resources because of their lower health status, and so have a greater need for healthcare. Such inequality is clearly not inequitable. To measure inequity, inequality in utilisation of healthcare has to be standardised for differences in need. After standardising, any residual inequality in utilisation by income can be interpreted as horizontal inequity, which could be either pro-rich or pro-poor.

The OECD study attempted to determine possible sources of inequity per country. This revealed that income itself is not the only factor leading to income-related patterns of use. In many instances, education turned out to be an important contributor to a pro-rich distribution, while work activity status often contributes to a more pro-poor distribution. Other determinants of total country utilisation include regional discrepancies and, as indicated at the outset of this discussion, the terms of health insurance coverage.

The study notes that the available survey data limit discussion of the topic to differences in quantity of use, and offer no possibility of accounting for potential differentials in quality. This could be extended to include timeliness of care: an under-researched question is whether income-related inequities exist with respect to the time spent waiting for proper care. Another way of extending the scope of this work, and obtaining greater comparability of need, would be by focusing attention on specific treatments for specific sub-populations (e.g. the pregnant, the chronically ill, etc.). A final question relates to whether, and to what extent, inequities in diagnostic and therapeutic usage also translate into inequities in health outcomes.

15 E. Van Doorslaer and C. Masseria, "Income-related inequality in the use of medical care in 21 OECD countries," OECD Health Equity Research Group Members, *OECD Health Working Paper 14* (Paris: OECD, 2004).

Equity is a fundamental concept underlying publicly funded healthcare systems, but is often difficult to deliver, and may be undermined by conflicting policies (such as decentralisation). The SMF Health Project will consider further what is considered fair in the modern NHS, what are the public's margins of tolerance and how this might affect the organisation and delivery of healthcare in the future.

QUALITY AND OUTCOMES

The classic statement of analysis of quality of medical care is to be found in Avedis Donabedian's "Evaluating the quality of medical care."¹⁶ He describes the quality of medical care as "a remarkably difficult notion to define", and quotes Klein et al. as having concluded that patient care, like morale, cannot be considered as a unitary concept and that "it seems likely that there will never be a single comprehensive criterion by which to measure the quality of patient care."¹⁷

Donabedian's contribution to the debate was to distinguish three separate modalities of measuring quality of medical care. First is the assessment of outcomes, which is about the recovery of function and of survival after receiving medical care. Second is the notion of medical care as a process, which is to do with whether what is known to be "good" medical care has been applied and properly practised. Finally, he distinguished settings in which care takes place – what he described as the assessment of structure (for example, the adequacy of facilities and equipment, the qualifications of medical staff and their organisation, the administrative structure and operations of programmes). The implicit justification for looking at settings of care is that, given the proper settings and instrumentalities, good medical care will follow.

Much of what Donabedian subsequently discussed in his seminal paper relates to the practical difficulties of measurement – for example, the difficulty of accessing medical records for research purposes, and the completeness and accuracy of such records. However, more difficult

16 Avedis Donabedian, "Evaluating the quality of medical care", *The Millbank Memorial Fund Quarterly* 44, no. 3 (1966).

17 Rudolph Klein et al. "Problems of measuring patient care in the out patient department," *Journal of Health and Human Behaviour* 2 (1961), 138–44.

conceptual issues arise too – namely, that the relationship between structure and process and outcomes is not well established. In the case of outcomes, although there is a range of possible measures available (for example, perinatal mortality, surgical fatality rates), the definition of a “good” outcome is itself subject to interpretation and value judgements, based on circumstances. Another problem, discussed below, is that the relationship between medical care and outcomes is difficult to determine precisely, and many factors other than medical care may influence outcomes and health status. A third is that the application of medicine is frequently about probability of outcomes, and results are subject to uncertainty. In some cases, outcomes may only be known after a long time lapse. Finally, biomedical “success” has to be weighed in the balance with a range of other pertinent factors such as patient attitudes and satisfaction. Consequently, although use of outcomes as a criterion of good medical care is the ultimate goal, they must be used with care.

The contribution of healthcare to health outcomes

There is a long-term trend of significant improvements in many population health indicators. For example, infant mortality in England fell from 12 per 1,000 live births in 1980 to 5 in 2004. Life expectancy rose from 76 per 1,000 for women and 71 for men in 1981, to 80 for women and 76 for men in 2001.¹⁸

However, only some of these overall improvements in health outcomes will be a result of healthcare. For example, while part of the fall in infant mortality could be attributed to factors such as better antenatal care and improved and extended vaccination programmes, health outcomes are also affected by factors largely outside the control of the NHS, such as housing, education and the environment. In practice, it is difficult to isolate the impact of the NHS on health outcomes from these other factors. There can also be a long time lag between policy changes and changes in, for example, life expectancy.

¹⁸ Office of National Statistics Life Expectancy Statistics: www.statistics.gov.uk.

McKeown has suggested that three-quarters of the decline in mortality in England and Wales between 1841 and 1971 was due to a reduction in deaths from infectious diseases and that three-quarters of this reduction preceded the widespread introduction of immunisation or antibiotics. He argued that the main drivers of improvements in health were nutrition, environment and behaviour.¹⁹

In addition to the problem that it is difficult to isolate the impact of the NHS from other societal factors on health outcomes, some commentators have even suggested that there is an inverse association, with greater healthcare resources leading to worse overall health. This view is particularly associated with Ivan Illich, who has pointed to the problem of iatrogenic illnesses, adverse drug reactions, hospital acquired infections and poorly performed surgery.²⁰ Somewhere in between these extremes are those who argue that increased expenditure on health systems does not have an obvious impact on high-level measures of health status.

More recently, however, opinion seems to have shifted more in favour of the efficacy of health services as a contributor to population health. Beeson has shown how many treatments advocated in a 1927 textbook of medicine were, by 1980, known to be either ineffective or harmful.²¹ The 1975 edition of this textbook displayed a major shift to treatments that had been proven to be effective. Since then, however, the rate of change has accelerated and many new treatments have been shown, by high-quality evaluation, to be able to prolong life. These include effective treatment for, e.g., hypertension and heart failure, and use of chemotherapy, etc. Much of this is due to the increasing adoption of evidence-based medicine, of which NICE (see Background Paper 3) is the prime exponent.

Recent studies investigating the likely effects of healthcare on population health have adopted the concept of “preventable deaths” or conditions “amenable to medical care”, and have found that deaths due to causes amendable to medical care have tended to fall at a faster rate than other deaths. For example, Mackenbach and colleagues have concluded that the healthcare interventions they studied in the

19 T. McKeown, *The Role of Medicine: Dream Mirage or Nemesis?* (Oxford: Blackwell, 1979).

20 Ivan Illich, *Limits to Medicine* (London: Marion Boyars, 2001).

21 P. B. Beeson, “Changes in medical therapy,” *Medicine* 59 (1980), 79–84.

Netherlands added 2.9 years to life expectancy at birth for men between 1950 and 1984, and 3.9 years for women.²² Velkova and colleagues have estimated that conditions amenable to healthcare in the former communist countries of Central and Eastern Europe accounted for 24% of the gap in male life expectancy between birth and age 75 in 1998, and 39% for females.²³

An increasing number of studies track trends relating to specific medical problems or interventions. Boyle and colleagues found that deaths from surgery to treat benign prostatic hypertrophy fell in many countries between 1950 and 1990, the improvements being much greater in Northern Europe and North America than in Central and Eastern Europe and South America.²⁴ Death rates from childhood cancers for which effective treatments are now available have decreased in most European countries.

Quality indicators

In recent years the OECD has attempted to collect internationally comparable data reflecting the health outcomes/improvements attributable to medical care in its Health Care Quality Indicators Project and has proposed the following categories as an initial dataset:

- breast cancer survival
- mammography screening
- cervical cancer survival
- cervical cancer screening
- colorectal cancer survival
- incidence of vaccine preventable diseases
- coverage for basic vaccination

22 J. P. Mackenbach, "The contribution of medical care to mortality decline", *Journal of Clinical Epidemiology* 49 (1996), 1207–13

23 A. Velkova, J. H. Wolleswinkel-van den Bosch and J. P. Mackenbach, "The east–west life expectancy gap: differences in mortality from conditions amenable to medical intervention," *International Journal of Epidemiology* 26, 1997, 75–84.

24 P. Boyle, P. Maisonneuve and A. Steg, "Decrease in mortality from benign prostatic hyperplasia: a major unheralded health triumph," *Journal of Urology* 155, 176–80.

- asthma mortality rate
- AMI 30-day case fatality rate
- stroke 30-day case fatality rate
- waiting time for femur fracture surgery
- influenza vaccination for adults over 65
- smoking rates

Future work will focus on patient safety , quality of mental-health care, health promotion, prevention and primary care diabetes and cardiac care.²⁵

In England, many different outcome measures are used in research, both generic and disease-specific, but none is collected routinely. Following the publication in 2007 of its "Standard NHS contract for acute hospital services", the Department of Health announced that from April 2009 providers must record patient-reported outcome measures for primary unilateral hip-replacement, primary unilateral knee-replacement, groin hernia repair and varicose vein procedures.²⁶

A recent report by the Office of Health Economics (OHE) Commission considers the possibility of using disaggregated measures of health outcomes, although such an approach is still in its infancy.²⁷ The OHE Commission considered four "tracer" disease areas to cover acute and long-term conditions, primary and secondary care, and life-extending and life-improving care, namely: elective surgery, mental health, chronic obstructive pulmonary disease and colorectal cancer.

25 <http://www.oecd.org/health/hcqi>

26 www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_081100.

27 Office of Health Economics, *Report by the Office of Health Economics Commission on NHS Outcomes, Performance and Productivity* (Paris: OHE, 2008).

The OHE Commission recommends that routine collection and use of outcome measures is essential and would lead to improved outcomes, performance and productivity. The Commission comments:

it is reasonable to expect that within 5 years [from now] outcomes data are collected for the majority of NHS activity and that within 10 years it would be the exception rather than the rule to find an area of the NHS which lacked routine measures of the impact of an intervention on patients in terms of their survival, quality of life and experiences of care.²⁸

It recommends that these measures should be fully integrated into the monitoring and inspection frameworks, as well as being used to inform the commissioning process.

In addition to measures of improved health, the OHE Commission notes that patients have expectations over and above getting better. These relate to the speed of access which they experience to receive care, and also to the quality of the process of care-giving. Another recommendation, therefore, is that data should be collected on the wider patient experience, covering aspects such as access, care coordination, autonomy, choice, communication, confidentiality, dignity, quality of amenities and support for carers.

EFFICIENCY

Efficiency has two main dimensions. Allocative efficiency concerns the deployment of resources in cost-effective ways. As research into healthcare interventions has increasingly led to queries about the efficacy of some treatments, so there have been more explicit attempts to divert resources to more cost-effective treatments.

Technical efficiency refers to the ability to deliver healthcare at minimum cost. Usually the focus is on hospital costs, since these represent such a high proportion of overall health system costs. For example, the trend towards day-case procedures and away

28 Ibid

from inpatient elective care, and the resulting fall in length of stay, represents an important source of reduced costs/improved efficiency in the hospital sector.

PRODUCTIVITY

Productivity is the ratio of a measure of total health services outputs to a measure of total inputs; and *productivity growth*, which measures a change in output relative to a change in inputs. It is usually interpreted as reflecting the impact of technical change on healthcare.

Chapter 6 considers recent evidence on productivity growth in the NHS; that is to say, the rate at which NHS outputs have increased relative to increases in inputs over a period of time. However, it is important to note that negative productivity growth, when expanding an existing service, may imply neither inefficiency nor a failure to secure value for money, but may simply be a reflection of diminishing returns to technology change.



6 HISTORY AND REFORM IN THE NHS

STRUCTURES AND GOVERNANCE

Prior to 1948, there was statutory provision for only limited health insurance in England, which gave only manual workers access to general practitioner services (excluding even their families). Hospital care was provided by municipal and voluntary institutions on the basis of charging those who could afford to pay and giving free care to those who could not. Quality of care was highly variable and access heavily skewed to where hospital consultants were prepared to live and work.

Faced with the need for reform, policy-makers confronted a number of options. One, which involved a more individualistic model emphasising the right of the individual to care, was to extend the Lloyd George insurance-based model, imported from Bismarck's Germany. This model was the one adopted by nearly all other Western societies in the post-war period (as well as more recently by most newly acceded EU countries). It was the solution advocated by the British Medical Association (BMA) in the 1930s. The alternative, more collectivist, model was that of a public health service whereby public authorities would make provision for the healthcare of the population. Two variants of the latter theme were discussed. One was to develop the existing arrangements whereby local government already provided healthcare ranging from curative care in hospitals, to chronic care for the elderly and mentally ill, to maternity and child health clinics – and would in future employ general practitioners and hospital doctors. However, the opposition of the BMA to this option determined that it was never adopted. A possible sub-variation of this theme was the creation of joint regional board and district committees, which would be responsible for planning both municipal and voluntary hospitals – the latter, it is worth noting, in a contractual relationship with the joint authorities. The alternative, which was eventually adopted, was that the hospitals of England and Wales would become a National Health Service, administered from the centre by the Ministry of Health.

Consequently, the NHS started life as a tax-financed, integrated, deconstructed system of healthcare delivery, although it has evolved considerably since its inception in 1948, and is now a tax-financed, quasi-market-based contractual system. In 1948, a network of 700 different authorities was set up, comprising regional hospital boards, boards of governors of teaching hospitals, hospital management committees and executive councils.

After a relatively stable period of consolidation, it came to be felt that the original structures of the NHS needed reform, partly to address the problem of the separation of hospital, general practitioner and local authority services, but also to provide an appropriate administrative machinery for implementing more systematic planning within the system. This led to a significant overhaul of the founding institutions in 1974, when the old structures gave way to 15 regional health authorities, 90 area health authorities, each with a linked family practitioner committee which administered GPs, and 200 district management teams, each with a community health council which, for the first time, incorporated the voice of patients and patient groups. On the finance side, the period saw a gradual movement towards a more systematic treatment of devolved budgets, which were increasingly shared out on formulaic terms designed to improve equitable distribution both of resources and of strategic service planning. Part of the thinking in the 1974 reforms was the notion that boundaries drawn up for different health service areas could become coterminous with those of local authorities, reverting to a theme which had always been evident in the run-up to the creation of the NHS, but which had not been taken any further.

In the event, the 1974 reorganisation was widely agreed to be too elaborate and bureaucratic and only lasted until 1982, when the central tier of area health authorities was abolished, to be replaced by district health authorities.²⁹

Another significant date, 1983, saw the introduction of a new ethos of general management into the NHS, following the inquiry led by Sir Roy Griffiths.³⁰ The Griffiths Report was the precursor to perhaps the most significant conceptual shift in NHS reform in 1991, the creation

29 Department of Health, *Patients First* (London: HMSO, 1979).

30 Roy Griffiths, *The NHS Management Inquiry* (London: HMSO, 1983).

of a quasi-market, with the introduction of a split between purchasers (health authorities) and independent service providers in the form of newly created hospital trusts.

The introduction of a quasi-market system of healthcare delivery, following the *Working for Patients* White Paper of 1989,³¹ was by far the most radical departure from the original concept of the NHS. District health authorities became “purchasers” (later “commissioners”) of healthcare, alongside those GP practices which opted to become fundholders. Healthcare was thenceforth to be delivered by contracts established between purchasers and (in theory at least) newly established provider trusts competing with one another, on price, for the work. One implication of the move to contracts was that choice of provider became more restricted than hitherto, in favour of providers with which the health authority actually had contracts. In practice, however, for reasons of cost and to protect local sources of supply, health authorities maintained block contracts with local providers and, generally, competition did not occur.

Although abolished by New Labour when it came to power in 1997, a form of market-based healthcare delivery has since been reintroduced. The New Labour version of the quasi-market is based on patient choice of provider and payment by results, essentially a national tariff of HRG prices, derived from average national hospital costs. Payments follow patients, who in theory choose between providers on the basis of quality. Provision by NHS trusts and foundation trusts is supplemented by independent sector treatment centres (ISTCs).

Whether patients will shop around for services any more than health authorities did after 1991 remains to be seen. In addition, patient choice of provider sits alongside practice-based commissioning and ongoing commissioning by primary care trusts (PCTs), and it is as yet unclear how these respective roles will work, or what their overall effect will be.

31 Department of Health, *Working for Patients*.



PERFORMANCE-MANAGEMENT AND REGULATION

When the NHS was first established, central government had little or no prior experience of running a national hospital service, particularly in peacetime conditions. In the early years, the relationship between the centre and the front-line services was largely confined to very specific issues of national interest such as pay and conditions of service, advisory circulars about possible patterns of service-provision and technical literature about building standards. Generally speaking, during this period the centre felt that it simply did not have enough information at its disposal to do more.

The financial crisis in NHS funding which occurred soon after its establishment, in the late 1940s and early 1950s, led to a fundamental change in financial planning. Whereas the NHS was set up essentially as a demand-led service, with a bottom-up system of generating budgets – demands from local hospital boards – it quickly became a top-down system of dividing out a fixed total and hence of capped budgets for individual authorities. However, hospital spending in this period accounted for only about half of total expenditure on the NHS. The remainder was on general practitioners, pharmaceutical, ophthalmic and dental services, where spending continued to be demand-led and, hence, effectively open-ended until the market reforms of 1991. However, Sir Cyril Jones, appointed in 1950 to review the financial workings of the NHS, challenged even then “the doctor’s right to prescribe for his patient as he wishes.” He argued both that the use of more expensive appliances should be reviewed by lay managers of the service, and that doctors should be excluded from the management authorities of the NHS. This referred to the local executive committees which had been set up in 1948, and which had given doctors a rather stronger representation than under the previous arrangements, the regional hospital boards, whose medical membership averaged about 30% in the mid-1950s, and the hospital management boards where the proportion tended to fluctuate between about 20% and 30%.³²

32 R. Klein, *The New Politics of the NHS*, 5th edn (Radcliffe Publishing, 2006).

In 1961 new machinery for controlling public expenditure was set up – the Public Expenditure Survey Committee – and the era saw the introduction into government of more rational and systematic techniques of planning and measurement. In 1962, *A Hospital Plan for England and Wales* was published³³ – the first attempt since the establishment of the NHS to take an overall view of the hospital service and to bring about a distribution of beds based on centrally determined criteria for matching resources to local needs. A new information system, the Hospital Activity Analysis, was developed, which provided consultants with better information about what they were doing but also had the effect of making their activities more generally transparent.

In 1976, the Department of Health and Social Security (DHSS) had implemented a planning system under which the health authorities were to produce strategic plans, reflecting DHSS guidelines and national priorities as set out in *Priorities for Health and Personal Social Services in England*.³⁴ In 1977, the social services sub-committee of the Public Expenditure Survey Committee urged the DHSS to devise more effective tools for monitoring what was happening in the NHS, arguing that expenditure statistics should be complemented by information about “the adequacy or otherwise of the services provided, in terms either of the availability of facilities for treatment or of standards of care.”³⁵ However, in the absence of any instruments of measurement, its successor body, the Social Services Committee, stressed in 1980 the need for “a comprehensive information system which would permit this Committee and the public to assess the effects of changes in expenditure levels or patterns on the quality and scope of services provided.”³⁶

By the 1980s, it had become imperative to control the seemingly inexorable rise of demand in the primary care sector, not least on the drugs budget. A surprise initiative of the Social Services Committee in November 1984 was the introduction of a limited list of medicines, which also marked an unprecedented failure in the history of the

33 Ministry of Health, *A Hospital Plan for England and Wales* (London: HMSO, 1962).

34 Department of Health and Social Security, *Priorities for Health and Personal Social Services in England* (London: HMSO, 1976).

35 Expenditure Committee, Ninth report, Session 1876–1977, *Spending on the Health and Personal Social Services* (London: HMSO, 1977).

36 Social Services Committee, Third Report, Session 1979–80 (London: HMSO, 1980).

NHS to consult the medical profession on a major item of policy.³⁷ Further proposals for increasing central control over spending in primary care were mooted, but were eventually overtaken by the 1989 White Paper, *Working for Patients*.³⁸ This introduced cash limits into the family practitioner services budgets in the form of indicative prescribing budgets for all, and GP fundholding for those who opted for it, alongside the imposition in 1990 of a new GP contract which laid down in considerable detail what GPs were supposed to do. At the same time, family practitioner committees, which had formerly had a largely passive attitude towards general practice, became family health services associations (FHSAs). FHSAs had statutory responsibilities for actively policing the GP contract, and set up as small managerial (rather than representative) bodies with only one GP member who was appointed by the regional health authority and served in a personal, rather than a representative, capacity.

In 1983, the Financial Management Initiative (FMI)³⁹ was introduced into central government. The FMI required all government programmes to have explicitly stated objectives and performance measurements, by means of which progress towards goals could be measured. The FMI resulted in the creation of performance indicators (PIs) throughout the public sector, an initiative made possible by the development and explosion in availability of information technology. The growth in PIs has accompanied the transformation of the welfare state into the “regulatory state”, with increasing emphasis on government not as a provider of services, but as a regulator of services provided by others. In the NHS, the advent of PIs was accompanied by the introduction of an annual performance review – a tighter system of control and accountability than had ever existed in its history. At the same time, the PIs heralded a change from the language of norms and inputs to the language of activity and outputs: for example, increases in the numbers of hip-replacements, or coronary artery bypass grafts, to be achieved within certain time limits.

37 Department of Health and Social Security, *Prevention and Health: Everybody's Business* (London: HMSO, 1976).

38 Department of Health, *Working for Patients*, Cm. 555.

39 Prime Minister and Chancellor of the Exchequer, *Financial Management in Government Departments* (London: HMSO, 1983).

In the same year, 1983, the Griffiths Report was published, and with it the introduction of a new culture of managerialism into the NHS.⁴⁰ At the top was to be a Supervisory Board, to set objectives, take strategic decisions and receive reports on performance. Within the Department of Health, there was to be a chief executive, responsible for implementing policy. At local level, general managers were to take charge of health authorities. The logic of managerialism was further extended with the introduction of the internal market into the NHS in 1991.⁴¹ Essentially, these reforms were about the transformation of an organisation based on trust into an organisation based on contract: from one based on profession-dominated values, to one based on managerial values.

At the same time, the traditional right of individual doctors to determine which patients to treat and how was being challenged both by the development of formal techniques for evaluating the cost-effectiveness of clinical care – and hence determining priorities by objective and external means (see Background Paper 3 on the establishment of NICE) – and by medical audit,⁴² which evaluated the cost-effectiveness of clinical practice. The issue of variations in care – differences in prescribing and referral patterns between individual clinicians which were sometimes dramatic in scale – had already begun to be documented, and questions asked about the effectiveness of many medical interventions.⁴³

Several high-profile events contributed to the movement to provide increasing scrutiny of clinical practice, including a highly publicised case involving the deaths of 15 small children and babies in a cardiac surgical department in Bristol,⁴⁴ and the conviction of Dr Harold Shipman, GP, of murdering 15 of his elderly patients, with very many more suspected victims. The immediate result of the Bristol case was the establishment of a system of clinical governance which exposed the performance of doctors to an unprecedented level of professional scrutiny. All trusts were charged with setting up a system

40 Griffiths, *The NHS Management Inquiry*.

41 Department of Health, *Working for Patients*, Cm. 555

42 See, e.g. www.healthcarecommission.org.uk/serviceproviderinformation/nationalclinicalaudit.cfm

43 See e.g. John Wennberg, "Unwarranted variations in healthcare delivery: implications for academic medical centres," *BMJ* 324 (2002), 961–4.

44 HMSO, *Learning from Bristol: The Report of the Public Inquiry into Children's Heart Surgery at The Bristol Royal Infirmary 1984–1995* (London: HMSO, 2001).

for monitoring standards and identifying poor performance, as well as with implementing the clinical standards of the national service frameworks and the advice of NICE (see Background Paper 3). No longer was participation in clinical audit voluntary.

MONITORING AND INSPECTION

The reform package of 1989 and onward had already granted responsibility to the Audit Commission for scrutinising the activities of both purchasers and providers: an opportunity which the commission, already well entrenched in scrutiny of local government, was not slow to exploit.⁴⁵

The period around and following the Bristol Royal Infirmary inquiry, however, saw the establishment of a number of bodies charged with independent, external regulation of the NHS. The government's immediate response to Bristol was to set up the Commission for Health Improvement (CHI), which had wide powers to monitor how clinical governance was implemented and to carry out investigations into management, provision or quality of healthcare provided by trusts, with every trust being reviewed within four years of its establishment. Subsequently, following completion of the Kennedy review into the Bristol cardiac deaths, the CHI was transformed into the Healthcare Commission, alongside two other new bodies: the National Clinical Assessment Authority, overseeing doctors whose performance was seen as problematic, and the National Patient Safety Agency.

When it was launched, the Healthcare Commission assessed the performance of NHS organisations on the basis of the Performance Assessment Framework (PAF), drawn up in 1998 and implemented in 1999. The PAF comprises a raft of performance measures (37 at its inception in 1998) used to classify all NHS organisations (health authorities and trusts) as 'green', 'yellow' or 'red'. A 'green' rating meant the organisation met all national targets and scored in the top 25% of comparable organisations.

45 www.audit-commission.gov.uk/

A 'yellow' classification meant that the organisation met all or nearly all national targets, but did not score in the top 25%. 'Red' meant that the organisation failed to meet an acceptable number of the targets. Through this schema, the PAF was intended to integrate both absolute standards and relative achievement into its measure of performance.

On the basis of these assessments, the Healthcare Commission awarded star ratings to trusts (one, two or three stars). Moreover, NHS bodies with 'green' ratings earned access to National Performance Fund incentives, along with greater autonomy and less frequent monitoring. 'Yellow'-rated bodies gained access to the same funds, on condition that they submitted an improvement plan to the Healthcare Commission. 'Red' organisations had their share of the same money held by the Modernisation Agency, which allocated it, but with strings attached and subject to close monitoring of performance. Finally, *The NHS Plan*, published in 2000 set out a 'rising scale of intervention',⁴⁶ as part of which the Healthcare Commission can replace managerial staff in poorly performing NHS organisations and even, as a last resort, force the merger or break-up of trusts (allowing the take-over of 'red' trusts by 'green'-rated ones, for example).

As part of the process of creating greater transparency for the public in assessing NHS performance, the Healthcare Commission replaced the star ratings system in 2006 with an "annual health check."⁴⁷ This aims to offer greater breadth of coverage than the previous approach and assesses the organisations as "weak", "fair", "good" or "excellent." This new system is intended to signal something of a shift away from national target-setting mechanisms as part of the government's new "light-touch" strategy, announced by Gordon Brown in his 2005 budget, in order to make NHS trusts first and foremost responsive to the needs of local populations.

CENTRALISM VS LOCALISM

Implicit in the increased tendency of the centre to monitor, regulate and performance-manage the NHS is a debate about the respective roles of the centre versus devolved authorities. It is perhaps worth recalling that

46 Department of Health, *The NHS Plan* (London: HMSO, 2000), 67.

47 Healthcare Commission, *The Annual Health Check in 2006–07: Assessing and Rating the NHS* (London: Commission for Healthcare Audit and Inspection, 2006), 3.

the creation of the NHS was the highly contentious outcome of a long public debate during the inter-war years, which considered a number of competing options and compromises for a British health system. The majority of the most fundamental issues which were debated then have not gone away, but continue to influence the shape of the policy debate today.⁴⁸ A dilemma which continues to haunt debates about the structure and organisation of the NHS is represented by Herbert Morrison, then voice of local government, speaking in 1945:

The Minister of Health is on the horns of a dilemma. If the Regional Boards and District Committees are to be subject to the Minister's directions on all questions of policy, they will be mere creatures of the Ministry of Health, with little vitality of their own. ... Yet it is difficult under a State system to envisage the alternative situation in which, in order to give them vitality, they are left free to spend Exchequer money without the Minister's approval and to pursue policies which at any rate in detail may not be the Minister's, but for which he would presumably be answerable.⁴⁹

Nor did this theme go away. For example, Rudolph Klein writes:

It is not surprising to find, throughout the first decade of the NHS, two contrasting themes running through the debate about relations between the central government department and the peripheral health authorities. From the centre came pressure on the Ministry of Health to exercise stricter control over what was happening at the periphery. Rumbling through successive reports of the Public Accounts and Estimates Committee are demands for stricter central control in the pursuit of national uniformity. ... From the periphery, however, there came complaints that the Ministry of Health was interfering too much: drowning administrators in a stream of circulars.⁵⁰

48 For an excellent account of the history and politics of the NHS, see Klein, *The New Politics of the NHS*, on which the following historical account draws extensively

49 *Ibid.*, 13

50 *Ibid.*, 13

Quite a lot of the history of the NHS since then has been about the tension between devolved responsibility for spending the NHS budget and central accountability of the government to Parliament for its ultimate use. The backdrop to this debate, as discussed in more detail below, has been the evolution of better information systems and performance-management tools, which have fuelled a move away from medical practice dominated by front-line professional practice and autonomy to the exercise of practice overseen by management disciplines.

This tension is nowhere more in evidence than in much of the government's health policy over the past ten years. Superficially, this has stressed the importance of devolved power rather than central control. For instance, New Labour's first health White Paper, *The New NHS: Modern and Dependable*,⁵¹ emphasised the role of the (then) primary care groups (PCGs) in organising integrated local care. This was followed by *Shifting the Balance of Power*,⁵² which continued to highlight the importance of "supporting front-line staff" to deliver improved services and empowering them to "make decisions locally."⁵³ Finally, the introduction of foundation trusts has led to of some control being ceded to local bodies.

In *Delivering the NHS Plan*, the government clearly set out its desire to move away from "a top-down, centralised system that inhibits local innovation",⁵⁴ stating that, instead, "power needs to be devolved to locally-run services with the freedom to innovate and improve care for patients."⁵⁵

However, despite the rhetoric of devolution, a top-heavy interventionist culture has remained ingrained in the NHS. A number of initiatives have strengthened the central grip on the NHS, including an extensive framework of national commissioning and provider targets, the creation of independent sector treatment centres, and the Private Finance Initiative (PFI), all of which have necessitated tight central con-

51 Department of Health, *The New NHS: Modern and Dependable* (London: HMSO, 1997).

52 Department of Health, *Shifting the Balance of Power Within the NHS* (London: HMSO, 2001).

53 *Ibid.*, 3.

54 Department of Health, *Delivering the NHS Plan: Next Steps on Investment, Next Steps on Reform* (London: HMSO, 2002), 11.

55 *Ibid.*, 28.

control by the Treasury.⁵⁶ In his book *New Labour's State of Health*, Calum Paton argues that the government's aspiration to a national service, defined by initiatives such as national service frameworks and targets, is preventing power from flowing to local bodies. According to Paton, localism has become nothing more than local responsibility for doing national bidding, rather than real local power.⁵⁷

The conflict between centralising and localising tendencies can also be seen in the way the government has recently reformed the operation of PCTs. The devolution of around 75% of the NHS budget to PCTs is cited by the government as proof that they are moving away from their command-and-control tendencies. But, as John Appleby, chief economist of the King's Fund, argues, "being given the money is not necessarily synonymous with being truly in control of how it is spent."⁵⁸ PCTs have been criticised by the government for "Kremlin watching": focusing their gaze upwards towards government rather than out into their local communities. However, the government places constraints upon PCTs within which they are forced to operate. For instance, PCTs' commissioning plans must satisfy "nationally set policy goals", some of which "can conflict with locally determined priorities, reduce the scope for local manoeuvre and leave little management time to focus on local priorities."⁵⁹ Thus, the local control implied by holding 75% of the NHS budget is diluted by government policies that ensure the continuation of a high degree of central control.

The conflict between national diktat and a desire to devolve power outwards is further highlighted in the NHS *Operating Framework for 2008/9*. In this document, 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."⁶⁰ However, a number of commentators argue that the new framework does very little to strengthen local control. David

56 C. Paton, *New Labour's State of Health: Political Economy, Public Policy and the NHS* (Aldershot: Ashgate, 2006), 9.

57 Ibid.

58 John Appleby, "New year priorities for NHS under the microscope," King's Fund: www.kingsfund.org.uk/enewsletters/updatewebversion.htm.

59 Ibid.

60 Department of Health and NHS Finance Performance & Operations, *The NHS in England: The Operating Framework for 2008/09* (London: HMSO, 2007), 3.

Stout, director of the PCT network, points out that there are at least “60 instructions to PCTs, and some of those are instructions which have other instructions within them.”⁶¹ He declares that the *Operating Framework* “does not sit well with a localised approach.”⁶² This line of argument is also taken up by Appleby, who points out that there are ten pages detailing “national priorities (with 29 instances of the phrase ‘we expect’) and only one paragraph on priorities determined locally.”⁶³ The Department of Health even exerts central control over the local priorities that PCTs have been granted the freedom to set, stating: “There are issues that some PCTs will need to ensure are covered as part of their local priority setting process.”⁶⁴ This desire to manage even that which has been specifically designated as a local priority sums up the conflict between the Department of Health’s centralising and localising agenda. (See the Annex at the end of Background Paper 3 for an elaboration of the range of targets and priorities which Department of Health expects PCTs to meet.)

AN INDEPENDENT NHS AUTHORITY?

Publicly funded healthcare has become more and more important a commodity, and in the UK it has increasingly become a key issue in political debate, never more so than in the run-up to general elections. The NHS was an important battleground between the right and the traditional left. The former, which tended to support the use of quasi-market structures in healthcare delivery, depicted the NHS as the last remnant of the partially planned economic settlement that had been created in the aftermath of the Second World War. By contrast, those on the traditional left saw the creation of an internal market within the NHS in 1991, and the Conservative Party manifesto promise to introduce more private money into the NHS capital programme through the development of the PFI,⁶⁵ as harbingers of a move towards a privatised service. The market in private healthcare and health insurance, from

61 David Stout, cited in Sally Gainsbury, ‘Operating framework reasserts DoH’s central control,’ *HSJ*, 19 December 2007. www.hsj.co.uk/news/2007/12/operating_framework_reasserts_central_control.html.

62 Ibid.

63 Appleby, ‘New year priorities for NHS under the microscope.’

64 Department of Health and NHS Finance Performance & Operations, *The NHS in England*, 20.

65 Conservative Party, *You Can Only Be Sure With the Conservatives: General Election Manifesto* (London: Conservative Party, 1997).

providers such as BUPA, also expanded during the 1980s and 1990s, possibly partly in response to general gloom about the NHS.⁶⁶

Although many in the Conservative Party strongly rejected these claims, the accusation of a privatisation agenda stuck. Public concern over the Conservative position on the NHS was high. A month before the 1997 general election, New Labour had a 32% opinion poll lead over the ruling Conservatives as the party to be most trusted on healthcare.⁶⁷ The former Conservative chancellor of the exchequer, Nigel Lawson, had called the NHS, perhaps with a touch of resentment, “the national religion.”⁶⁸ It was against this backdrop that Tony Blair could tell supporters on the eve of the 1997 general election: “We have only 24 hours to save the National Health Service.”⁶⁹

A desire to take the NHS away from the direct control of ministers has given rise to a renewed interest in the fundamentals of the old debate about national versus local governance. On behalf of the Nuffield Trust, Professor Brian Edwards has recently considered options for an “independent NHS”, which aims to move the debate away from the polarised territory whose claims are, on the one hand, “that the sheer size of the NHS budget demands political accountability and control, and on the other that the electoral cycle has the effect of making the NHS a ‘political football.’”⁷⁰ In his analysis, Brian Edwards identifies the seven most likely models of governance for providing the NHS with a degree of independence from central government:

66 OECD, “Growth of expenditure on health,” *OECD Health Data* (2001), 1: www.oecd.org/dataoecd/51/35/1913396.pdf.

67 Ipsos MORI, “Best party on key issues,” *Ipsos MORI*: www.ipsos-mori.com/polls/trends/bpoki-health.shtml.

68 Brian Cathcart, “NHS is becoming a four-letter word,” *New Statesman*, 19 February 2007: www.newstatesman.com/200702190025.

69 Sarah Boggan, “24 hours to change the country,” *Independent*, 1 May 1997.

70 Brian Edwards, *An Independent NHS Review of the Options* (London: Nuffield Trust, 2007).

- a modernised NHS Executive within the Department of Health;
- an NHS Commissioning Authority;
- an NHS Corporation – a fully-managed national service;
- an NHS Corporation – a planning and commissioning organisation;
- a regionalised NHS;
- an NHS commissioned by local government;
- an NHS as a public insurance company.

All organisations would have one independent regulator, responsible principally for the inspection and regulation of health providers.

Edwards notes that the main perceived disadvantages of having an independent NHS Authority (NHSA) are threefold:

- the perceived need for tight national and political control over a sizeable piece of public expenditure;
- the potential diminution of parliamentary accountability;
- the need for ministers to drive change in what would otherwise be a professionally-dominated organisation.

The main advantages he identifies would be: “the creation of a professional and managerial environment and culture at the top which would enhance the opportunity for remodelling clinical processes, improving the efficiency of the whole system, improve the quality of service delivery and secure a full return on recent investment in the NHS.”⁷¹

71 Ibid.

This is not the first time that such a proposal has been considered. In 1979 the Royal Commission on the NHS considered the idea of an independent health commission to provide the service with “permanent and easily identifiable leadership.”⁷² The 1983 Griffiths Inquiry thought such a solution politically unacceptable.⁷³ Norman Fowler, secretary of state for health between 1981 and 1987, became convinced that an independent NHS commission was desirable.⁷⁴ The question is whether, 20 years on, the time is now ripe for such a development.

The question of independent management of the NHS is critical to the discussion of how the NHS should evolve in future, and will feature in the next stage of SMF research.

IS THERE A NEED FOR AN NHS CONSTITUTION?

Closely related is another question: should the NHS have a constitution? This has been the subject of a recent publication and debate orchestrated by the King’s Fund, in which a number of possible options have emerged:⁷⁵

- a general statement of objectives (universal, comprehensive, free at point of delivery, etc.);
- a statement of core values and patient’s specific rights and entitlements;
- a broad statement of principles – what patients could expect from the NHS;
- an “internal governance constitution” – a statement of roles and responsibilities and of accountabilities of the various key players.

72 HMSO, *Royal Commission on the National Health Service* (London: HMSO, 1979).

73 Griffiths, *The NHS Management Inquiry*.

74 Norman Fowler, *Ministers Decide: A Memoir of the Thatcher Years* (London: Chapman’s, 1991).

75 Anna Dixon and Arturo Alvarez-Rosete, “Governing the NHS alternatives to an independent board,” *King’s Fund Discussion Paper* 2008.

The main challenge for any NHS constitution is whether it will genuinely “add value” and help to improve levels of service.

In the next stage of research, the SMF will consider further the options for an NHS constitution.

A CORE PACKAGE OF ENTITLEMENTS FOR THE NHS?

Another interesting question, which arises from the rationing debate, is to what extent it might be possible to define a core package of treatments to be funded on the NHS, i.e. a complete list of all the treatments that will receive public funding. The Annex at the end of this paper contains a survey of international models of priority-setting, which are instructive on this question. In both the Netherlands and New Zealand, the task of constructing a core package was abandoned as being too difficult on conceptual, practical and political grounds. Both countries switched their attention away from the construction of a core package towards the delineation of broad principles that would structure resource-allocation decisions on an ongoing, incremental, piecemeal basis. This is the approach that Sweden adopted from the outset.

By contrast, in the USA, the state of Oregon has stuck with the task of setting out a defined list of treatments, although it has encountered considerable difficulty along the way, and even now its decisions remain controversial. It is perhaps unsurprising that Oregon has stuck with the task of constructing a core package of healthcare: even relatively liberal states in the US are still marked by a greater degree of suspicion about the costs of publicly provided forms of healthcare than are most European countries. In such a political climate, the aim of getting absolute clarity on where the boundaries of healthcare provision are to lie will probably receive a good deal of support. Conversely, one might think that the UK is a very unpromising context in which to construct a core package of care. Healthcare provision in the UK is politicised to a degree not found in almost any other developed nation. Both the mainstream parties are extremely wary about taking responsibility for clearly defining the boundaries of NHS care, since this will unavoidably involve alienating sections of the electorate.

It may also be taken as a “binding promise” to citizens to provide everything that is on the menu on an ongoing basis, which could pave the way for costly legal challenges were gaps in provision to emerge.

The SMF Health Commission considered the feasibility of constructing a core package of care for the NHS in a report published in July 2004.⁷⁶ The commission concluded that while constructing such a package would bring significant benefits (chiefly, a gain in honesty and transparency about the scope of NHS provision),⁷⁷ the task of doing so would be marked by considerable problems of principle and practice. The commission recommended that, instead of a “big bang” approach whereby a core package was set out here and now, the preconditions for such a package to emerge over time should be put in place. Foremost amongst those conditions is a well-resourced and sufficiently independent National Institute for Health and Clinical Excellence (NICE), the UK body currently charged with making healthcare resource-allocation decisions. Indeed, a paper on the UK healthcare system published by the European Health Management Association has argued that while the NHS remains a long way from possessing a defined benefit package, NICE has certainly helped to clarify the boundaries of provision.⁷⁸ (In Paper 3 of this series of background papers we will consider the workings of NICE in more detail.)

INTEGRATED CARE

Whether or not the 1991 reforms did generate a truly competitive market, they did take place against the backdrop of a clinical and organisational debate which was increasingly stressing the importance of “joined-up” care for patients accessing health services at different points. This depends on high degrees of cooperation between healthcare providers if patients are to experience relatively seamless pathways in their contacts with health services. It was a period which saw the development of safer anaesthesia, non-invasive surgical techniques

76 Social Market Foundation Health Commission, “Defining a core package for the NHS: Report 2c,” (London: SMF, 2004)

77 This is not only valuable in itself, but also allows for considerable extrinsic benefits. One such benefit is allowing individuals to make more targeted use of non-NHS services in augmenting the kinds of care available to them.

78 Anne R. Mason and Peter C. Smith, *Description of the Benefit Catalogue: England* (York: University of York, 2005).

and the growth of day surgery. All these facilitated a new philosophy of treating patients as near to home as possible, and with it the concept of a primary care-led NHS and the introduction of new forms of care traditionally reserved for hospitals – particularly intermediate care and “hospital at home” services. Developments in information technology offered the promise of networking patient records and diagnostic tests in support of better integrated health services.

However, ministers have also stated that collaboration will have to be promoted alongside competition. In a speech at the London School of Economics in December 2005, Patricia Hewitt made this clear:

In the new NHS, there will be an element of competition – on quality, effectiveness, responsiveness to patient needs. ... But we also want hospitals to collaborate – where appropriate, with each other, and with local GPs and PCTs. ... And although it may seem odd to expect organisations sometimes to compete and sometimes to collaborate with each other, it's worth remembering that this is exactly what happens in the private sector – with the most successful global organisations, often simultaneously, being competitors, collaborators, suppliers and customers of each other.⁷⁹

Competition and collaboration can operate side by side within the NHS, particularly in developing integrated care for patients with multiple needs. However, Chris Ham, in a Nuffield Trust briefing paper, argues that the government has focused on competition at the expense of integration, which “could result in increased fragmentation rather than closer collaboration.” For example, NHS foundation trusts are under pressure to achieve high levels of financial performance which might lead them to prioritise the development of their own services at the expense of collaboration with other providers in service networks.⁸⁰

79 Patricia Hewitt, cited in Chris Ham, *Clinically Integrated Systems: The Next Step in English Health Reform?* (London: Nuffield Trust, 2007), 2.

80 Ham, *Clinically Integrated Systems*, 6.

This point is picked up by Monitor, the Foundation Trust Regulator, which argues that although competition between providers brings many benefits, it also provides an incentive for providers to hide information from each other and guard best practice.⁸¹

Ham concludes that more attention needs to be given to turning policy aspirations for collaboration into reality. He acknowledges that the interim report of the 2007 Darzi Review stresses the importance of integrated care, but argues that the final report must provide a coherent and credible account of how this will happen in practice.⁸²

As part of its ongoing work, the SMF Health Project will consider the extent to which reformed NHS structures and incentives can allow for the mutual development of elements of competition and collaborative working practices. It may be that there is a genuine trade-off between these goals, in which case choices will have to be made regarding the sectors of the health service we wish to be marked primarily by competitive pressures and those in which we wish to retain collaborative arrangements (see also Background Paper 4).

PRODUCTIVITY

Investment and reform since 1997

By 1997 the NHS was portrayed by some commentators as being under serious threat, a concern that was reflected in Labour's election campaign. Against the backdrop of demand-side pressures and an ageing infrastructure, it was variously depicted as outdated, inefficient, underfunded and bureaucratic. These sentiments were reinforced by the fact that health spending as a percentage of GDP in the UK was far below that of many other comparable developed nations throughout the 1980s and 1990s (as shown in figure 1),⁸³ while public health in the UK was generally worse.⁸⁴

81 Monitor, *Ensuring Payment by Results Enable System Reform* (London: Monitor, 2006), 6.

82 Ham, *Clinically Integrated Systems*, 11.

83 OECD, "Growth of expenditure on health," *OECD Health Data* (2001), 2: www.oecd.org/dataoecd/51/35/1913396.pdf.

84 Anthony Giddens, *Sociology*, 5th edn (Cambridge: Polity, 2006).

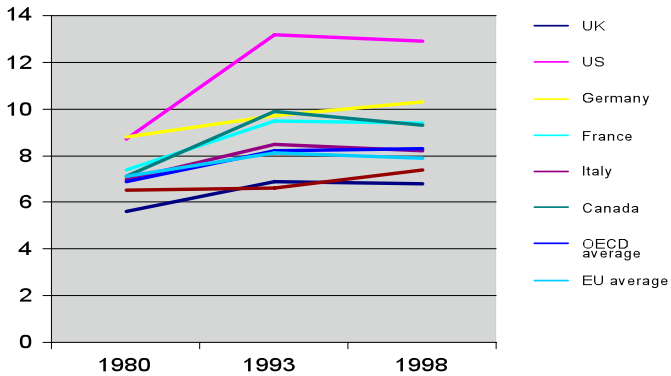


Figure 1: Health spending as a percentage of GDP, 1980–1998
Source: OECD Health Data

One of Labour's key manifesto pledges when it came into power in 1997 was a commitment to stay within the spending plans of the previous Conservative Government for the first two years of office. After this, however, the government took the funding brakes off. In 2001, the then chancellor, Gordon Brown, claimed that "a significantly higher share of national income" would have to be spent on the NHS in order to create a "world class health service that meets the needs of the people of Britain and puts patients first."⁸⁵ Increases in NHS funding followed closely the recommendations of a government-commissioned report by Derek Wanless, delivered in 2002.⁸⁶ Wanless noted "how far the UK has fallen behind other countries in health outcomes." He argued that, "we have achieved less because we have spent very much less and not spent it well. That shows up in significant shortfalls in our capacity to deliver."⁸⁷ This provided the catalyst for the government to announce that spending on the NHS would almost treble, from £33 billion in 1996/7 to £90 billion in 2007/8, raising the share of national income devoted by the UK to health to the OECD average.⁸⁸

85 BBC News, "Brown commits to NHS spending boost," 27 November 2001: http://news.bbc.co.uk/1/hi/uk_politics/1679198.stm.

86 Derek Wanless, *Securing our Future Health: Taking a Long-Term View* (London: HMSO, 2002).

87 Ibid.

88 HM Treasury, *Budget 2002* (London: HMSO, 2002).

Although a significant proportion of the extra funding for the NHS has been spent on increases in medical pay, the money has also been used to expand and upgrade the capacity of the NHS. Today, more than 1.3 million people work in the NHS, 28% more than a decade ago. This includes 400,000 extra nurses and 120,000 more doctors. There has also been significant investment to improve both the quantity and quality of NHS capital facilities. For example, the government is on track to deliver its 2001 commitment to complete more than 100 hospital schemes by 2010. Even more significantly, in the decade since 1997, and particularly in the years following the publication of *The NHS Plan* in 2000, the NHS has undergone a period of significant reform that has introduced greater choice, new models of commissioning, a new organisational structure and substantial workforce change. These reforms have been coupled with substantial investment, at times via new and often controversial arrangements with the private sector.

However, many commentators have raised concerns that much of the extra spending has not been effectively tied to reform, and that too much money has been wasted. The following sections examine that claim by looking at how productivity has changed in the NHS over the last decade.

Activity, outputs and outcomes

As discussed in the first part of this paper, activities (which can be defined as operative procedures, diagnostic tests, outpatient visits, consultations, etc.), and outputs (courses of treatment) are to be distinguished from outcomes. Outcomes relate to changes in the health status of patients in response to treatments. Since a primary objective of the NHS is to produce health outcomes, this is, in principle, the indicator of most interest. However, as discussed above, there is currently very little suitable data on health outcomes in the NHS, and the relationship between healthcare and high-level health status indicators is itself very tentative.

Measuring productivity in the NHS

As a result of the difficulty of isolating the impact of the NHS on health outcomes, its performance has traditionally been measured instead by its outputs rather than outcomes. The overall activity of the NHS is now measured by examining a large basket of more than 1,900 treatment activities – such as operations and GP appointments – and weighting

these according to their cost. The Department of Health estimates that this basket covers around four-fifths of NHS activity in England. On this measure, NHS output grew by an annual average of 3.2% between 1995 and 2004 (3.9% between 1999 and 2004).⁸⁹

The current situation reflects significant improvements in the measurement of NHS output. The first was the shift in 2004 to measuring many more types of activity, up from 16 to more than 1,700 (and, since 2005, more than 1,900). In addition, there are increasing attempts to make allowance for changes in the *quality* as well as the *quantity* of output. This has followed recommendations by the Atkinson Review, established by the government to look into measuring the productivity of public services.⁹⁰ Quality change is accounted for through shifts in survival rates, health effects, life expectancy and waiting times.⁹¹ Accounting for quality leads to an estimated annual average growth in NHS output between 1999 and 2004 of 5%.

A final adjustment recommended by the Atkinson Review is to account for the fact that public services become increasingly valuable to a society as it grows richer. For example, as real earnings rise, the cost of ill health to the economy through impacts such as lost output rise too. While not yet widely accepted, accounting for this gives an estimated increase in NHS output of 6.5% per year between 1999 and 2004. The three measures of NHS output are summarised in figure 2.

89 Office for National Statistics, *Public Service Productivity* (London: HMSO, 2006), 1.

90 Tony Atkinson, *Atkinson Review: Final Report* (Hampshire: Palgrave Macmillan, 2005).

91 Diane Dawson et al., *Developing New Approaches to Measuring NHS Output and Productivity* (York: Centre for Health Economics, University of York, 2005), 10.

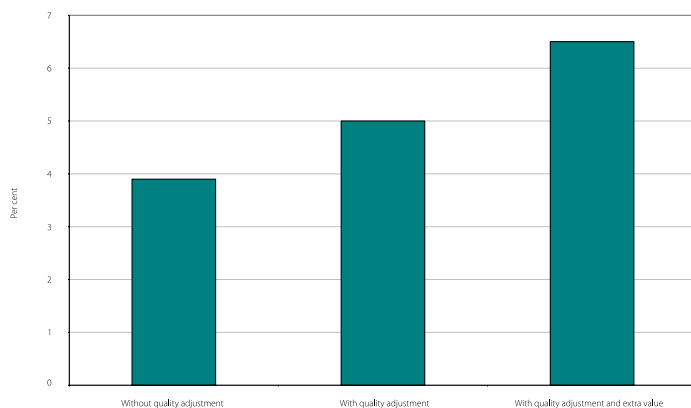


Figure 2: Measures of annual average NHS output growth, 1999–2004

Source: Office for National Statistics

It is clear that, no matter which measure is used, the output of the NHS has increased significantly over the past decade. Indeed, all the measures show that the output of the NHS grew at a faster pace than the output of the economy as a whole. But it is clear too that there is not yet a perfect measure of NHS output.

While it is undeniable that increased investment in the NHS has delivered increased outputs, this still leaves open the question of what the rate of increase of outputs has been relative to the increased investment in physical resources – manpower, plant and equipment and whether this has represented productivity growth.

Table 1:

Estimates of average annual NHS productivity growth, 1999–2003

Measure	Average annual productivity growth, 1999–2003
No quality adjustment	-0.6% to -1.3%
With quality adjustment	+0.2% to -0.5%
With quality adjustment and allowance for increasing value	+0.9% to +1.6%

Source: Office for National Statistics

Estimates of NHS productivity growth range from an annual fall of 1.3% to an annual rise of 1.6%, depending on whether they are adjusted for quality or not (see table 1). However, it is unsatisfactory not to account for changes in quality (this is a key adjustment across the rest of the economy), and the allowance for the increasing value of healthcare to richer societies is not currently widely accepted. Thus, the estimate of a range from growth of 0.2% per year to a fall of 0.5% per year appears the best measure to use. In other words, the current best estimates suggest that NHS productivity – the amount of outputs produced by each unit of inputs – has been broadly stagnant over the past decade. This compares to average productivity growth for the economy as a whole of around 2%,⁹² although productivity in the service sectors of the economy, public and private, has traditionally grown more slowly than the national average. For example, in 2006 output per hour worked in the service sector grew at 3%, compared to 3.8% in manufacturing.⁹³ There is a range of reasons for this, including the fact that the service sector tends to be more labour-intensive than manufacturing. Given this, there is a natural limit to the impact that investment in, for example, new machinery can have. The health sector, like much of the rest of the service sector, remains relatively labour-intensive and hence its productivity might be expected to grow more slowly than the national average, in common with the whole service sector.

Even so, this natural tendency for service-sector productivity to grow more slowly than the national average does not fully explain the performance of the NHS – its productivity has grown more slowly than that of the service sector as a whole over the past decade. It is likely that the speed at which investment increased made it difficult to improve productivity. It is, perhaps, remarkable in the circumstances that the outputs of the NHS appear to have grown broadly in line with the investment in it (that is, that productivity has remained stable).

92 Office for National Statistics, *Productivity First Release: 3rd Quarter 2007* (London: HMSO, 2007), 3.

93 *Ibid.*, 3.

It is worth noting that the focus in the early stages of NHS reform on increased activity levels in certain key areas has not been without its critics. Representatives of the BMA have declared that some of the targets imposed by the Department of Health “do not benefit patients” and have “a negative effect on the care of patients.”⁹⁴

In addition to target-setting, it has been argued that payment by results has also encouraged activity without regard to outcomes. By setting a fixed national tariff for each unit of activity, PbR rewards providers for activity performed. Monitor, the Foundation Trust regulator, states that PbR tariffs “reward higher activity, not necessarily higher quality of care”, and that there is a risk that PbR could “incentivise ‘low-cost, average-quality’ provision.”⁹⁵ Monitor goes on to emphasise that PbR incentivises innovations which lower costs relative to tariff, while failing to incentivise innovations that improve quality while raising cost. They conclude that it is possible for the tariff structure to create perverse incentives that could “subvert policy goals and lead to unwanted outcomes.”⁹⁶ This point is also expressed by the King’s Fund, which states that “Payment by Results rewards volume, not quality.”⁹⁷ They reveal that evidence from other countries such as the United States shows that quality of care can suffer when hospitals are given incentives similar to those introduced under PbR.⁹⁸ As such, PbR embodies the clash of two government policy drives: it incentivises activity and efficiency, but possibly at the expense of quality and outcomes.

94 Cited in Linda Beecham, “BMA annual representative meeting,” *BMJ*, 12 July 2003: www.bmj.com/cgi/content/full/327/7406/72-g.

95 Monitor, *Ensuring Payment by Results Enable System Reform* (London: Monitor, 2006), 6.

96 *Ibid.*, 6.

97 King’s Fund, “Payment by results,” 1 April 2005: www.kingsfund.org.uk/publications/briefings/payment_by.html.

98 *Ibid.*

Overall, the evidence is that PbR *has* delivered improved outcomes. However, since the 2007 Comprehensive Spending Review confirmed that the NHS would receive funding increases of only 4% promised over the next three years, there will clearly be challenges ahead as the service adjusts to leaner times following the unprecedented investment of the past decade. Improving productivity will be an increasingly important challenge.

The SMF Health Project will consider how to ensure, now the funding slowdown has begun, that reformed NHS structures can work efficiently to improve substantive health outcomes. The project may also examine whether the existing financial reimbursement structures within the NHS are up to this task.

In the next stage of its research, the SMF Health Project will consider:

1. What are the key drivers for the NHS to improve its productivity in the coming years?
2. Will NHS performance continue to improve, given a funding slowdown?



ANNEX INTERNATIONAL EXPERIENCES OF EXPLICIT RATIONING

OREGON, USA

The Oregon Health Plan (OHP), which began operation in 1994, was an initiative undertaken by local service users and providers to extend the scope of Medicaid (a government-funded programme to provide payment for medical services for low-income citizens). At a time when most states were lowering the income eligibility for medical assistance, the designers of the OHP proposed to extend Medicaid coverage to all persons living below the poverty line, regardless of traditional eligibility categories. This expansion of Medicaid enrolment was to be financed by covering fewer treatments. In order to carry this out, a Health Services Commission was established to define clearly the set of treatments that would be made available.

The process of defining this set of treatments attracted controversy, and the criteria used have changed on a number of occasions over the years. The initial criteria focused heavily on considerations of cost-effectiveness. They gave rise to several anomalous rankings of treatments, and as a result greater stress was placed on including the views of citizens, gathered at various community meetings. However, the federal government then charged the commission with violating the Americans with Disabilities Act, because the ranking system was influenced by an assessment of the potential for restoring "perfect quality of life", an outcome that was judged as being unattainable for many disabled persons.⁹⁹ As a result, the criteria were changed once again to place the emphasis on cost and on the likelihood of a treatment preventing death or alleviating symptoms.

Despite these difficulties, the OHP initially delivered on its promise to expand access to Medicaid. The number of uninsured Oregonians fell dramatically after implementation of the OHP in 1994. In 1993, 17% of Oregonians had lacked health insurance; the proportion dropped to 11% in 1996, largely because of the increased coverage offered to low-income individuals and families through the OHP, but also because of strong economic performance in the private sector. By 1999, Oregon's

99 Chris Ham, "Retracing the Oregon trail: The experience of rationing and the Oregon Health Plan," *BMJ* 316 (1998), 1965–9.

Medicaid program was covering all residents below the poverty line.¹⁰⁰ In 2002, state leaders were looking to widen access to Medicaid still further by expanding eligibility from 100% to 185% of the federal poverty level.

More recently the OHP has been beset with difficulties. In the wake of the terrorist attacks of 11 September 2001, the state of Oregon experienced an economic downturn. New state funds were not made available to extend OHP coverage and so its expansion was instead financed by dividing the health plan into two parts, OHP Plus and OHP Standard.¹⁰¹ OHP Plus covered those eligible for Medicaid under federal guidelines (such as low-income pregnant women and children), and its benefits remained based on the prioritised list. OHP Standard covered those not eligible for Medicaid under federal guidelines. OHP Standard enrollees received a reduced benefit package as compared to OHP Plus. In addition, premiums for OHP Standard enrollees were increased, and providers are allowed to refuse to see those who were not able to make their co-payments.

Not surprisingly, these changes resulted in a significant decline in the number of people enrolling in the plan. In the year after the changes were made, enrolment of the Medicaid-expansion population dropped by 53%, falling from 104,000 in January 2003 to 49,000 in December 2003. In the following 18 months, OHP Standard enrolment fell a further 50%.¹⁰² The programme was closed to new enrolment in 2004, and by April 2007 only about 24,000 enrollees remained in the program. Oregon's uninsured rate has subsequently climbed to 17%, more or less bringing it back to levels experienced when OHP began operation in 1994. Critics argue that the OHP "is now covering both fewer services and fewer people."¹⁰³

100 Lawrence Jacobs, Theodore Marmor and Jonathan Oberlander, "The Oregon Health Plan and the political paradox of rationing: What advocates and critics have claimed and what Oregon did," *Journal of Health Politics, Policy and Law* 24, no. 1 (1999), 161–80

101 Jonathan Oberlander, "Health Reform interrupted: The unraveling of the Oregon Health Plan," *Health Affairs* 26 (2007), 96–105.

102 Ibid.

103 Ibid.

The success of the OHP has been further undermined by another fundamental failing: the plan has not actually resulted in the sensitive rationing of healthcare. The guiding idea behind the OHP was that the introduction of a prioritised list would result in fewer healthcare treatments being offered, which would save money, meaning that more people could be offered a core service. However, despite the initial rhetoric, in reality the OHP did not generate substantial savings by rationing Medicaid services. Jacobs et al. reveal that the expansion of Medicaid enrolment and subsidies to those above the poverty line were largely financed through general revenues and the imposition of a tobacco tax.¹⁰⁴ Far from prioritisation of health services financing Medicaid expansion, OHP administrators now estimate that the Oregon list “saved the state only 2% on total costs for the program over its first five years of operation.”¹⁰⁵ Jacobs et al. argue that this is because, rather than resulting in a reduction of treatments available as had been planned, the process of drawing up the list actually generated a more generous package of benefits than was offered by Medicaid, or even the private sector prior to OHP’s implementation. In addition, OHP’s list has not been strictly enforced by medical providers. Doctors and hospitals regularly provide services “below the line” that they consider appropriate or medically necessary.

Another failing of the OHP (also highlighted by Jacobs et al.) that further weakened the plan’s effectiveness was that the proposed model of rationing was never in fact properly implemented. It had been envisaged by those who designed the OHP that the prioritisation list would be drawn up and modified on the basis of a cost-benefit formula, ensuring that scientific and objective measures would determine the state’s health-spending priorities. However, in practice, adjustments to the list were determined “not by scientific formula but ‘by hand’ on the basis of the Health Services Commission, which was influenced by political pressures and administrative judgments.”¹⁰⁶

104 Jacobs et al., “The Oregon Health Plan.”

105 Ibid.

106 Ibid.

Despite the foregoing, Oberlander concludes that it would be “a mistake to count out Oregon’s health reformers, who have proved resourceful and adaptive in their drive to expand coverage.”¹⁰⁷ Now that Oregon’s economy is recovering, Oberlander believes that there is a renewed effort to breathe life into the OHP. This is evidenced by an effort by the Oregon Health Services Commission to reprioritise the list of Medicaid-fundable health services into a single list that would enable more people to be covered.

A number of lessons can be taken from the Oregon experience:

1. It is important to take account of citizens’ values when designing a prioritisation process: these provide a useful check on the anomalous results that can be thrown up by concentrating too closely on considerations of cost-effectiveness.
2. When including the values of citizens, it is vital to ensure that the opinions of a large and representative sample have been canvassed. Even when this is done, however, the values reported are often multiple and conflicting, and it can be difficult to draw balanced conclusions.¹⁰⁸
3. It is often practically and politically difficult to exclude entire categories of care from public provision. Many Medicaid recipients continued to receive services that were meant to have been excluded from the health plan.¹⁰⁹
4. Defining an explicit package of services must be an *ongoing* process. It must keep pace with the continuing advance of medical technology and keep abreast of new information about the effectiveness of existing treatments.

107 Oberlander, “Health Reform interrupted.”

108 Rudolph Klein, “Warning Signals from Oregon,” *BMJ* 309 (1992), 1457–8.

109 Jonathan Oberlander, Theodore Marmor and Lawrence Jacobs, “The Oregon Health Plan: rhetoric, rationing & reality,” *Journal of Healthcare Management* 7, no. 9 (2001), 358–62.

THE NETHERLANDS

Prioritisation of healthcare became a major public issue in the Netherlands in 1991, when the Committee on Choices in Healthcare, known as the Dunning Committee, published a report advocating substantial reform. Four main strategies were proposed: investment in health technology assessment; the use of standardised guidelines in clinical decision-making; the development of criteria for access to waiting lists; and the establishment of a set of core treatments and services that should receive public funding.¹¹⁰

The Dunning Committee set out four principles to decide on the elements of this set of core treatments:

1. Is the particular treatment necessary?
2. Is it effective?
3. Is it efficient?
4. Could individuals, as opposed to the state, fund the treatment?¹¹¹

These principles were referred to as "Dunning's Funnel" because they are hierarchical in nature, with necessity taken to be the most important principle and personal funding the least.

The Funnel principles were strongly criticised, primarily because citizens were concerned that they would be used to exclude services from government funding. Since clarity on what is not to be publicly funded is precisely the point of the healthcare rationing exercise, public disquiet on this issue suggests that the Dutch government of the time had not won the argument about the need to prioritise services. There was also anger at the way in which the government interpreted the principle of necessity in such a way as to place the needs of the community higher than those of the individual patient. The cumulative effect of this adverse public reaction resulted in all recommendations being dropped. In more recent years, the Netherlands has focused less on the strategy of setting out a core package of treatments that will

110 Marc Berg and Tom Van der Grinten, "The Netherlands," in Chris Ham and Glenn B. Robert (eds), *Reasonable Rationing: International Experience of Priority Setting in Healthcare* (Maldenhead: Open University Press, 2003), 115–40.

111 Chris Ham, "Priority setting in healthcare: Learning from international experience," *Health Policy* 42, no. 1 (1997), 49–66.

receive public funding, and more on the creation of clinical guidelines for the treatment of specific conditions. However, difficulty has also been experienced in getting practitioners to adopt these guidelines.¹¹²

NEW ZEALAND

Like the Netherlands, New Zealand also initially set out to define a core package of health services. In 1992 the Core Services Committee (CSC) was established “to advise the Government on core health and disability support services to which the public should have access on fair terms.”¹¹³ It was intended that the committee would follow Oregon’s lead and determine which health services should be publicly funded.

However, having considered the different methods through which a core package could be achieved, the CSC decided to reject this approach. They felt it would be unable to take account of the different clinical contexts in which interventions take place, and would generate rankings that would be substantively unfair. Instead, the committee developed a set of principles to guide prioritisation decisions.¹¹⁴ These principles were:

- effectiveness – a funded intervention should show good evidence of benefit;
- equity – funding an intervention should constitute a fair use of public resources;
- acceptability – offering an intervention should be consistent with community values;
- efficiency – funding an intervention should offer good value for money.¹¹⁵

These principles have underpinned all subsequent work on prioritisation in New Zealand.

112 Berg and Van der Grinten, ‘The Netherlands.’

113 National Health Committee, *Prioritising Health Services: A Background Paper for the National Health Committee* (London: National Health Committee, 2004).

114 National Advisory Committee on Health and Disability, *The Best of Health 3: Are We Doing the Right Things and Are We Doing the Right Things Right?* (Wellington: National Health Committee, 1997).

115 National Health Committee, *Prioritising Health Services*.

SWEDEN

The Swedish approach to priority-setting, unlike the Oregon Plan, is less explicitly concerned with cost-containment and more with wider ethical concerns.¹¹⁶ A Parliamentary Priorities Commission (PPC) was set up in 1992 to consider prioritisation, and it took as its main goal the inclusion of public values in any distribution of healthcare resources.¹¹⁷

The PPC produced a final report in 1995 which set out a list of principles to guide decision-making:

- The principle of human dignity – all people are equal in dignity, regardless of personal characteristics and functions in society.
- The principle of need and solidarity – resources should be committed to the person or medical activity most in need of them.
- The principle of cost-efficiency – when choosing between different treatments, a reasonable relation between cost and effectiveness, measured in improved health and improved quality of life, should be aimed for.¹¹⁸

Like the Dunning Principles in the Netherlands, the Swedish PPC principles are considered to be hierarchal: cost-efficiency is the least important principle, and is considered to be trumped by the first two. In addition to this, the Commission explicitly ruled out the possibility of using the principle of cost-efficiency alone to prioritise between treatments for different conditions.

116 Chris Ham and Angela Coulter, "International experience of rationing (or priority setting)," in Chris Ham and Angela Coulter (eds), *The Global Challenge of Healthcare Rationing* (Buckingham: Open University Press, 2001), 15–26.

117 National Health Committee, *Prioritising Health Services*.

118 *Ibid.*

ISRAEL

Israel has also grappled with the difficulty of setting out a “benefit basket” of core healthcare services to be provided by the state. On 1 January 1995, Israel introduced the National Health Insurance (NHI) law. Its aim was to improve the equity and efficiency of healthcare provision in Israel. Before the introduction of the law, 96% of the Israeli population were insured by four non-profit health plans. The health plans provided near-universal coverage, along with high levels of medical services and a good ratio of doctors to patients (more than three doctors per 1,000 population).¹¹⁹ However, during the early 1990s the health plans were blighted by financial deficit, inequity due to selective enrolment practices used by some of the plans, and an increase in private financing of services.¹²⁰ As a result, pressure for reform grew, resulting in the introduction of National Health Insurance.

NHI has made it compulsory for all citizens to join one of the four health plans, which are now required to accept anyone who applies for cover. Citizens are able to switch health plans once a year, ensuring that a degree of competition exists in the system. Health plans receive a risk-adjusted (based on age) payment from the government for every standard basic basket of services that they provide. The basket covers preventive care and almost all acute care in the community and in hospitals. There is no price competition among the plans over provision of the basic basket. However, health plans can charge extra premiums for supplementary insurance that does not cover services included in the basic basket.

Since 1997, formal priority-setting has been in place for the addition of new services to the basic benefits package. As part of the annual budgeting process, the government decides how much money to allocate to fund new treatments. The Ministry of Health then solicits recommendations from the health plans,

119 David Chinitz et al., ‘Israel’s basket of health services: The importance of being explicitly implicit’, in Chris Ham and Angela Coulter (eds), *The Global Challenge of Healthcare Rationing* (Buckingham: Open University Press, 2001), 45.

120 Carmel Shalev and David Chinitz, ‘In search of equity, efficiency, universality and comprehensiveness: Health reform and managed competition in Israel,’ *BMJ* 317, (1998), 1007–10.

pharmaceutical companies, the Israel Medical Association (IMA) and patient organisations and other groups, about which new technologies should be given priority for inclusion in the benefits package. Having received recommendations, the Ministry of Health carries out a cost-benefit analysis, after which a public committee advises on what new technologies should be adopted. The public committee's recommendations are not legally binding, and the final decision as to what will be included is made by the Minister of Health, but so far the public committee's recommendations have been fully adopted.¹²¹ A report by the European Observatory on Healthcare Systems reveals that in the first few years of the priority-setting process in Israel, most additions to the benefits package were pharmaceuticals. Between 1998 and 2002, due to a lack of resources, new technologies and many cost-beneficial items were not included in the benefits package. Initially, 1% of the cost of the benefits package was allocated every year to fund new technologies, but this amount was drastically reduced, and almost eliminated, in 2003.¹²²

Israel's introduction of explicit priority-setting in healthcare decision-making is considered to be highly innovative by many health policy analysts. It certainly represents a serious effort to base decisions about how to allocate scarce healthcare resources on solid information and a structured procedure. However, the European Observatory on Healthcare Systems has a number of criticisms of the process. It argues that:

- not enough use is made of cost-benefit analyses, quality-adjusted life years (QALYs), and disability-adjusted life years (DALYs) in the decision-making process or in the background documents prepared by staff;
- not enough has been done to incorporate the priorities, values, views and preferences of the general public;
- the process does not benefit from sufficient input and guidance from the
National Health Council;

121 B. Rosen et al., *Healthcare Systems in Transition: Israel* (European Observatory on Healthcare Systems, 2003), 26.

122 Ibid.

- the health plans tend to share only those data that advance their interests;
- interested parties, particularly the health plans themselves, have too much power on the public committee;
- the Israeli courts have seen fit to allow the health plans to provide certain benefits not recommended by the public committee.¹²³

Occasionally, the health plans have called for the removal of some services from the benefits package or for reductions in the number of treatments covered for particular services. However, these proposals have been met with strong public opposition and none of them has been adopted.

MASSACHUSETTS, USA

Since 1988, the state of Massachusetts has attempted to expand health coverage through a combination of public programmes, greater employer participation, and safety-net programmes for the uninsured and underinsured.¹²⁴ In 1995, the state created MassHealth, an expanded Medicaid programme that covers children, parents and childless adults.¹²⁵ In 2006, Massachusetts passed the Health Reform Act, which built on previous reforms by expanding eligibility to MassHealth. As well as expanding public programmes, the Act also aimed to create affordable private coverage. Two new programmes were introduced – Commonwealth Care and Commonwealth Choice – for Massachusetts residents who did not qualify for MassHealth and who did not have employer-sponsored insurance. The 2006 Act also requires employers with more than

123 Ibid., 27.

124 Families USA, *Massachusetts Health Reform of 2006* (New York: Families USA, 2007), 1.

125 Robert W. Seifert, *The Basics of Mass Health: the Medicaid Program in Massachusetts* (Massachusetts: Massachusetts Medicaid Policy Institute, 2004).

ten employees to contribute a “fair and reasonable” amount for employee health coverage.¹²⁶

The goal of the 2006 Act is to provide universal coverage across the state. All residents over the age of 18 are required to obtain health insurance. Residents may be exempted from purchasing insurance only if they can demonstrate that they cannot afford it. It is estimated that only about 1–2% of the population of Massachusetts – about 60,000 residents – will be exempted.¹²⁷ The Act requires people to obtain Minimum Creditable Coverage (MCC). The “Connector Board”, made up of representatives of business, trade unions and consumers, was charged with defining which services would fall under this description. The board defined MCC as coverage provided by “comprehensive health plans that include preventive and primary care, emergency services, hospitalization benefits, ambulatory patient services, mental health services and prescription drug coverage.”¹²⁸ The board also disallowed coverage that capped the amount of benefits covered in a year or capped treatment for a specific condition. In addition, the board set limits on deductibles and other out-of-pocket costs.

The board's definition of MCC was strongly opposed by representatives of businesses and health insurers who were concerned that many existing employer-sponsored and individually purchased plans did not meet the board's criteria, particularly with respect to drug coverage. As a result, the board developed alternative minimum drug coverage requirements and has put off enforcement of the MCC until 2009.¹²⁹

126 Families USA, *Massachusetts Health Reform of 2006*, 10.

127 Alan Raymond, *The 2006 Massachusetts Health Reform Law: Progress and Challenges After One Year of Implementation* (Boston: Blue Cross Blue Shield of Massachusetts Foundation, 2007).

128 Cited in Seifert, *The Basics of Mass Health*, 19.

129 *Ibid.*, 20.

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