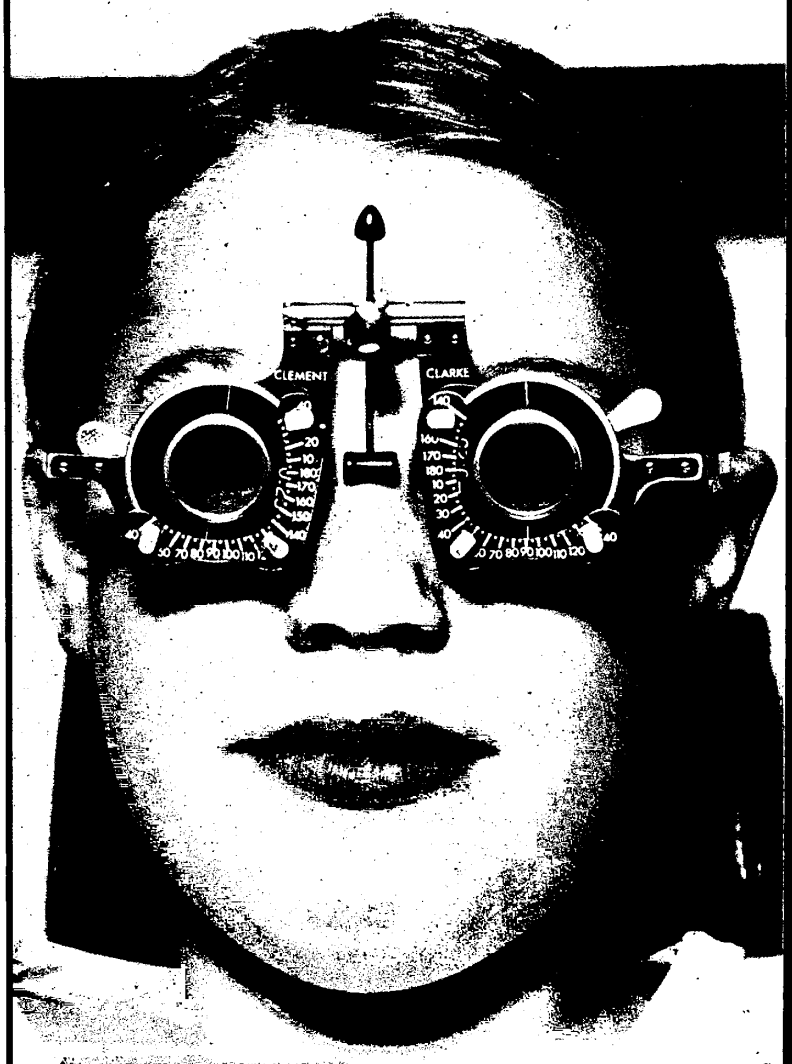
King's Fund

Health Care UK

The King's Fund review of health policy

Edited by John Appleby and Anthony Harrison



Spring 2000

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Published by
King's Fund Publishing
11–13 Cavendish Square
London W1M 0AN

First published 2000

ISBN 1 85717 413 5

A CIP catalogue record for this book is available from the British Library

Available from:

King's Fund Bookshop
11–13 Cavendish Square
London
W1M 0AN

Tel: 020 7307 2591
Fax: 020 7307 2801

Printed and bound in Great Britain

Typeset by Peter Powell Origination
& Print Limited

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EDITORIALS

In this issue

Performance management ... Blair's pledge ... the media and Relenza

John Appleby

Everyone can agree that the NHS should produce the right kind of health care, at the right time, for the right people as efficiently and as effectively as possible. But how can the performance of such a complex system be managed to achieve these goals?

As **Clive Smee** points out, hands-on management of performance was more hands-off while the internal market was in place – the market itself was the *process* that would encourage good performance. But the market has gone, taking with it the perverse outcomes of the purchaser efficiency index/target. Something had to fill their place; pressures within government would not let up – as **Gill Noble** and **Rebecca Lawrence** note, the Treasury is as keen as ever to see that taxpayers' money is being well-spent.

Trapped between a rock and a hard place, New Labour has reinvented performance indicators in the context of the Performance Assessment Framework (PAF), a modern approach to a more rounded view of measuring and encouraging performance in the NHS. But will this succeed where it failed last time (circa the late 1980s)? There are some warnings from **Andrew Street**, who reveals some of the technical problems with the new reference cost indices (are efficiency measures for all acute trusts statistically indistinguishable?), and **Chris Deeming**, who describes the problems of turning raw PI data into something more useful – like information that would help improve performance.

The PAF fits in or connects to many other performance management initiatives – clinical governance, for instance. **Steve Dewar** and **Alison Hill** describe their findings from a stock-take of clinical governance activity from around the London Region. And **Kathy Rowan** and **Nick Black** show how measures of performance do not have to be invented on high and posted down to the frontline – the frontline has been busy developing its own indicators for some time.

And what about the users of the NHS? Do they have any role or say in its performance? In the light of Bristol, Shipman, extended waits for out-patient appointments, a complaints system that's overburdened, GMC and Royal College initiatives to shore up confidence and trust in doctors, the answer is surely yes. **John Appleby** and **Jo-Ann Mulligan** describe a joint King's Fund/Channel 4 exercise to involve the public in NHS performance measures.

Tony Blair's pledge (promise? aspiration?) to increase funding for the NHS so as to reach the European Union average spend on health care (as a percentage of GDP) receives some critical investigation in this issue of HCUK. **Tony Harrison** asks whether *any* amount of money will be enough; **Justin Keen**

grapples with the measurement of private health care spending and **John Appleby** and **Seán Boyle** suggest how the money could be found to meet the Prime Minister's target.

The media – as ever – play an important role in the life of the NHS (for good and perhaps ill). The first '48-hour trolley wait shock!' story of winter is the NHS equivalent of the first cuckoo in spring. For everyone involved in health care such stories can be frustrating – the complexity and ethical dilemmas of management, treatment and rationing decisions are rarely conveyed by much of the media. The media reaction to the decision by NICE not to recommend the influenza drug Relenza is analysed by **Andrew Bell**, who suggests that what seems to pass for an open and public debate on such issues is more often than not a rather restricted set of monologues from self-selected interest groups.

The Performance Assessment Framework: where did it come from and where is it going?

Clive Smee*

The Performance Assessment Framework (PAF) announced in the 1997 White Paper *The New NHS: modern, dependable* was the product of a long period of learning about the use of performance indicators in the NHS. What were the origins of the Framework? What is its current role in promoting performance in the NHS? How could or should the Framework develop? Here, Clive Smee provides a personal reflection on these questions. It is both subjective – as the author was closely involved in many of the developments reported here – and partial – because no pretence is made to capture the experiences of those outside the Department of Health.

HISTORY

The immediate catalyst for the announcement of the Performance Assessment Framework was the coming to power of the Labour Government. The Labour Party's manifesto for the 1997 General Election stated:

> *The Tories' so-called 'Efficiency Index' counts the number of patient 'episodes', not the quality of success of treatment. With Labour the measure will be quality of outcome, itself an incentive for effectiveness.*

This statement captured concerns that had been growing in the NHS and among policy analysts, the media and the public for ten years or more.

The use of performance indicators in the NHS can be traced back at least to the NHS Performance Indicators initiative launched in 1983. Then the emphasis was on internal control by local managers, not on public accountability or on performance management by the Department of Health and Social Security (or later the NHS Management Executive). The indicators were drawn from routine administrative data sets and focused almost entirely on activities and costs. There was little or no attention to outcomes or indeed to measures of efficiency. As the data sets became increasingly complex they were converted into electronic form and handbooks and an expert system supported their use. Some of the indicators generated unintended behaviours later documented by researchers: tunnel vision, sub-optimisation, myopia, misrepresentation and gaming.

But others were undoubtedly helpful to health districts (and later, when renamed Health Service Indicators, to hospitals and other providers). However, despite its best efforts, the DHSS was unable to use them to rigorously assess the performance of regional health authorities or for accountability to the Treasury, Parliament and the public.

* *This editorial has been written in a personal capacity and does not represent the views of either the Department of Health or the Government.*

The sheer number of indicators (by the late 1980s there were several hundred) taxed management understanding and precluded the making of simple comparisons or the drawing of general conclusions. The focus on activities and costs also reduced their interest to the public and to politicians.

There were two exceptions to these generalisations. First, by weighting individual activities by their unit costs and aggregating across the country, it was possible to produce a cost-weighted activity index. Relating this index to expenditure produced a crude measure of trends in technical efficiency. Once such a measure had been developed by the Department's economists in the 1980s, it could be used to track efficiency back to the mid-1970s; to demonstrate to the Treasury that the NHS was steadily making better use of public funds; and to set increasingly demanding efficiency targets as part of the annual public expenditure round.

The other area where aggregation facilitated accountability was for the various measures of waiting times that went into the Patient's Charter. The Charter included the first set of performance indicators specifically aimed at informing the public about the performance of their local health service. In addition to waiting times they also included data relating to vaccination and immunisation rates and cervical cytology screening.

The *Working for Patients* reforms announced in 1989 introduced a major element of decentralisation into the NHS, but they also gave the NHS Management Executive new regulatory and performance management responsibilities. By the early 1990s it was clear to the Executive that it lacked the information tools to effectively manage regional health authorities. It had too much data and too little useful information. Those indicators that had been summarised and turned into targets – notably the cost-weighted activity indicator and various waiting time measures – shed light on only limited aspects of the NHS's performance. Moreover the cost-weighted activity indicator and the targets related to it gave all levels of the health service strong incentives to reduce or to shift costs regardless of the impact on the quality of care or on the performance of the whole health care system.

The sheer number of indicators (by the late 1980s there were several hundred) taxed management understanding and precluded the making of simple comparisons or the drawing of general conclusions.

Responding to these concerns at the end of 1992, the then Chief Executive, Sir Duncan Nichol, set up a group 'to consider what measures of quality, effectiveness and health outcomes and patient satisfaction can be used as systematic measures of NHS performance for the national accountability process including PES'. The group was specifically asked to identify a small number of indicators, 'around six', that could inform future performance contracts with regional health authorities. In two reports in 1993 the group identified a set of summary indicators that could be used to monitor progress under the Management Executive's then key strategies: *Health of the Nation*, community care, effective purchasing, Patient's Charter, clinical quality, strengthening the scientific base, and giving choice and influence to health service users.

In subsequent years, work on developing summary indicators of performance proceeded at different speeds as the various policy groups tested their proposals with the professions and other stakeholders. Doubts about data quality and the appropriateness of the indicators and worries about professional and management reactions led to a strong emphasis on using

the indicators to raise questions rather than to measure or judge performance. In the search for providing the centre with a more balanced set of high level indicators, further working groups identified additional potential indicators, most notably in relation to primary care.

One of the incidental benefits of this slow developmental process was that it sharpened up thinking about policy objectives. For example, the process of identifying performance indicators for primary care revealed that the GP terms of service included no particular requirements to meet patients' expectations or to provide them with hotel or clinical services that they found satisfactory. The work on performance indicators for primary care also prompted another important conclusion: ideally, measures of efficiency should look at the resources used to achieve health service objectives not at the cost of specific activities that happened to be easy to measure.

By 1997 there were several new sets of indicators under development but their relationship with each other was unclear and none was being published or used for performance management purposes. The election of the Labour Government and its manifesto commitment to change the focus of performance management provided the spur to develop a conceptual framework to pull together the proliferating indicator sets.

Borrowing from the thinking behind the 'balanced scorecard' approach to measuring private sector performance and from the attempts of US employers to systematically compare the performance of American health plans (the Health Plan Employer Data and Information Set – HEDIS), an attempt was made to identify the aspects of the health service that were given most importance by patients, the public and other stakeholders. The objective was to channel indicators, monitoring and management towards those aspects of performance that most resonated with the users and funders of the NHS. Consideration was given to various approaches to identifying the key domains of health service performance. The approach adopted required the indicators to:

- reflect the purposes of the NHS
- be easily understood as a concept
- focus on the perspectives of most importance for stakeholders, including those of users, carers, professionals and the public
- be small in number
- be as mutually exclusive as categories as possible
- reflect a rounded approach to the NHS's performance.

The six areas of the new performance framework – health improvement, health outcomes of health care, effective care delivery, equity of access, patient/carer experience and efficiency – were agreed by Ministers by mid-summer 1997. Work began immediately to populate the areas with high level indicators. The work was able to draw on the large number of new indicator sets already under development and was spurred on by the political commitment to develop a new approach to performance management. The selection criteria drew on the experience of the previous 15 years and paid particular attention to minimising adverse behavioural effects. The first set of high level indicators was selected by the late summer. This selection proved surprisingly robust, with most of the indicators surviving extensive consultation and field testing with the NHS.

The Performance Assessment Framework was announced in *The New NHS: modern, dependable* in November 1997 and proposals for the nature and content of the Framework were issued for consultation in January 1998. The first set of High Level Performance Indicators was published in June 1999.

Looking back on this short history, one noticeable feature is how long it took to move from awareness of the distorting effects of focusing public accountability and performance management on an activity-based measure of efficiency (and to a lesser extent waiting times) to the development of a more rounded set of outcome-based performance measures adequately reflecting the objectives of the health service.

Factors that contributed to the delay included the lack of incentive to develop an effective performance management system while performance was expected to be driven by the internal market; worries about resistance from clinicians if Clinical Indicators were introduced without lengthy consultation; the research community's wish to provide an evidence base for any new performance indicators; and concerns about raising public expectations if patients were systematically surveyed on their experiences.

THE ROLE OF THE PERFORMANCE ASSESSMENT FRAMEWORK IN PROMOTING PERFORMANCE

The Performance Assessment Framework supplies a major element of the infrastructure for effective performance management. It provides a framework for capturing the past performance of NHS organisations in a rounded and balanced way. It provides a framework for monitoring how the performance of those organisations will change in the future. It also provides a tool for making comparisons between health authorities, primary care groups and trusts. How well it performs these roles will depend, first, on whether the areas within the Framework are a good reflection of stakeholders' views on what is important about the NHS and, second, on whether it is possible to populate the areas with relevant and robust indicators.

Assuming these conditions are met, the Framework can be a useful tool for raising questions about neglected areas of performance and for highlighting outstanding performance. But, as the Government's policy initiatives recognise, performance management is much more than performance assessment and it requires other tools. In particular it requires:

- **mechanisms for defining standards and targets.** Key national innovations here are the Public Service Agreements and the national and local initiatives on which they draw, including the National Service Frameworks, the guidance produced by the National Institute for Clinical Excellence (NICE) and the local Health Improvement Programmes.
- **incentives to change behaviour.** New initiatives here include the unification of budgets under primary care groups and trusts, freedoms to retain and redeploy surpluses and the catalyst of reference costs and increasingly sophisticated benchmarking.
- **support to behavioural change.** Here initiatives include clinical governance, the Commission for Health Improvement, the NHSnet learning zone and a growing number of regional learning centres.

Other future tasks are likely to include developing tools that aggregate performance across the six domains of the Framework and that explore trade-offs between the domains.

The PAF must be sufficiently broadly drawn and flexible to accommodate and support these other elements of an effective performance management system. As targets and standards change it should be possible to incorporate new indicators of performance within the Framework, as indeed is already planned in relation to the National Service Frameworks (NSFs). Similarly, it should be possible to use the PAF to identify those local or national areas where incentives need to be strengthened and/or where there needs to be greater support of training and mentoring. In these ways the PAF can be used to assist with target and priority setting, both nationally and locally, and with monitoring the impact of new targets, standards, incentives and support mechanisms.

THE FUTURE

The PAF was initially developed as a tool for strengthening health authority accountability to the NHS Executive and for encouraging a focus on outcomes at all levels of the NHS. Other purposes for which it is already being used or for which it might be developed include:

- **by the NHS Executive,** as a tool of accountability to the Treasury and to help determine national priorities; as a tool for appraising trust performance; to encourage benchmarking within the NHS; and perhaps to guide resource allocation.

- **by health authorities (HAs),** to influence the priorities of Health Improvement Programmes; to affect local service agreements; and to facilitate benchmarking.

- **by primary care groups (PCGs),** to influence their own plans and contributions to Health Improvement Programmes; to affect local service agreements; to facilitate comparisons of performance and to change service policies where current policies are shown to be delivering relatively poor outcomes.

- **by NHS trusts,** to review policies, particularly on service quality and to facilitate the search for areas for improvement.

- **by the public and patients,** to facilitate dialogue with health authorities, primary care groups and local providers on improving performance, and to promote informed choice.

A pilot project in the North West Regional Office is testing specific ways in which the Framework can be used to enhance performance in the NHS.

The general trend is to move beyond accountability to using the Framework to change behaviours. For the PAF to be effective in any of the roles that require behavioural change it will be necessary for those using it to:

- have confidence in the quality and relevance of the indicators
- find the messages conveyed by the indicators easily understandable
- have the skills and incentives to translate the messages conveyed by the indicators first into understanding of the reasons for poor (or good) performance and then into corrective action.

All these conditions represent major unfinished tasks.

The initial set of High Level Performance Indicators was necessarily constrained to data sets already to hand. The roll-out of patient experience surveys, the development of new Clinical Indicators and the specification of data sets to monitor the NSFs and the work of NICE should offer a choice of much richer and more relevant performance measures. Taking the indicators down to primary care groups and trusts is a further challenge. Relevance will also be improved if, as expected, local NHS organisations use the PAF structure to look at locally, as well as nationally, generated information.

Alongside more robust and relevant indicators – particularly of outcomes – must go better presentation. Providers and clinicians can be expected to react to indicators only if they recognise and have confidence in them. Similarly, the public will show interest only if the information is understandable and relevant to their concerns. Meeting these conditions will require effort to be put into developing supportive and explanatory materials and tool kits for future indicator sets. Other future tasks are likely to include developing tools that aggregate performance across the six domains of the Framework and that explore trade-offs between the domains.

Before the high level indicators within the Framework can be expected to stimulate changes in behaviour they must be seen as providing information that is important to the objectives of NHS actors and organisations, whether those objectives are self-imposed or laid down by others. More work is required to ensure that the Departmental priorities set out in the Public Service Agreements, the National Priorities Guidance

and the Service and Financial Frameworks (SaFFs) are reflected in the indicators used in the PAF. Indicators that monitor progress with Departmental priorities should have their own feedback mechanisms. For other indicators it may be necessary to strengthen the incentives to take action.

An issue requiring further thought is how the PAF can strike a balance between providing a broad overview of the general performance of local health systems/organisations and an assessment of their progress in relation to current strategic priorities. Striking this balance will not be easy, but the long-term success of the Framework may depend on its ability to perform both functions.

NHS performance and taxpayers' money: a view from HM Treasury

Gill Noble and Rebecca Lawrence

THE OVERALL FRAMEWORK

Efficiency, effectiveness and value for money – getting the most out of every penny of taxpayer's money spent – have always been at the heart of the Treasury's work on public services. It has certainly always been a key concern in relation to the National Health Service, with its large budget (currently running at over £50 billion for the UK as a whole – the second largest spending programme after social security).

Pressure to improve performance can be created in a number of ways: through the budgetary process; by structural changes, which create the right sort of incentives in the relationship between different players in an organisation; by setting performance targets with appropriate rewards and sanctions; through benchmarking and the use of comparative statistics; and by helping users of a service to bring their expectations of the service to bear more effectively on the service providers.

The Treasury has promoted variants of all of these over the years, both in relation to public services generally and in relation to the health service in particular, but the approach has been in many ways somewhat opportunistic and ad hoc. The annual spending round typically offered the main opportunity to press for improvements in performance, for example by setting conditions on the money provided and, in the case of the NHS, by setting the annual target for efficiency improvement. However there was arguably no overall, coherent framework into which these performance management initiatives clearly fitted. That has now changed.

The new framework of the Public Service Agreements (PSAs) published at the end of the Comprehensive Spending Review in 1998 represents a significant step forward in the performance management of the public sector. For the first time, these PSAs set out for each department its key aims and objectives; the budget allocated to it for the next three years; key performance targets for the delivery of its services, together with, in some cases, a list of key policy initiatives to be delivered; and a statement of how the department will improve the productivity of its operations. The key aims and objectives for the Department of Health are show in Box 1. The Department's PSA also included a list of key performance targets for the NHS, such as the waiting list target, targets to improve access to and quality of primary care services, and an overall efficiency target.

For all departmental programmes, the PSAs set out the Government's key priorities, expressed wherever possible as measurable targets that can be cascaded down to compatible targets for service providers at local level. Performance against each of the targets in the PSAs is now regularly monitored by a Cabinet sub-committee, PSX, and outcomes against the targets will be published. So the PSAs for the first time provide a comprehensive, overarching framework for the systematic performance management of public services.

BOX 1: DEPARTMENT OF HEALTH AIM AND OBJECTIVES

The Department of Health's overall *aim* is to improve the health and wellbeing of the people of England, through resources available, by:

- supporting activity at national level to protect, promote and improve the nation's health
- securing the provision of comprehensive, high quality health care for all those who need it, regardless of their ability to pay or where they live
- securing responsive social care and child protection for those who lack the support they need.

The key objectives in pursuing these aims are:

a) to reduce the incidence of avoidable illness, disease and injury in the population
b) to treat people with illness, disease or injury quickly, effectively and on the basis of need alone
c) to enable people who are unable to perform essential activities of daily living, including those with chronic illness, disability or terminal illness, to live as full and normal lives as possible
d) to maximise the social development of children within stable family settings.

Source: *Public Services for the Future: Modernisation, Reform, Accountability, Comprehensive Spending Review: PSAs 1999–2002.* London: HM Treasury, December 1998.

Putting this framework in place was a substantial achievement, involving a great deal of work by departments. It required departments to clarify the outcomes they were striving to deliver and to think in a structured, systemic way both about how those outcomes were to be achieved and how progress against them could be monitored. These first PSAs are, however, clearly capable of improvement: some are quite complicated and it is sometimes difficult to judge priorities amongst the targets; in some cases, a good deal more technical work is needed before a suitable performance indicator can be selected and an appropriate target set. As part of the next Spending Review, the Treasury will therefore be working with departments to simplify the PSAs. They are to be made sharper and to focus on a more limited number of key objectives; the performance targets chosen will be reviewed in the light of experience, to check that they are the best ones to drive performance towards the desired outcome.

These first Public Service Agreements are clearly capable of improvement: some are quite complicated and it is difficult to judge priorities among targets.

The next set of PSAs will be supplemented by Service Delivery Agreements, which will include more detailed information on how the PSA targets will be measured and delivered, and the impact they will have on key groups and issues. They will also bring together the existing productivity targets for departments and the agenda of the *Modernising Government* White Paper (published March 1999). The aims are to make a clearer distinction between the key results the Government hopes to achieve and the means to deliver them; to create shorter, more strategic, more accessible PSAs; and to integrate the new PSAs and SDAs as far as possible with the Modernising Government agenda, and with the improved approach to business planning and performance management outlined in Sir Richard Wilson's December 1999 report to the Prime Minister on the reform of the Civil Service.[1]

In a separate but related exercise, the Treasury is overseeing the introduction of resource accounting and budgeting (RAB). RAB involves producing the equivalent of the main financial statements from commercial accounts, in particular the balance sheet and the equivalent of a profit and loss statement, and using this as the basis for planning and controlling public spending. It involves moving from cash accounting to accruals – that is, to accounting for resources when they are used to provide services, not just when the bills are paid. The main impact is on the treatment of capital so that investment in assets will no longer be added to current spending as if they were the same things (see Box 2). But RAB also involves for the first time a requirement on departments to report systematically on how the resources they use are allocated to their objectives, and on what is achieved as a result. Together with the PSAs and SDAs, this means that, for the first time ever, the Government will be setting out in a systematic coherent framework:

a) its objectives
b) the extent to which it is succeeding in meeting them
c) what these are costing
d) what outputs and outcomes the resources are buying
e) how efficiently departments are running their operations.

Specifically, the PSAs will set out the Government's objectives – (a) above – and associated with these, the main targets against which its achievements may be judged – (b) above. Schedule 5 of the resource accounts will show in resource terms how much the Government has spent in pursuit of its objectives – (c) above. More detailed information on the outputs and outcomes produced – (d) above – and the efficiency with which departments are operating – (e) above – will be included in the SDAs. The SDAs will also contain additional measures of achievement that are not suitable for target setting.

PERFORMANCE MEASURES AND TARGETS FOR THE NHS

The various initiatives on performance management within the NHS nest comfortably into this framework. The key priorities that the Government has set for the NHS are built into the current PSA and they will similarly be incorporated into the next set of PSAs. Also, the PSA and SDA to be published for the Department of Health at the end of the Spending Review will include performance targets that will be compatible with the more detailed performance indicators set through the NHS Performance Assessment Framework, which is described in detail in Clive Smee's editorial.

The Performance Assessment Framework was published in March 1999 to meet the remit of *The New NHS: modern, dependable* White Paper in bringing quality and efficiency together. It defines six overlapping dimensions of performance assessment: improvements in health, fair access to services, effective delivery of appropriate health care, efficiency, patient experience and the outcomes of care. This is a robust framework; if developed to be fully comprehensive and to cover all of the key targets in the PSA, it

BOX 2: RESOURCE ACCOUNTING AND BUDGETING

Resource accounting and budgeting (RAB) is part of the Modernising Government agenda and builds on the current fiscal regime by planning, controlling and accounting for departmental spending on a full accruals basis. It will provide a better basis for the allocation and use of resources, enhancing the distinction between capital and current spending by recognising the capital costs (i.e. depreciation and interest) of public investments and assets as they occur, consistent with and alongside other current spending. The 2000 Spending Review will incorporate the use of resource accounting information.

Source: *Pre-Budget Report.* London: HM Treasury, November 1999.

should provide a means to tackle both the efficiency and the quality of the NHS services so that the two are no longer seen as alternatives.

GENERAL OBSERVATIONS ON THE DESIGN AND USE OF PERFORMANCE MEASURES

The key aim of any system of setting targets and measuring performance of public services through indicators is to provide an evidence-based framework that can act as a management tool for improving both the quality and cost-effectiveness of its services.
It does this by:

- allowing robust horizontal comparisons and benchmarking between providers, to learn from each other and tackle unacceptable variations in performance
- providing a framework for assessing the drivers of change in outcomes
- providing information to inform resource allocation by showing where resources could be used most effectively, where there is unmet need or inefficiency.

How indicators are selected and defined will never be entirely value-free but will inevitably reflect to some extent the policy priorities of the Government. Nevertheless, to be fully effective in helping the Government secure its objectives for services, performance measures need to:

a) be as comprehensive as possible, to cover the full range of inputs and outputs for the sector

How indicators are selected and defined will never be entirely value-free but will inevitably reflect to some extent the policy priorities of the Government.

b) measure performance against key service objectives
c) be pitched at the right level to get at the driver of performance (in the NHS, this might be health authority, trust, PCG, etc.)
d) be meaningful to staff and managers, command their support and encourage the right sort of behavioural changes.

Performance management systems also need to be transparent if they are to be fully effective. There are arguments for and against publishing performance indicators, especially in the field of health care. Evidence shows that publication must be carefully handled to avoid the negative effects of a blame culture: measurement should be for performance improvement, not invite judgemental comment.

But if the use of published data is handled sensitively, it can sharpen the incentives to learn, spread best practice and improve data quality.

In designing any framework of indicators it is also very important to guard against creating perverse incentives or skewing measurement to certain areas ('what counts is what can be counted'). One of the main criticisms of the NHS purchaser efficiency index is that it encouraged activity, in this case consultant episodes, without reference to quality. Its successor, the reference cost schedule, has also been open to such criticisms, so it is continually being improved and extended so that it gives powerful and relevant comparative cost information. The remedy may also lie in the further development of the Performance Assessment Framework. A better handle on outcomes, through the Performance Assessment Framework, RAB and elsewhere, will give a fuller approach to efficiency or value for money, taking into account both quality and cost.

Performance indicators do not improve performance on their own. Performance improvement comes not only through performance management but also through the alignment of intrinsic incentives with objectives, and performance

indicators need both to be seen in context and used in a way that recognises that they are only part of a wider picture. They need to be properly embedded in a broadly based system of performance management so that all the levers that affect performance, such as pay, incentives, human resources strategy, can be brought to bear. That is why, in the case of health, performance assessment is located within the framework for quality improvement. It is this whole agenda taken together that will drive performance improvement: the National Institute for Clinical Excellence and the National Service Frameworks set the standards the NHS must achieve; clinical governance arrangements within health care providers will be the process by which each part of the NHS delivers improved quality; the Commission for Health Improvement and the Performance Assessment Framework will monitor the standards and ensure they happen.

COMPARISONS WITH OTHER PUBLIC SERVICES

The process of developing performance measurement systems such as the Performance Assessment Framework, linked to PSA targets and backed up by performance management regimes, is not just restricted to health. A similar framework is being put in place for social services and also, for example, for the criminal justice system, where targets in a joint PSA covering the Home Office, Lord Chancellor's Department and the CPS are being cascaded down to a range of service deliverers, such as the police, the courts and the probation service. And of course the 'best value' regime for performance management is currently being embedded into the management processes of local government.

PERFORMANCE MANAGEMENT AND JOINED-UP SERVICE DELIVERY

Because performance indicators provide a framework for assessing the drivers of change in outcomes (which in health, as in other public services, will be determined by factors both outside and within the control of the NHS), they can help promote joined-up working. This might be joined-up working within the health care sector, for example improving results on coronary heart disease needs co-operation between primary and secondary care. Indicators can help show where this is effective. Or it can go wider, for example successful outcomes for the elderly very often depend on effective joined-up working between the NHS and social services. More generally, a range of factors – poverty, environment and housing as well as the quality of health care – drive health outcomes. Carefully chosen, performance targets and indicators can help to bind services together. For example, the Department of Health has a PSA target to improve the educational attainment of children looked after by local authorities, which can be achieved only if a number of agencies work effectively together.

IMPROVING THE DESIGN AND USE OF PERFORMANCE MEASURES

Clive Smee's article describes the work in hand to improve performance measurement in the NHS. This is part of a wider body of work in progress to look at ways of improving the design and use of performance measures more generally and in particular in relation to interagency working. For example, the Cabinet Office's Measurement and Performance Project is looking at six case studies, including Bradford Health Action Zone, to try to understand and improve the use of performance measures and targets in multi-agency working. Its interim report can be found on the Cabinet Office web site (www.cabinet-office.gov.uk/eeg/1999/mapp.htm). One of the Social Exclusion Unit's policy action teams is looking at many of the same issues in relation to tackling poverty and deprivation, as is the Government Statistical Service Policy and Management Committee. The Treasury-sponsored Public Service Productivity Panel has also being pursuing a number of projects on performance management and its reports can be found on the Treasury web site (www.hm-treasury.gov.uk/pspp/studies.html).

To pull all of this work together, following a recommendation in a report by the Cabinet Office Performance and Innovation Unit into ways to improve Whitehall's management of cross-cutting policies and services, *Wiring it Up* (www.cabinet-office.gov.uk/innovation), an interdepartmental group chaired by the Treasury has now been commissioned to develop a Government Performance Information Strategy to bring together all existing and future Government work on the design, usability and accessibility of performance measures and targets.

THE TREASURY'S OWN OBJECTIVES

One final point may be worth noting. The Treasury is often accused of being interested only in cutting costs irrespective of the impact on the quality of public services. However, the Treasury's own PSA includes an explicit aim: 'To improve the quality and cost-effectiveness of public services.' Both halves of that aim are important to us: put quite simply, we will fail to meet our own objectives if cost-effectiveness is secured at the expense of quality.

REFERENCES

1. www.cabinet-office.gov.uk/civil-service-reform/1999

That spending pledge and winter crisis

Anthony Harrison

The NHS and financial crisis have been bedfellows since the 1950s. But the crisis of this winter was unique, eliciting as it did a statement from the Prime Minister that he wished to see spending on the NHS rise to the average level of the European Union. As John Appleby and Seán Boyle indicate in Datascan, the precise meaning of that statement, later termed an aspiration, is not clear. But it was clear enough that the Prime Minister intended that the NHS should receive substantially larger increases than it has enjoyed in recent years, as the Chancellor in his budget subsequently confirmed.

By making his statement, the Prime Minister appeared to be offering assurance to the nation that the NHS was safe in Labour's hands. More specifically, the timing of the statement itself implied that the failure to cope with the winter peak was a matter of a lack of resources, not poor management of the human and physical resources that are already available. It also implied that any subsequent failure – provided extra resources have been forthcoming – may seem to confirm what many commentators said this year and last as soon as long waits began to be reported in A&E departments: that the NHS cannot continue as a tax-financed service.

Towards the end of last year, two reports were published that bear on the question of whether the NHS's management of its existing resources is as good as it might be. The first, by the Emergency Services Action team, was concerned with winter 1998/99.[1] The report in general is upbeat in tone: 'joint planning and collaboration between NHS trusts, health authorities and Social Services continued to improve', but it goes on to say '... progress around the country was far from uniform and much more needs to be done fully to engage primary care'.

The second report came from the Audit Commission, *Critical to success*,[2] and focused on critical care services within hospitals. That too indicated that there was large scope for technical improvement in these services, and also warned against investing in intensive care beds without looking at the full range of bed options – i.e. the balance between intensive, high dependency and acute medical beds.

During 1999, the NHS, mindful of the Millennium, did try to improve its forward planning, but it would be naive to expect that all the poor performing areas were as well prepared as they might have been. It is arguable, therefore, that a better-prepared NHS, with a better allocation of physical and human resources, could have performed better. But it is also arguable that that it still might fail.

During the first week of the crisis, there were reports from other countries that appeared to be doing better. The French system came in for substantial praise: what went unnoticed was that the French were considering changing their financing system to one more like the NHS – and as the UK crisis died down at least in the hospitals, the French system, like parts of the American and the Canadian systems, was overwhelmed by the inflow of patients. Their larger stock of beds and doctors relative to population proved to be insufficient.

This leads to the second point, the link between extra funding and success in dealing with the winter crisis. The experience in other countries, which spend much more than the UK and

have a much larger stock of doctors and beds, suggests that substantial extra resources are not enough to guarantee the ability of a health care system to deal with the surges in demand that can occur during winter months. Both the method of finance and the level of finance are irrelevant if the planning and appropriate organisation are not in place.

But even if they are, should any health care system guarantee that it will always be able to cope promptly with any conceivable peak in demand? As with any public facility, such as electricity supply, the cost of providing for peaks rises with the degree of confidence sought in its ability to meet any eventuality. The value of being able to 'cope' all or most of the time must be set against all the other priorities that the Government announced in autumn 1999, when the new Secretary of State took over.

The weather and the extent of the flu 'epidemic' were not particularly severe – as far as one can tell – during January 2000, so the chances are that the NHS will face a more severe test in future years. The risk the Government has taken is that any such failure in future will be taken as indicating not simply that the NHS does not have enough resources but that it never will have as long as it is mainly reliant on Treasury finance. The Government has, in other words, bet the future of the NHS as a tax-financed system on its ability to cope with winter peaks in demand.

. . . should any health care system guarantee that it will always be able to cope promptly with any conceivable peak in demand?

Given the experience of better-resourced countries, that was a foolish risk to run. The only way out of the trap the Prime Minister has eagerly jumped into is for it to be made plain that the bet is off, that winter crises will occur and that the NHS as always has other priorities to pursue.

That said, technical tasks remain – the Audit Commission report makes that clear. These will have to be tackled urgently. But the main problem is a political one: this year the NHS seemed poorly protected from the barrage of press criticism and the Government itself appeared to panic in the face of a barrage of press reports focused on particular individuals whose lives appeared to have been endangered by a shortage of beds. Throughout all this, very little hard information was available about the situation across the country as a whole.

If the private sector financing option is not to appear inescapable, the performance of the NHS on the ground must improve. But so must its capacity to explain and justify what it is doing, to respond to evident failures of service and above all to distinguish local failures – which will always occur – from system-level failures, which can be avoided by the right combination of resources and effective management.

REFERENCES

1. Department of Health. *Emergency services action team 1999 report.* London: DoH, 1999.

2. Audit Commission. *Critical to success: the place of efficient and effective critical care services within the acute hospital.* London: Audit Commission, 1999.

CALENDAR OF EVENTS

SEPTEMBER 1999

1 **Winter pressures:** information pack issued, covering public education and guidance for local planning, and supporting a national advertising campaign, 'Choose the Right Remedy this Winter'.

6 **Cancer:** guidance issued for achieving the two-week target for seeing a specialist in cases of suspected cancer. It sets out the timescale and milestones for achieving this standard and announces the availability of a £10 million fund to support projects to assist the achievement of the standard. Health authorities (HAs), trusts and primary care groups (PCGs) are required to assess existing capacity for dealing with referrals and to agree action plans.

10 **Primary care trusts:** guidance issued on the process by which health authorities should undertake consultations on the establishment of primary care trusts.

17 **Fraud:** guidance issued on checking claims for exemptions from prescription charges.

24 **Workforce planning:** review of NHS workforce planning announced, to cover roles and responsibilities for workforce planning at all levels in the NHS and explore the barriers to and opportunities for better planning.

Drugs: reductions of 4.5 per cent in the prices of branded medicines announced as a result of the re-negotiation of the Pharmaceutical Price Regulation Scheme during 1999.

OCTOBER 1999

8 **Pay:** joint framework of principles and an agreed statement on the way forward published. Proposals should:

- assist ways of working that best deliver the range and quality of services required in as efficient and effective a way as possible, and that are organised to best meet the needs of patients
- assist the goal of achieving a quality workforce in the right numbers with the right skills and diversity, which is organised in the right way
- improve the recruitment and retention, morale and motivation of the NHS's workforce
- seek to improve all aspects of equal opportunity and diversity – especially in the areas of career and training opportunities and working patterns that are not easily flexible with family commitments
- meet equal pay for work of equal value criteria, recognising that pay constitutes any benefit in cash or conditions
- be capable of being implemented within the management capacity that is likely to be in place
- apply to all staff employed by NHS statutory bodies and should, wherever possible, assist the goal of strengthening the NHS as a whole
- be able to demonstrate that their likely benefits outweigh the likely disadvantages in respect of the above criteria
- subject all aspects of negotiations, including the implementation of any agreement, to a social partnership approach at all levels

- be consistent with the wider national human resources (HR) strategies and should cement the principles therein.

Drugs: the National Institute for Clinical Excellence issued guidance on the use of Relenza within the NHS. The Institute advised that it should not be prescribed during the coming winter. Although its use reduces the duration of illness by 24 hours, there was insufficient information to judge its impact on patients at risk of secondary complications, e.g. elderly people and those with cardiovascular disease, asthma, chronic obstructive pulmonary disease or immuno-suppression. See Andrew Bell's article, p.30.

12 **Ministers:** Alan Milburn appointed as Secretary of State for Health.

18 **Cardiac surgery:** Secretary of State for Health Alan Milburn announced a £50 million boost to cardiac surgery to increase the number of heart operations by 10 per cent over the next two years. He also announced an increase in the number of heart specialists by over 400 in the next six years. The announcement stated that the Government's priorities for the NHS will be cancer, heart disease and mental health, but that action to reduce overall waiting lists will continue. See John Appleby and Jo-Ann Mulligan's article, p.59.

20 **Users:** results of first National Survey of NHS Patients – covering general practice – published. It found high levels of satisfaction with most GP services, but considerable dissatisfaction among some population groups (see *Health Care UK 1999/2000*, p.55).

25 **Cancer:** a package of measures to improve cancer services announced, including:

- the appointment of Professor Mike Richards as National Cancer Director to spearhead the delivery of a national care blueprint and ensure standards are implemented across the NHS
- an £80 million cash boost to cut waiting times for patients with suspected cancer and step-up the modernisation of services
- steps to end the postcode lottery of care by releasing early clear-cut guidance on drugs to treat breast and ovarian cancer, produced by NICE, the new independent body of medical experts.

27 **Nurses:** *Making a Difference to Nursing and Midwifery Pre-registration Education* published, setting out action for education consortia in respect of changes to nurse pre-registration education, and following up the earlier reports *Making a Difference* and *Fit for Practice*. The changes are designed to lead to more flexible career pathways into and within nursing and midwifery, increase the level of practical skills and make the system more responsive to the needs of the NHS.

Critical care: the Audit Commission published *Critical to success: the place of efficient and effective critical care services within the acute hospital*. This sets out a series of recommendations designed to help hospitals determine what intensive and high dependency bed capacity they need and how that should be provided.

29 **Smoking:** the High Court granted tobacco companies an injunction against a ban on tobacco advertising. The Government published draft regulations to implement Directive 98/43/EC on 17 June 1999. The proposals would have banned tobacco advertising in the UK from 10 December 1999. The tobacco companies sought to prevent the ban by challenging the validity of the European Directive.

Antibiotics: a £1.3 million public education campaign to tackle antibiotic resistance launched by Professor Liam Donaldson, the Chief Medical Officer, who warned that sufferers of coughs and colds should not expect to be given a prescription for antibiotics unless their GPs felt they really needed it.

30 **Mental health:** National Service Framework published, setting out standards and service models for mental health services. The Framework sets out national standards for local services to achieve, broad service models for the delivery of care and performance indicators designed to allow progress against standards to be measured.

NOVEMBER 1999

4 **Public and patient involvement:** review announced of Department of Health work programme on patient and public involvement, which aims to provide better-targeted support to frontline clinicians as they involve the public in the delivery of local services. This followed the publication of a consultation document, *Patient and public involvement in the new NHS*, in September.

12 **Clinical governance:** Health Secretary Alan Milburn published proposals to tackle the problem of poorly performing doctors. The proposals, drawn up by Chief Medical Officer Professor Liam Donaldson, completely overhaul key aspects of the NHS that have remained largely unchanged since 1948.

For hospital doctors the plans mean:

- all doctors to participate in external clinical audit and take part in an annual appraisal of their performance
- new independent and impartial 'Assessment and Support Centres' where doctors suspected of poor practice will be referred to see if they need retraining or disciplinary action
- doctors being investigated for personal misconduct (for example sexual assault, fraud) or failure to meet their contracts (for example not turning up for a ward round or out-patient clinic) will be subject to exactly the same disciplinary process as any other NHS employee
- ending the right of consultants undergoing disciplinary action to appeal directly to the Secretary of State to overturn the action.

For GPs the proposals would mean they:

- have to participate in external clinical audit
- have annual appraisals of their standards
- may be suspended by health authorities where there are serious concerns
- may be referred to the new Assessment and Support Centres.

16 **Mental health:** Alan Milburn announced changes to the Mental Health Act following an inquiry led by Professor Genevra Richardson. They include plans for compulsory treatment orders for people with severe mental illnesses living in the community.

Clinical negligence: the Court of Appeal ruled that three women who developed a rare form of cervical cancer after being given false negative smear test readings at Kent and Canterbury Hospital are as much entitled to compensation as other women who developed the more common form of the disease.

17 **Clinical audit:** the 1999 report from the National Confidential Enquiry into Perioperative Deaths (NCEPOD) is published, focusing on care for children and the very elderly. It makes a series of recommendations designed to reduce the risks of surgery in both groups, including further centralisation of expertise in children's surgical services and adequate and better arrangements for patient transfer.

23 **Complaints:** The Health Committee's *Procedures Related to Adverse Clinical Incidents and Outcomes in Medical Care* published. The Committee found that existing arrangements were not working well, including the new complaints procedure. It made a large number of recommendations, both on the complaints procedure itself and on risk management and reporting of incidents within trusts, as follows:

- there should be a statutory duty to provide information to relatives about the circumstances surrounding a patient's death
- the Department of Health should maintain a central, national database of adverse incidents
- when a claim is made against a doctor or health care professional, the health authority or trust should initiate an investigation into why such circumstances arose and whether patient safety is at risk
- GPs should be permitted to remove patients from their lists only as a last resort and should provide an account to the patient of the reasons for the removal
- for patients complaining about primary care, there should be an alternative route through the primary care group, trust or health authority – this matter should be urgently addressed
- community health councils should have a clearer remit for giving support and advice to patients and relatives with complaints, and their remit should be extended to the independent sector
- the role of convenor as it currently stands should be abolished – patients, their relatives or carers who would like an independent review of their complaint should apply directly to the Independent Review Panel (IRP) for 'leave to appeal'
- there should be significant changes to the manner in which IRPs are conducted.

24 **Expert patients:** Chief Medical Officer Professor Liam Donaldson announced the membership and terms of reference of the Expert Patients Task Force. The Task Force was announced in the White Paper *Saving Lives: Our Healthier Nation*. It will design a programme to help people with a chronic disease or disability to take the lead in managing their conditions, with appropriate support from the health service.

29 **Winter pressures:** guidance issued to health authorities for management of the Millennium holiday period and the pressures expected over the winter as a whole, including the co-ordination of local winter planning groups. The groups are asked to monitor demand for health and social care services, implement agreed plans when pressures mount and provide feedback to NHS Executive Regional Offices. The guidance also sets out standards for patient waiting times and treatment.

DECEMBER 1999

2 **Inequalities:** a Bristol University report found that inequalities in health and wealth have been rising in the UK over the past two years despite promises by the Government to narrow the health gap between rich and poor.

Long-term care: *Better Care, Higher Standards: a charter for long term care* published. The national charter is designed to ensure that:

- people will have better information about the services that their local authorities and health services can provide and how they can use these services more easily
- people will know what standards of service they can reasonably expect from their local authorities and health services
- users and carers will know what to do if they are not satisfied with the services they are getting
- services should be more effective because local authorities and health services will be working together in a co-ordinated way to provide services
- users will know what their responsibilities are
- users and carers will be involved in drawing up joint *local charters* with local authorities and, every year, health services will ask them if their expectations have been met and how services could be improved

- there will be a more consistent approach to drawing up *local charters* in England.

3 **Regulation:** the Government published its Care Standards Bill, setting out wide-scale reform of the systems to prevent abuse in social services and private health care. The Bill includes provisions to reform the system of inspection throughout social services, private health care and child care. Its main elements are:

- a National Care Standards Commission, a new independent national body to regulate the whole range of social care services, with a separate arm to regulate private health services
- a General Social Care Council to raise professional and training standards for the social care workforce.

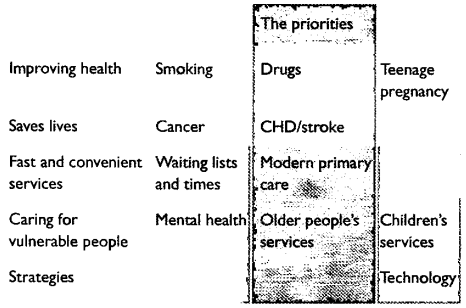
7 **NHS Direct:** the Government launched NHS Direct online and expanded the NHS Direct telephone service to 65 per cent of the country. The new service is intended to help the public to deal with the most common health problems themselves.

9 **Smoking:** one year after publication of *Smoking Kills*, a campaign is launched to encourage people to give up smoking. The three-year campaign is a central part of the Government's strategy to tackle the causes of the nation's major killer diseases – cancer, heart disease and stroke.

Drugs: Health Committee report on *The Cost and Availability of Generic Drugs to the NHS* published. It notes that the cost of some generics had increased by 700 per cent over the previous 18 months and that some drugs had been in short supply during this period. It welcomes the Government's decision to launch a wide-ranging review of the generics market.

19 **NHS funding:** the Secretary of State affirmed the Government's commitment to a tax-financed NHS in a speech at the Institute for Public Policy Research.

21 **Planning:** National Priorities Guidance 2000/01–2002/03 issued, setting out the priority areas:



It also set out the 'must-dos':

- overall NHS resources must be carefully managed to reduce waiting lists and times, ensure provision of prompt and effective emergency care, maintain financial stability and restore working balances
- services must be strengthened to prevent and control communicable diseases, especially hospital-acquired infection, take action to reduce anti-microbial resistance and meet immunisation targets, including for meningitis
- local authorities must continue to purchase and provide sage and secure services for those who need them, balancing costs and outcomes, and achieving best value.

Guidance issued on Health Improvement Programmes, Service and Financial Frameworks, Joint Investment Plans (JIP) and Primary Care Investment Plans, setting out action required of health authorities, primary care groups (and trusts), NHS trusts and local authorities and the overall planning process.

Health authorities are required to:

- continue to lead the development of HImPs and SaFFs in partnership with local stakeholders and, where appropriate, prepare applications for the HImP Performance Scheme

- agree monitoring arrangements to ensure local organisations' contribution to the delivery of agreed plans
- adopt an appropriate range of operational and financial flexibilities to achieve greater improvements in health and health care, including supporting the delegation of further financial and commissioning responsibilities to primary care groups/trusts (PCG/Ts)
- work with local authority partners to roll forward their JIP for older people, to include detailed financial information for 2000/01, and to develop JIPs for adults of working age with mental health problems to cover the period 2000/01–2002/03
- agree the distribution of management resources with each PCG/T to enable it properly to discharge its delegated responsibilities, meet its commitments under the HImP and the SaFF, and ensure that activity information is available at practice level
- agree and implement an organisational development plan with each PCG/T to ensure they develop and take on additional responsibilities at a pace determined locally
- take account, with NHS trusts and PCG/Ts, of all future National Institute for Clinical Excellence (NICE) recommendations
- work as fully engaged members of regional specialised commissioning groups (RSCGs), including the use of consortia arrangements and service agreements to ensure that spending plans and risk-sharing arrangements fully support the objectives of the HImP
- ensure plans are clear, concise and understandable for the general public.

Drugs: Health Committee report on *The Cost and Availability of Generic Drugs to the NHS* published.

22 **Primary care groups:** guidance issued for the development of primary care groups and the preparation for the move to trust status.

Health authorities should:

- take continuing management action to support PCGs in their continued development so that they are able to take on the responsibilities for delivering better health care and better services for patients
- agree fair and equitable distribution of management resources
- assist those who wish to progress to PCT status to achieve that ambition
- support those approved by the Secretary of State as PCTs in their establishment and during their preparatory period.

PCGs should:

- work with their HAs to take the opportunity to play an active part in determining local priorities, targets and the use of resources, to deliver more accessible and convenient services for patients through participation in the production of a local Health Improvement Programme (HImP) and by taking on responsibilities for delivery of a programme of action to achieve the HImP
- agree and implement development plans that allow each PCG to take on the responsibility for improving patient services and the health of its community
- work with NHS trusts and HA partners to commission services and align clinical responsibilities with incentives to maximise resources and deliver effective, efficient and quality care
- work with local partners to take forward any local application to move to PCT status, and become a successful PCT as outlined in this HSC.

NHS trusts should:

- work with HAs and PCG/Ts to ensure that regular, accurate and comprehensive data (covering out-patient activity, A&E attendance and waiting lists) is provided, which supports

Long Term Service Agreements (LTSAs) and can be disaggregated to practice level
- work with local PCT proponents to support the establishment of the PCT and to facilitate appropriate transfer of staff and premises
- work co-operatively with PCTs to enable effective commissioning and delivery of health care services
- discuss with local PCG/Ts and HA partners how HR and other management functions might best be utilised across the local health system to maximise NHS resources and skills in that area.

JANUARY 2000

4 **Efficiency:** 1999 National Schedule of Reference Costs published. The new figures continue to show large variations between trusts, but the rankings have changed since the previous year. See the article by Andrew Street, p.47.

5 **Clinical governance:** the Royal College of GPs and British Medical Association published consultation documents for the revalidation of family doctors. The documents, *Revalidation for Clinical General Practice* and *Good Medical Practice for General Practitioners*, set out what makes an 'excellent' GP and how to identify 'unacceptable' practice among GPs who consistently fail to meet the standards.

Dentistry: the Government announced proposals for 34 'phone and go' Dental Access Centres as part of a plan to modernise dental services. The Centres will be set up in a number of locations, including high streets, clinics and some of the new primary care walk-in centres. Patients do not need to be registered with the Centre in order to access the service and can simply make appointments by telephone. The Centres will provide both emergency and routine services.

7 **Cancer care:** a commitment to extending breast cancer screening to women aged 65–69 was announced.

Trusts: the Department of Health announced the first 13 primary care trusts for England, to come into operation in April 2000.

13 **NHS finance:** Lord Winston, in a *New Statesman* article, claimed the NHS is under-resourced and failing to provide an adequate quality of care.

15 **NHS finance:** Tony Blair announced on *Breakfast with Frost* that spending on the NHS would be brought up to the European Union average. See articles by John Appleby and Seán Boyle p.64, Anthony Harrison p.15 and Justin Keen p.27.

17 **Pay:** the Government stated that the pay awards proposed by the Pay Review Bodies for doctors, dentists and nurses would be paid in full.

18 **Nursing:** the first nurse consultant posts are announced. These are intended to create new career opportunities, which will help the NHS retain the most experienced and expert nurses, midwives and health visitors.

20 **General practice:** measures announced to modernise primary care premises, particularly but not exclusively in Health Action Zones. Health authorities are to gain powers to fund new facilities and to develop public–private partnerships, which will allow them, for example, to share risk and rental income or to invest in mobile services.

Trusts: approval announced for four more primary care trusts.

Cancer: £10 million funding announced for improvement to cancer services, specifically to support the achievement of the two-week target for access to hospital specialists.

28 **Carers:** the Carers and Disabled Children Bill published. It includes the following key provisions.

Adults:

- carers to be given the new right to have their own assessment in cases where the person they are caring for has refused one (currently, carers can have their needs assessed only if the person they are caring for is being assessed)
- local authorities to be given the new power to provide prescribed carer's services directly for the carers, e.g. home helps, travel fares, mobile phones or pagers to help them stay in touch with the person they are caring for
- new provision for local authorities to make direct payments to carers in respect of carer's services. Direct payments will give carers the opportunity to choose to purchase bespoke services where they decide the nature, timing and type of carer's services they receive.

Children:

- direct payments to support the role of the parent carer, meaning that parents will be able to purchase services to meet their own needs
- direct payments for 16- and 17-year-old young carers so that they can purchase carer's services to meet their needs
- extension of direct payments scheme to parent carers to allow them to purchase services for their disabled children.

FEBRUARY 2000

1 **Clinical governance:** the independent inquiry into the Shipman case announced changes to GP reporting of deaths.

Primary care: the National Primary Care Development Team was announced.

2 **Primary care:** the National Primary Care Development Team is to support primary care groups and trusts in improving access and waiting times. Those signing up will have to commit themselves to the following:

- improving access for patients by ensuring that 90 per cent of their patients can access their primary health care professional the next working day, or the same day if it is urgent
- tackling coronary heart disease by reducing deaths of patients with proven ischaemic heart disease by 30 per cent in three years and 50 per cent in five years
- cutting waiting lists and times by managing demand and capacity in primary and secondary care to end the current approach to waiting lists.

Social care: the direct payments scheme was extended to older people.

3 **Primary care:** the Audit Commission published a briefing on primary care groups based on a survey of chief executives and interviews. The results suggest that while many had made a promising start, they faced problems arising from limited time and resources, poor data and conflicts between local and national priorities. It also found that:

- many PCGs are promoting re-organisation of community care and social services around practices or clusters of practices
- some have agreed common evidence-based treatment protocols across practice and community nursing
- others are developing cover arrangements to allow all nurses to attend courses and to maintain services when nurses are on leave
- one in five PCGs has developed a database of nursing skills by practice to ensure equity of cover and to help to identify development needs.

Cancer care: £23 million of Lottery money made available for improved home care for cancer patients.

9 **Cataract services:** measures announced to tackle wide variations in speed of access to cataract care. £20 million to be spent on about 50 'modernisation' sites designed to boost rates of treatment where they are currently low and to reduce waits.

10 **Personal Medical Services pilots:** Health Minister announced that the first 83 pilots would continue for another two years.

Hospital beds: report of the National Beds Inquiry published. The Secretary of State indicated that he believed the NHS needed more beds and services and that better links were required for older people between hospital and home. The main findings of the report were:

- two-thirds of general and acute NHS beds are occupied by people aged over 65, who also account for more than half the recent growth in emergency admissions
- at least two out of every ten days spent by people aged over 65 in acute hospital beds could be better provided in alternative facilities, such as intermediate care beds
- the number of NHS beds has been falling for over 30 years – from a peak of 250,000 to 147,000 now, although the decline has slowed in recent years.

The Inquiry went on to set out three possible scenarios for the future of the NHS, dependent on different ways of providing care and the different types of beds involved. All three scenarios involve an overall increase in the number of hospital and intermediate care beds.

The Inquiry's report also showed wide variations across the NHS in the number and type of beds and their relationship with the quality of care patients receive. For example, health authorities differ greatly on average lengths of stay in hospital and the proportion of surgery carried out on a day case basis.

14 **Public health:** eight Public Health Laboratories launched. They are to:

- monitor disease patterns and trends at local level, drawing together information from different sources and organisations to facilitate local priority setting and planning. They will then share this information with other agencies to improve their evidence base for decision-making
- analyse existing data and identify gaps in data to give early warning of emerging health problems and of changes in health trends, ensuring that policy is kept locally relevant and up-to-date
- evaluate the impact of local actions and assess the effectiveness of local agencies in improving health and tackling health inequalities.

Waiting lists: numbers waiting for admission at the end of 1999 were 65,600 fewer than in December 1998. But the total rose between November 1999 and December 1999. Ministers confirmed, however, that they were still on target to reduce the total by 100,000 from the level of May 1997, in line with their pre-election pledge. For the first time for three years, numbers waiting more than 13 weeks for an out-patient appointment fell – by 16,000 between September and December 1999.

17 **Charges:** prescription charges raised by ten pence, in line with the rate of inflation – the smallest amount for more than 20 years.

28 **Nursing workforce:** a Year 2000 nursing recruitment campaign launched. In 1999, the NHS recorded an increase of 4500 in the number of nurses working within it.

A&E: plans announced for the modernisation of A&E departments, including:

- greater powers and responsibilities for nurses. Nurse practitioners and nurse consultants will have greater powers to

request x-rays, blood tests and other diagnostic procedures, to interpret the results, give medication and discharge patients

- faster treatment times. Patients will receive faster treatment on arrival at A&E, by separating the treatment of minor injuries and illnesses from major injuries and conditions. NHS Direct assessment procedures will help to do this
- fast-tracking for patients. Many patients will be fast-tracked on arrival at A&E directly to the appropriate specialty, e.g. patients with fractured hips to orthopaedics
- wider responsibilities for physiotherapists, radiographers and paramedics
- consultants to spend more time treating the most complex cases.

POLICY COMMENT

Private health care: tough choices ahead

What implications will the Prime Minister's pledge to increase NHS funding have for Government policies on private health care?

Justin Keen

Much of the commentary on Tony Blair's pledge to raise UK health care expenditure to the EU average has focused on the extent of possible increases in NHS spending. But UK estimates include a range of non-NHS expenditure, ranging from individuals' purchases of over-the-counter medicines to hip replacements in private hospitals. The OECD estimates that this accounts for some 16 per cent of UK expenditure, or some £9 billion per annum.[1] This is a large enough percentage to ensure that any changes in private expenditure – whether up or down – will significantly affect the Government's chances of keeping the pledge.

Three questions seem pertinent. First, given the uncertainties over the projections of expenditure set out in Datascan below,[2] how much does the UK spend on private health care? Second, should we be looking more closely at the public–private boundary? Third, what are the implications of the pledge for Government policies on private health care?

Figure 1 shows the main flows of financial resources in UK private health care. The private sector is not a single entity, but comprises a number of distinct markets, some of them retail markets (e.g. for over-the-counter medicines) and others a mix of retail and insurance (e.g. the private hospital sector). There are also transfers between the state and private sectors, for example in NHS user charges (mainly for general dentistry, prescriptions and some ophthalmic services) and the use of NHS pay beds. These transfers have to be clearly identified to avoid the double counting of expenditure.

Figure 1

PUBLIC AND PRIVATE FINANCING AND PROVISION OF HEALTH CARE

	Public financing	Private financing
Public provision	NHS services	NHS pays beds, NHS user charges
Private provision	Some waiting list surgery, some acute mental health services	Services financed through out-of-pocket payments, loans, private medical insurance and contributory schemes

Table 1 lists the private health care services for which expenditure figures are available. The list is not complete – for example there are no reliable estimates of private physiotherapy – but it does illustrate the extent of private expenditure. In addition, the data presented are collected in different ways by different bodies, so the figures should be viewed as indicative only, but they are in broad agreement with OECD figures.

Table 1

ESTIMATE OF PRIVATE HEALTH CARE EXPENDITURE IN THE UK, 1997

Source of expenditure	Expenditure (£ million)
Private medical insurance:[a]	
Company paid	1008
Individually paid[b]	1034
Out-of-pocket payment for hospital care[a]	500
Health Cash Plans[c]	150
Complementary therapies[d]	450
NHS user charges	800
Private general dentistry[e]	331
General ophthalmic services[e]	240
Out-of-pocket pharmaceuticals[e,f]	2472
Charitable donations[g]	500
Total	**7485**

Notes

a) Laing and Buisson. *Laing's Healthcare Market Review 1999–2000*. London: Laing and Buisson, 1999.
b) Includes all types of non-company payment: Laing and Buisson.
c) Youngman I. *A market guide to health cash insurance*. Norwich: Ian Youngman, 1998.
d) Estimated out-of-pocket expenditure for six frequently used therapies: Thomas K. Personal communication.
e) Additional to NHS user charges: Department of Health. Personal communication.
f) Office for National Statistics. *Input – Output Annual Supply and Use Tables, 1997*. London: TSO, 1999.
g) Estimated from Department of Health accounts: National Audit Office.

The second question concerns the boundary between NHS and private health care. Figure 1 emphasises the point that the latter comprises a number of distinct markets, for elective surgery, complementary therapies and so on. In some places the boundary is clearly drawn and a service is on one side or the other, as for example in the provision of over-the-counter medicines by the market. Elsewhere, however, the boundary is blurred: surgeons work in both the NHS and private sectors, dentists provide NHS and private care from the same premises, and complementary therapists can be accessed both privately and via GPs.

One possible policy response to the Blair pledge is to delineate the boundary more sharply. An obvious – though politically delicate – place to act is the NHS consultant's contract. If the Government believes that surgeons will be most efficiently deployed if they do almost all of their work within the NHS (which is a reasonable assumption), then the next contract should build in incentives to encourage this to happen. Looking at the boundary more generally, there is an opportunity to move beyond the ideological sparring of the early weeks of 2000, and take a hard look at the arguments for providing particular services within the NHS, privately or in a mixed economy of the kind that already exists in dentistry. In principle, at least, boundaries should be drawn in the places that maximise social (or Pareto) efficiency. The sting in the tail now is that ideology is not enough – making the wrong decisions about the most efficient way of delivering services would put the pledge at risk.

Moving on to the policy implications, the pledge puts the Government in a tricky position in relation to private health care. On the one hand, Labour's traditional antagonism to private health care, exacerbated by the bruising battle with hospital consultants over NHS pay beds in the 1970s, is echoed in its current actions. In the 1999 budget,[3] for example, Chancellor Gordon Brown extended two taxes – employee's National Insurance contributions and Insurance Premium Tax – to cover general insurance products, including private medical insurance (PMI). PMI is used to finance around 80 per cent of all hospital-based private care, and increases in premia to take account of these tax increases seem likely to have a negative effect on sales of policies.

On the other hand, the Government needs the private sector to maintain its current size, or even grow in real terms, if the EU average is to be attained within a politically realistic timescale.[2] The Government will therefore have to face some tough questions: where will money for more private health care come from? Does it want the private health care sector to expand at the same rate as the NHS? Given that money currently buys faster access to many services, what level of inequity of access to health care (if any) is acceptable?

Underlying these questions is the fact that the NHS and private health care sectors, while not formally linked to one another, are in practice interdependent. The supply of doctors and other clinical staff is effectively fixed: growing NHS services effectively means static or decreasing private services, and vice-versa. On the question of financing, if more money for the NHS means shorter waiting times and higher average quality treatment, then the demand for private care might be expected to fall. Actions on one side of the public–private boundary will therefore have effects on the other.

This is the stuff of policy nightmares, where one part of the pledge (boosting the NHS) may serve to undermine another (reaching the EU average). At the same time, the pledge goes a long way to forcing the Government to decide whether it wants to help or hinder private health care, a subject it has shown no appetite for tackling. The Care Standards Bill,[4] published only in December 1999, contains no measures that will either encourage or discourage the growth of private health care, but simply seeks to keep it at arm's length. This position looks untenable only weeks after publication.

As is often the way, the current policy turmoil may have beneficial consequences. If the Government is indeed forced to consider the inter-relationships between the NHS and private health care, one result could be more considered policies on those services that straddle the divide, including elective surgery and general dentistry. Another result could be properly thought-out regulation for private health care, which tackles the weaknesses in consumer protection identified by the Health Committee[5] and others, and leads to explicit policies on equity, particularly for access to care. Nobody thinks these issues are easy to tackle – but tackled they must be.

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2. See Datascan, p.64.

3. Chancellor of the Exchequer. *Budget 1999: Building A Stronger Economic Future for Britain.* London: Stationery Office, 1999.

4. Care Standards Bill. London: Stationery Office, 1999.

5. Health Committee. *The regulation of private and other independent healthcare. Fifth Report, Session 1998–99, 281–I.* London: Stationery Office, 1999.

Relenza: out in the cold?

The controversy surrounding Relenza reveals how little involvement the public actually has in 'public' debate.

Andrew Bell

On 1 October 1999, the rapid assessment committee of the National Institute of Clinical Excellence announced its first decision. The committee ruled that Glaxo Wellcome, manufacturers of the influenza drug Relenza, had provided too little evidence that the drug was effective in treating flu in groups of people vulnerable to the infection. It concluded that the NHS was best served by continuing to spend money on vaccinating those groups against flu and treating the disease with conventional drugs where necessary.

One week later, the then Health Secretary Frank Dobson endorsed the committee's decision and produced guidelines stating that Relenza should not be prescribed on the NHS. Following the precedent laid down by the Viagra decision, described in the previous edition of *Health Care UK*, the Secretary of State took a decision to limit NHS availability of a drug licensed in the UK on the grounds of its value for money.[1]

BOX 1: NICE GUIDANCE ON RELENZA

The guidance to the NHS from NICE stated that:

Due to the limited numbers of 'high risk' patients ... that have been treated with Zanamivir (Relenza) in clinical trials, the Institute has not found it possible to conclude that the product reduces the frequency of serious secondary complications in these groups of patients.

On the basis of its findings and conclusions, the Institute advises that health professionals should not prescribe Zanamivir (Relenza) during the 1999/2000 influenza season ...

Source: NICE. *Rapid Assessment of Zanamivir (Relenza)*. NICE, 1999.

The story this created for the national press was one of a 'wonderdrug' under threat from the NHS because of financial concerns. Unlike Viagra, Relenza was a drug to treat a life-threatening condition and could not be dubbed a 'lifestyle' drug. The decision of the rapid assessment committee of NICE was reported by every major newspaper on 2 October, the only time this happened during the week in question. The majority, tabloids especially, framed the story as a battle between the needs of vulnerable people and an NHS battling to save money on drugs. Headlines that day included:

'Britons "set to be denied drug that eases flu misery"' (*Daily Mail*)
'Drug firm fights NHS ban on £24 flu cure' (*The Times*)
'Flu wonderdrug facing NHS ban' (*The Sun*)

During the rest of the week, there was a greater divergence between the newspapers in their treatment of the story. The main broadsheet newspapers discussed the implications of the decision for the NHS and how it related to wider debates about NHS rationing. The *Daily Mail* continued the early theme of NHS bosses 'banning' a drug that had been licensed in the UK, while the rest of the tabloids paid no more attention to the story. The *Financial Times*, meanwhile, focused on the implications of the decision for the pharmaceutical industry and its relationship with government and the NHS.

BOX 2: CALENDAR OF EVENTS, 2–9 OCTOBER 1999

2 October
All nine major newspapers report the finding of the NICE rapid assessment committee that Relenza is not good value for money for the NHS. Most reports frame the story as a financially driven 'ban' on a 'wonderdrug', although *The Times* produces an editorial calling on the Health Secretary to back the guidance.

3 October
The *Independent on Sunday* reports that Glaxo Wellcome is threatening to leave the UK because of the NICE decision.

4 October
The Guardian editorial backs the NICE decision and calls on the Health Secretary to support it.

5 October
News appears in the *Financial Times* and the *Daily Telegraph* that NICE has rejected Glaxo Wellcome's appeal against its decision.

6 October
Glaxo Wellcome announces the loss of 1700 jobs in the UK and writes to the Prime Minister warning about the dangers of NICE. The story is reported in the *Financial Times*, *The Guardian*, *The Times* and the *Daily Mail*.

7 October
Doctors warn that a flu epidemic could be on the way, which is reported in the *Daily Mail* with yesterday's warning from Glaxo Wellcome. The *Financial Times* reports on Government claims that Glaxo Wellcome are misleading the public.

8 October
A *Financial Times* editorial argues that NICE is a positive thing but should be even-handed towards drug companies.

9 October
The Independent, *The Times* and the *Daily Mail* report the Government decision backing NICE guidance on Relenza.

The activities of Glaxo Wellcome chair Sir Richard Sykes took up much of the coverage in the following week. On 5 October, the company was reported as having failed in its appeal bid with NICE. The following day, it announced the loss of 1700 jobs in its UK business – highlighting the effects of the Institute on the pharmaceutical industry. Sir Richard Sykes, along with the chairs of Astra Zeneca and SmithKline Beecham, also wrote an open letter, printed in full in the *Financial Times*, to the Prime Minister warning that NICE would damage the British pharmaceutical industry by creating an extra hurdle to the acceptance of new drugs.

By the end of the week, however, several articles had been produced in broadsheet newspapers that were more sympathetic towards the Government's position. *The Times*, *The Guardian* and the *Financial Times* all produced editorials arguing that NICE had to make rationing decisions even if they meant restricting the availability of effective treatments. By the time of the Government's announcement on 9 October, there was considerably more positive reporting of the decision. The *Daily Mail*, *The Times* and *The Independent* all quoted the Health Secretary and other voices in support of the decision along with the ubiquitous Sir Richard Sykes, and the BMA, in opposition.

During the week as a whole, the story received a considerable amount of media attention, particularly in the broadsheets and especially in the *Financial Times* (which covered it on five out of a possible six days). The majority of coverage followed the convention of reporting NHS decision-making as the grim realities of a public national health service being forced to restrict the availability of the wonders of science. This applied to almost all the coverage in the tabloid newspapers. In the broadsheets, however, there was an awareness about the trade-offs inherent in NHS resource allocation – that making such choices is not always a negative aspect of a national health service but a central part of its function as a means of distributing resources fairly and efficiently.

In a selection of 29 articles on the subject between 2 and 9 October 1999, of which three were

editorials, a total of 62 direct or indirect quotations were used – approximately two per article. Of that number, 26 were from the pharmaceutical industry, 12 were from the Government or NICE, 17 were from interest groups and seven from other observers. Sir Richard Sykes was quoted in eight articles, making him by far the most quoted individual. Among the interest groups, doctors were quoted ten times, unions three times and Age Concern four times. The quotations from Age Concern, all on 2 October, were the only occasions in which NHS users or their representatives had a voice in the whole debate.

Exactly half of the quotations used were generally opposed to the NICE decision, while of the remaining 31, 17 were largely in favour and 14 were neutral. Glaxo Wellcome produced most of the negative quotes and the Government and health economists gave most of the positive quotations. The majority of neutral statements came from doctors, with doctors' groups like the BMA and Royal College of GPs more likely to make neutral statements than individual doctors quoted, who attacked the NICE decision as a restriction on their freedom.

From such a content analysis, and a look at the language used in headlines, it is clear that the loudest voices heard were opposed to the NICE decision. That slant is particularly clear in tabloid newspapers, where debate about the rationing issues raised by the decision was largely absent or boiled down to Government parsimony. The concept that the NICE decision could in any way be positive was restricted mainly to the three editorials studied (in *The Guardian*, *The Times* and the *Financial Times*), all of which stated that priority setting in the NHS had to take at least some account of cost.

What does this mean for public debate about choices in health care? For one thing, just like Viagra, this case shows very clearly the political nature of NHS rationing decisions.[1] The judgements made by NICE have implications not just for medicine but for the British economy and the priorities of a publicly funded national health service. Yet debate about them is restricted to an unelected scientific body and a small number of interest groups. The place of the public in that debate is limited to that of passive onlooker.

This has major implications for the future of NICE. The Relenza decision will be the first of many cases where the institute rejects a treatment for a condition that attracts widespread public sympathy. For some while, at least, those decisions will attract considerable media interest. More often than not, both ministers and NICE will appear to be limiting medical science for the sake of saving money. If the Government wishes to move away from that scenario, it must develop a more open and inclusive method of making political decisions about NHS priorities.

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POLICY ANALYSIS

Performance indicators: making information out of data

Raw data needs to be repackaged and made available at a number of levels if performance indicators are to be of use.

Chris Deeming

Performance data for 100 health authorities and 280 NHS hospital trusts in England was published in 1999.[1, 2] These performance indicators are intended to support the national Performance Assessment Framework (PAF), which aims to introduce a broader based approach to assessing quality in the NHS.[3] There is however a lack of clear direction from the NHS Executive on how the data should be analysed and used at a local level. The Executive is currently in the process of trying to improve the presentation of the indicators and, over time, it claims that they will play an important role in the formal accountability arrangements of the NHS.

But how is the performance indicator data to be analysed and interpreted – especially in the light of the diverse target audiences it is hoped the indicators will inform.

THE NHS PERFORMANCE INDICATORS

The use of performance indicators has been promoted and encouraged in the NHS since the early 1980s. The first indicators were introduced in September 1983, but these were little more than existing NHS finance and activity statistics repackaged as performance indicators. Subsequently, the indicators became more refined and extensive, although the focus was still largely around NHS processes and outputs.[4] The latest indicators are therefore to be welcomed because they focus on health outcomes and patient experience.

The High Level Performance Indicators (HLPIs)[1] (for health authorities) support the PAF by providing a quantitative method for reviewing NHS performance across six dimensions:

- **health improvement** – reflecting the overarching aim of improving the health of the population
- **fair access** – ensuring that people's ability to obtain health care is related to their actual needs
- **effective delivery of appropriate health care** – recognising that the care that is provided should be clinically effective and in line with agreed standards
- **efficiency** – achieving value for money in the use of NHS resources
- **patient/carer experience** – ensuring that the NHS is responsive to individuals' needs and preferences

- **health outcomes of NHS care** – assessing the direct contribution of the NHS to improvements in health.

The Clinical Indicators (CIs)[2] focus on certain specific issues of clinical care for both trusts and authorities. There is some overlap between the two sets of indicators, e.g. returning home following treatment for a stroke and returning home following treatment for a fractured hip.

It is intended that the PAF, together with the performance indicators, will help to improve standards and reduce variations within the NHS by comparing (performance) and sharing (best practice). The indicators are not, however, direct measures of quality. Rather, they are intended to raise questions and prompt further investigation. There is, for instance, a strong influence from social factors such as housing, education and wealth on many of the population-based indicators, and many factors are outside the direct control of hospitals, such as care provided by GPs.

WHO IS THE AUDIENCE?

There are many potential users of NHS performance data:

- **politicians,** who wish to preserve accountability while decentralising responsibility
- **managers and professionals** seeking to ensure high quality services and value for money
- **service users and their representatives,** or the population at large, who may wish to monitor local services
- **journalists and broadcasters,** who provide a ready story of human interest and potential for scandalous interpretation of the poor performers.

The indicators will (or need to) appeal to all these interest groups, hence the need for the indicators to be packaged in a way, or indeed a variety of ways, that will best serve these groups. This is essential since nearly all the arguments for information on performance in the NHS focus ultimately on public accountability in a publicly funded system. Formal arrangements exist to hold health authorities to account by the Department of Health through the NHS Executive Regional Offices, between local NHS organisations and between a local health system and its patients and local population. These accountability arrangements form the backbone of NHS performance management systems, which ensure high quality services are delivered across the NHS and that they offer value for money. In order to help achieve accountability, the PIs have been made freely available to all, at the Department of Health web site. But they are not presented in an easily accessible form: it can be hard to pin down variations in indicators and it is not clear what the most appropriate point of reference for benchmarking should be.

HOW CAN WE MAKE SENSE OF THE NHS PERFORMANCE INDICATORS?

Performance indicators are essentially comparative tools: comparison with what has occurred before, with what occurs elsewhere, or with some other yardstick, norm or average. Comparison is an essential ingredient of evaluation, allowing judgements to be made about what is the dividing line between what is acceptable and what is not. Usually this involves setting standards.

One of the vital questions in discussing the NHS performance indicators is how they can be used to evaluate 'good' and 'bad' performance when there are often no explicit national standards or targets for districts or hospitals. Relativity plagues most of the indicators. For example, if surgical rates are indicators of performance across districts (as differing rates may suggest variable access and unmet need) what, then, is an *acceptable* intervention rate? Clearly, a comparative approach to the analysis of the indicators is needed.

In the absence of national targets, other ways of drawing comparisons include measuring performance over time (time series) and comparing performance across districts and across hospitals (cross-section). The time series approach is useful for districts and hospitals that serve unique or unusual populations. There is little concern with finding suitable comparators and there is not the level of anxiety around the validity of the comparison that accompanies the cross-sectional

approach. In practice, however, many variables are liable to change. For example, changes in the quality of information could make the time series redundant. Although the information may not exist at present to construct a reasonable time trend for each of the indicators, this approach does offer potential for the future.

The cross-sectional approach encourages the rank ordering of districts and hospitals from (relatively) 'good' performance to 'poor'. It enables examination of how a particular district or hospital is performing on a particular indicator in relation to others and the amount of variation that is identifiable, and it provides reference for benchmarking purposes. This approach usually forms the basis of a league table. Figure 1 provides an example, showing day case rates across districts in England.

One problem, however, is that the comparisons being drawn may not be valid – like may not be being compared with like. Grouping districts or hospitals on a relevant dimension can provide more valid comparisons. For example, the socio-economic status of districts' populations can be accommodated into the analysis, allowing those with a similar socio-economic profile to be compared. And hospitals can be grouped according to type. This approach is used by the NHS Executive in its published material on the NHS performance indicators (see Figure 2).

Another possible approach to comparative analysis is to compare a district's or hospital's performance against the national average. This may be particularly useful in assessing performance across a range of indicators (see Figure 3). There is a danger that average performance is equated with 'good' performance. Some of the HLPIs have been derived from a comparison against the national average. There are potential problems in doing this. While a performance indicator that is based on comparisons with an average will inevitably draw attention to outliers – prompting questions about those districts that are conspicuously above or below the national average – it can say little about the performance of those hidden in the 'pack'. Nor does it say anything about whether or not the national average represents 'good' or 'bad' performance. Longer term, there may be a tendency to the mean as poorly performing outliers move in – a good thing, but the implied target of the average may not be challenging.

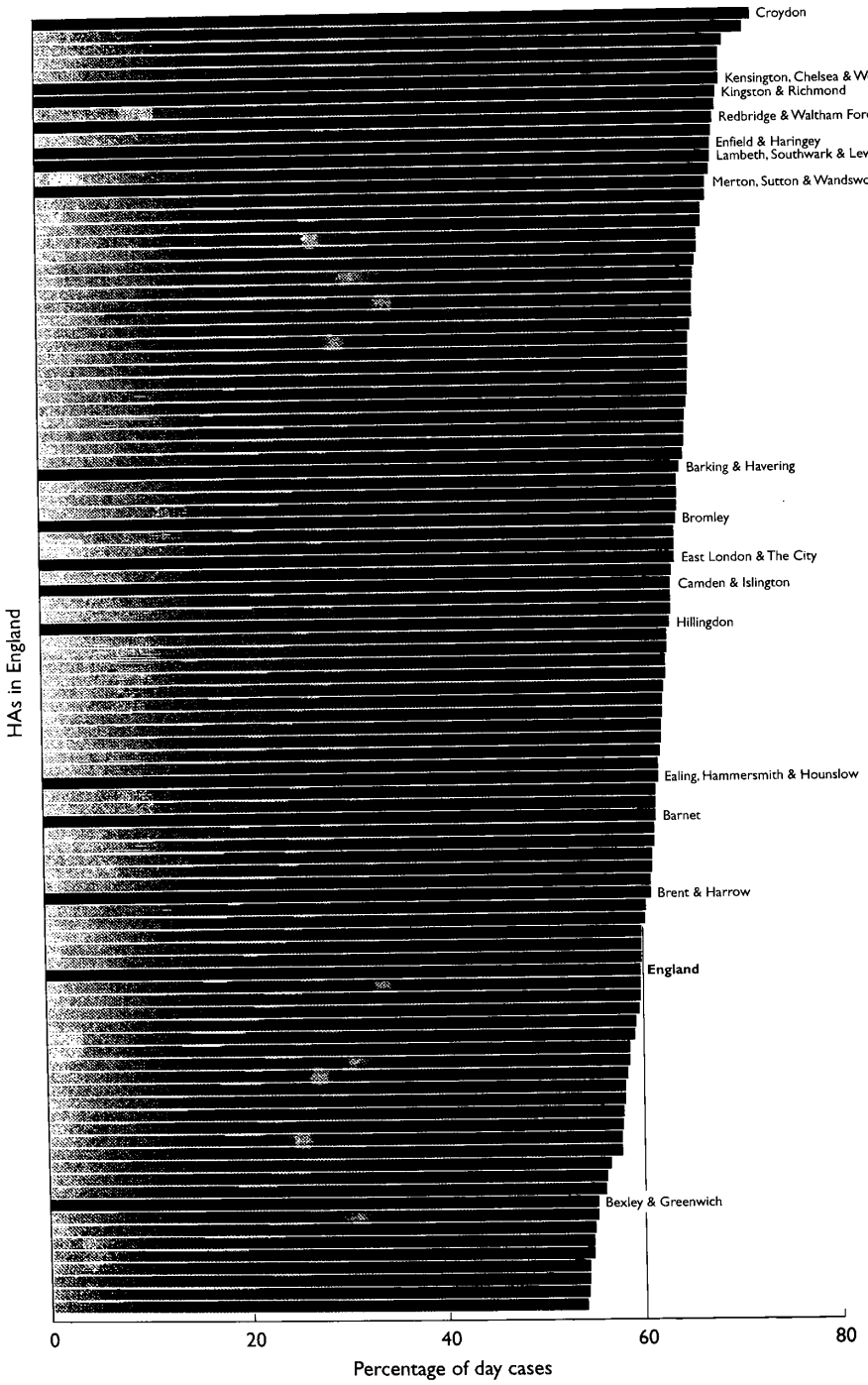
The PAF emphasises that a key objective is to generate a 'rounded assessment' of the overall performance of an authority or trust in delivering services for its population. But how might such a rounded assessment be made, given the volume and diversity of indicators? One option is to look at the average health authority ranking in each of the six dimensions of performance in the PAF. Figure 4 illustrates this, using data for Ealing, Hammersmith and Hounslow (EHH) Health Authority. For the most part EHH is around average, with the exception of *patient/carer experience of the NHS*, which, overall, is well below average.

This method can also be used to examine performance at NHS regional level. Figure 5 shows the average rankings on each of the six areas for Greater London. Overall, London does slightly better than average for *health improvement*. London is around average for the *effective delivery of health care*, *health outcomes of NHS health care* and *efficiency*. It is below average for *fair access* and *patient/carer experience of NHS*.

This method of obtaining the average ranking for each of the six performance dimensions may be misleading if the individual indicator rankings are very widely spread. For instance, Ealing, Hammersmith and Hounslow Health Authority is shown to be just over average for *fair access*, but the rankings on the individual indicators that make up the *fair access* dimension are very widely spread (from 3 to 96). Table 1 shows the rankings across the *fair access* for all of London's health authorities and presents a further method of analysis.

Figure 1

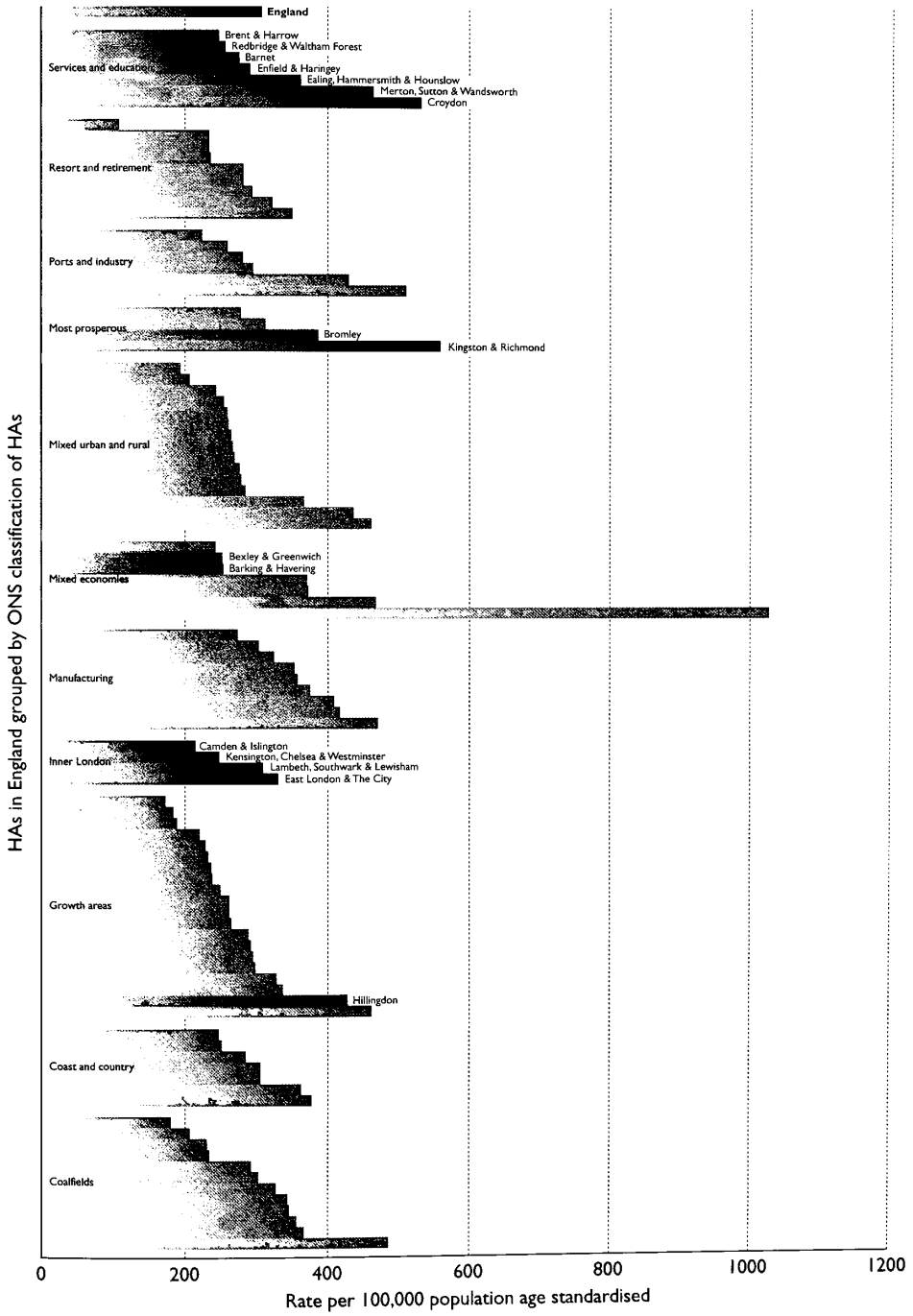
DAY CASE RATES, BASELINE YEAR 1997/98, SMALLER INDICATOR VALUES REFLECT LOWER MORTALITY RATES



Source: NHS Executive. *Quality and Performance in the NHS: High Level Performance Indicators.* Leeds: Department of Health, 1999.

Figure 2

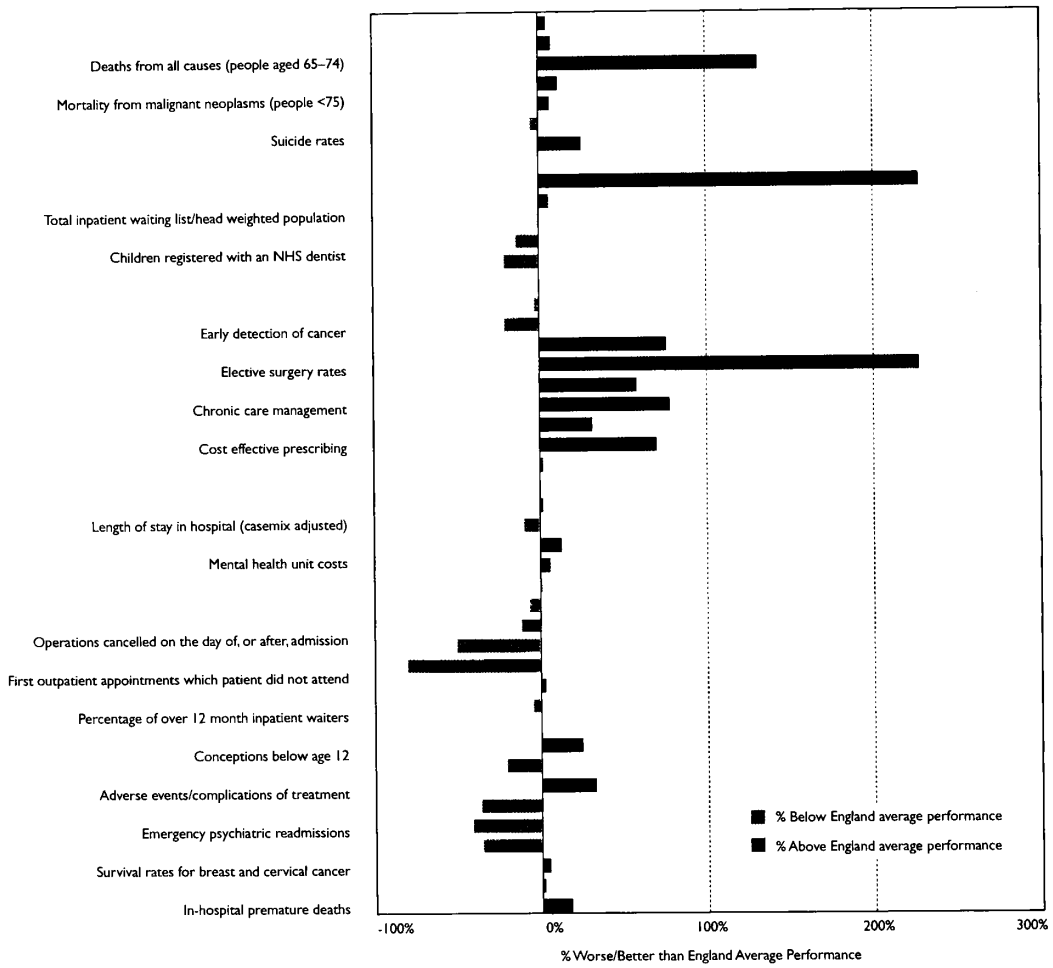
DEATHS IN HOSPITAL WITHIN 30 DAYS OF SURGERY (NON-EMERGENCY ADMISSIONS), BASELINE YEAR 1997/98, SMALLER INDICATOR VALUES REFLECT LOWER MORTALITY RATES



Source: NHS Executive. *Quality and Performance in the NHS: High Level Performance Indicators*. Leeds: Department of Health, 1999.

Figure 3

HLPI VALUES FOR KENSINGTON, CHELSEA AND WESTMINSTER HA



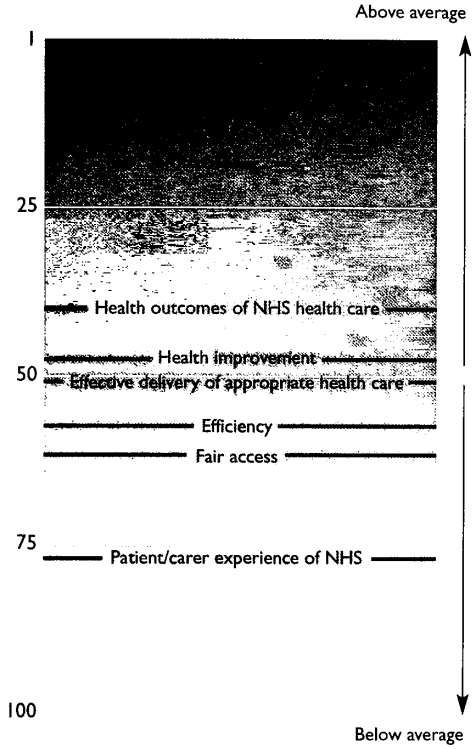
Source: NHS Executive London. *High Level Performance Indicators: London Health Authority Comparisons.* London: Corporate Performance Management, 19 July 1999.

There may also be value, at a system level, in drawing international comparisons, for example between UK performance and other countries or between London and other cities. This might provide a powerful means of communicating good practice. Figure 6, for instance, shows the relative survival for breast cancer across countries in Europe. Survival from breast cancer is part of a composite indicator (cancer five-year survival rates) in the HLPIs under the heading *health outcomes of NHS care*. This indicator also includes survival from cervical cancer.

Table 2 compares coronary heart disease standardised mortality ratios for people under 65 years for cities (or regions) in Europe. Mortality from CHD (in persons under 65) is part of the *potentially avoidable mortality* composite indicator within the performance dimension *health outcomes of NHS care*. Values over 100 indicate standardised mortality ratios (and therefore the underlying mortality rates) that are greater than those in London: values under 100 indicate mortality rates that are less than those in London.

Figure 4

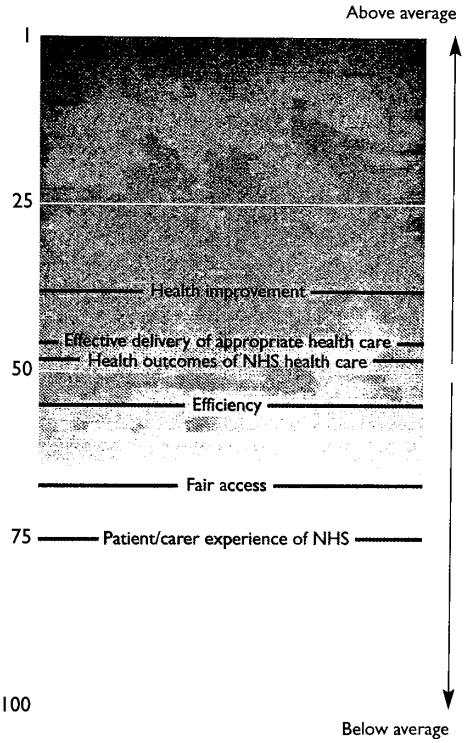
MEAN INDICATOR RANKING IN EACH OF THE SIX AREAS OF THE NHS PERFORMANCE ASSESSMENT FRAMEWORK FOR EALING, HAMMERSMITH AND HOUNSLOW HEALTH AUTHORITY



Source: NHS Executive. *Quality and Performance in the NHS: High Level Performance Indicators.* Leeds: Department of Health, 1999.

Figure 5

MEAN INDICATOR RANKING IN EACH OF THE SIX AREAS OF THE NHS PERFORMANCE ASSESSMENT FRAMEWORK ACROSS THE LONDON REGION



Source: NHS Executive. *Quality and Performance in the NHS: High Level Performance Indicators.* Leeds: Department of Health, 1999.

Interesting though they are, international comparisons can be very misleading due to definitional problems and variations in data collection between countries.

SUMMARY

Making sense of what is being measured is the real challenge. The only way to provide meaning to the indicators is by providing a context that will enable comparisons to be made. There are a number of options for the analysis and presentation of the NHS performance indicator data. Comparisons can be made using:

- targets
- time series
- rank order
- cross-section
- national average
- international performance.

There are trade-offs to be made, however, between trying to understand performance by examining each of the indicators and losing the range of performance when attempting to gain an overview.

Table 1

LONDON'S PERFORMANCE IN THE AREA 'FAIR ACCESS' (HA RANKINGS)

		Fair access			
	Surgery rates	*Size of in-patient waiting list/head of pop. (wghtd)*	*Adults registered with an NHS dentist*	*Children registered with an NHS dentist*	*Early detection of cancer*
Health authority					
Hillingdon	24	29	44	78	80
Kensington, Chelsea & Westminster	91	1	93	99	100
Enfield & Haringey	39	52	71	80	94
Redbridge & Waltham Forest	41	84	61	83	90
Bexley & Greenwich	37	32	77	68	79
Bromley	4	71	100	78	52
Croydon	9	61	73	74	89
Kingston & Richmond	98	68	97	51	84
Lambeth, Southwark & Lewisham	40	40	56	97	97
Merton, Sutton & Wandsworth	77	17	81	91	91
Barking & Havering	83	99	79	92	46
Barnet	52	34	99	94	93
Brent & Harrow	1	38	57	87	92
Camden & Islington	67	6	33	98	99
Ealing, Hammersmith & Hounslow	3	44	67	93	96
East London & The City	79	30	90	100	98

Source: NHS Executive. *Quality and Performance in the NHS: High Level Performance Indicators.* Leeds: Department of Health, 1999.

If the latest attempt to use performance indicators is not to go the way of attempts in the 1980s, then the information needs to be packaged and made available at a variety of levels and in a number of ways, making use of the full range of reference points described here. Only when this has been achieved can we hope to hold the NHS system to account.

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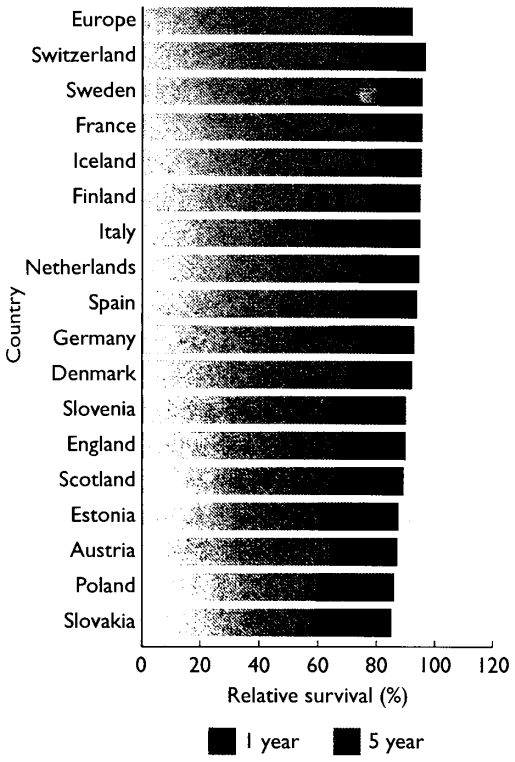
Figure 6

AGE STANDARDISED RELATIVE SURVIVAL FOR BREAST CANCER (PER CENT)



Source: Berrino F et *al. Survival of cancer patients in Europe: The EUROCARE-2 Study.* International Agency for Research on Cancer Scientific Publications No. 151, 1999.

Table 2

STANDARD MORTALITY RATES FOR CORONARY HEART DISEASE IN CITIES AND REGIONS IN WESTERN EUROPE

City	*Rate*
Lyon	33
Madrid	36
Bruxelles	54
Amsterdam	75
Copenhagen	90
Oslo	91
Stockholm	92
London	100
Vienna	117
Dublin	121

Source: *Project Megapoles.* A report prepared by The Health of Londoners Project, May 1999 (www.elcha.co.uk/holp/publications.htm).

A bottom-up approach to performance indicators through clinician networks

Employing specialised clinical databases may have a number of advantages for the NHS quality drive.

Kathy Rowan and Nick Black

INTRODUCTION

The NHS quality initiative is heavily reliant on the Performance Assessment Framework (PAF) to monitor the quality of services provided and to assess the success of the measures taken to enhance quality. The extent to which these goals can be achieved is inevitably limited by the PAF's dependence on the only routine data available – hospital episode statistics (HES). While these data are adequate as a source of information on some processes of care, such as in-patient admission rates and length of in-patient stays, they are inadequate for measuring outcomes and, hence, the effectiveness of care. Although the completeness of HES data may have improved in recent years, in 1997/98 only two-thirds of NHS trusts were able to supply HES data that were at least 75 per cent complete.[1]

A key requirement for any data used for assessing the quality of care is its credibility with clinicians. HES fails to achieve this with most clinicians for four reasons. First, its completeness and accuracy (validity and reliability) is poor. Second, there is inadequate consideration of case mix (factors such as severity of the principal condition and the existence of other, so-called, secondary conditions). Third, the indicators that can be derived are focused on processes, such as length of stay, most of which are of uncertain meaning. Fourth, the top-down way in which the variables included are chosen and the compulsory nature of their collection does not endear the system to those whose quality is being assessed.

Three decades of trying to overcome these drawbacks have achieved little, suggesting that the problem is not a technical but a conceptual one. One way forward is to lower the objectives and refocus HES on a more restricted data set including only administrative and basic clinical data (main diagnosis and principal operation only). This would permit a broad description of health care activities, which could then be complemented by specialised, sophisticated clinical databases of high quality in selected, priority areas of care, established by clinician networks. So what might such databases look like?

WHAT ARE HIGH QUALITY CLINICAL DATABASES?

High quality clinical databases (HQCDs) are characterised by five key features:

- the data set includes information on the main, known confounders to enable risk adjusted outcomes to be determined

- the variables and their method of collection are clearly defined
- they include data on consecutive cases (or on an unbiased sample) at an individual level (rather than an aggregated level)
- the data are complete and accurate (ideally with some form of external validation)
- information on outcome is included (at least relevant, immediate, short-term outcomes, though longer-term outcomes are desirable).[2]

While this represents an ideal that few, if any, databases have yet achieved, considerable progress has been made in some clinical areas in several countries. In the UK, one of the earliest attempts was in Lothian where the surgeons from several hospitals collaborated in creating an audit database in the 1970s.[3] During the 1980s there were several initiatives, including one covering obstetrics in the North West Thames region, orthopaedics in Trent and North Western regions, and haematological concerns in Northern regions.[4] More recently, databases covering renal replacement therapy (renal dialysis and transplantation),[5] organ transplantation,[6] intensive care,[7] cardiac surgery[8] and assisted reproduction[9] have been developed. Other attempts have been made but have proved unsuccessful.[10] If further attempts are to be made to pursue this approach to quality improvement of clinical care, then it is important to learn lessons from the past as to what factors may be associated with successful implementation. An analysis of the establishment of the national database of intensive care can teach us several lessons.

LESSONS FROM THE INTENSIVE CARE NATIONAL AUDIT & RESEARCH CENTRE (ICNARC)

ICNARC co-ordinates a national, comparative audit of patient outcome for adult, general intensive care units, high dependency units and combined units called the Case Mix Programme (see Box 1).

BOX 1: KEY FEATURES OF THE INTENSIVE CARE CASE MIX PROGRAMME

- Every interested unit is visited by ICNARC staff prior to participation.
- A comprehensive data set specification is available, which provides standardised definitions to be adhered to in the collection of casemix and outcome data for all admissions (all the main known confounders are included).
- Comprehensive data collection manuals are available.
- Up to three staff in each intensive care unit are trained in the rules and definitions prior to commencement of data collection. Retraining of original staff or training of new staff in participating units is also available, with training courses run every three months by ICNARC.
- A six-week pilot data collection period is undertaken to sort out local procedural matters and establish the facility to export data. Pilot data are tested centrally to ensure integrity.
- Data are collected on consecutive admissions to the participating unit in six-month cycles.
- A number of software applications are available to units from software developers who have incorporated the comprehensive data set specification into their applications.
- Data are validated at data entry according to the data set specification.
- Data are validated extensively by ICNARC for completeness, illogicalities and inconsistencies.
- Data validation reports are returned within four weeks of receipt of data.
- Data are validated until they are deemed to be 'clean'.
- Comparative data analysis reports are produced and disseminated within six weeks of data being clean. The report was designed by a group of intensive care practitioners.
- Interpretation of results is left to each participating unit.
- The identity of the source of data remains confidential, although individual participating units can identify their own performance in graphs comparing the performance of all participating units.
- An annual meeting is held for all participants to discuss both the operation of the Case Mix Programme and the results emanating from it.

We have identified ten factors that we perceive as having been important in the successful establishment of the Case Mix Programme and the resultant high quality, clinical database at ICNARC.

Close links with professional organisations

Our sister organisation is the Intensive Care Society, which is the national professional organisation of doctors working in critical care medicine. In addition, important links exist with the critical care nursing organisations. The professions were proud to be establishing rigorous quality assessment and comparative audit ahead of most other medical specialties.

Scientifically rigorous

The Case Mix Programme was built on a major research study[11, 12] that had established the means by which data could be collected from 26 dispersed units and be processed centrally. It also established excellent relations between the clinicians and the researchers (epidemiologists and statisticians). Scientific rigour has been maintained through the continuing involvement of academic health services researchers through ICNARC's advisory committees and collaborative research links.

Independence

ICNARC was set up as an independent charity rather than a profit-making organisation or part of the Department of Health or NHS Executive. This independence provided reassurance to clinicians as to the ownership of the data and who had access to such confidential and potentially sensitive information.

Central government support

ICNARC received core funding for an initial two years (commenced January 1994) with a remit to be self-financing after that period. These pump-priming funds allowed the necessary establishment of the infrastructure for the Case Mix Programme. Without this financial assistance, it would have proved almost impossible to establish the Programme. Continued support comes largely from the participating units paying an annual subscription.

Data is not just used for comparative audit

The potential of the Case Mix Programme database includes the opportunities to carry out methodological and evaluative research (four major research grants recently awarded), provide national statistics (for example, Case Mix Programme data underpinned *Critical to success*, the work of the Audit Commission[13]), and investigate policy issues (a recent example being a demonstration of the poorer survival of patients discharged prematurely, particularly at night[14]).

Value for money

Although this is a relatively sophisticated approach to measuring quality, its cost is low compared to the cost of providing intensive care. For example, establishment of the Case Mix Programme in all intensive care units in the West Midlands region, including the annual subscription to ICNARC, personnel for data collection and computer hardware/software/maintenance, costs 0.6 per cent of the total expenditure on intensive care in the region.

Participants' sense of belonging to a club

Viewing participation as being in a club is encouraged with newsletters and an annual meeting to share ideas, results, views and even moans! This sense of being part of a larger community, and the opportunities it brings to share experiences, seems to have met a previously unmet need. This may partly result from 'members' being not only doctors but also nurses, audit clerks and others who do not always get the opportunity to participate in clinical groups and meetings.

Facilitating not controlling

ICNARC has focused on getting the centre–local balance and the provider–commissioner balance correct. This has been a challenge but, we believe, it has been of vital importance. The centre needs to be both sensitive to the views and needs of units but also reasonably resilient to adverse comments at times!

Management skills

With the remit to be self-financing after two years, the Board of Management of ICNARC included not only clinicians but also individuals with skills

commensurate with running a charitable company (business management, finance) and people with knowledge and awareness of the wider political environment and processes (someone with experience in senior management in the NHSE). Such skills and knowledge are essential to help steer clinicians and researchers through what are often fairly turbulent environments.

PARTICIPANTS SUBSCRIBE FROM THE OUTSET

Although core funding for the initial two years was available, it was decided to institute subscription charges from day one rather than in the third year. This not only permitted us to cushion the financial risks of getting established over several years (the core funding was spent over three to four years), but also helped establish in participants' minds, from the start, the notion of having to pay a subscription.

HIGH QUALITY CLINICAL DATABASES – NOT JUST FOR CLINICAL AUDIT

While the focus of this article has been on the development of databases to support quality improvement, databases can also be used for three other purposes: evaluative research, aiding clinical practice and managing services.

EVALUATIVE RESEARCH

The benefits for evaluative research are better recognised than are the other uses for HQCDs. The high participation rate in data collection by clinicians from a wide range of hospitals (compared with that in traditional ad hoc research studies) enhances the generalisability of the results[15] and instils ownership of the research, which may encourage uptake of the results into practice (the aim of evidence-based medicine). Research using an HQCD is also relatively cheap since the data collection systems have already been established and their cost is spread over many research studies and is shared with the other applications (clinical practice, management and audit).

The attractions for researchers include the large samples of patients that can be generated rapidly because of the high number of participating centres and the possibility of studying rare disorders or interventions. Although evaluations restricted to the data in HQCDs are, by definition, non-randomised (or observational) comparisons, these databases can be used in two ways to promote randomised, controlled trials. First, by raising the level of uncertainty among clinicians as to the effectiveness of established interventions, they might increase clinicians' likelihood of participating in a randomised trial; and, second, by providing a permanent infrastructure for large multi-centre trials. Finally, the adoption of HQCDs means that research need no longer be the preserve of a minority of clinicians working in specialist centres. HQCDs enable clinicians working in typical secondary care settings to participate, thus enhancing the generalisability of the results.

CLINICAL PRACTICE

Clinical practice can be aided in two ways. First, by virtue of their size, generalisability and timeliness, HQCDs provide up-to-date, accurate estimates of the probabilities of different outcomes in typical settings. Decision analysts need this information for incorporation into their models to support the clinical management of individual patients and to help increase the scientific basis of health care policies.[16] Advances in patients' participation in decision-making are dependent on the availability of data from HQCDs.[17] Second, unlike most prospective trials, large numbers of patients are included in HQCDs, which enables sub-group analyses, which in turn provide clinicians with information on specific categories of patients and not just on some theoretically typical patient.[18]

MANAGING SERVICES

Data from HQCDs can also help in the management of health services. The data can be used by operational researchers for establishing the best use of resources, for example, the ideal distribution of intensive care beds to minimise inter-hospital transfers.

THE WAY FORWARD

Clinical databases will not be suitable for all areas of health care. In addition, their cost means that we need to select priority areas. The sorts of criteria that might be used to make such selections are: areas of low volume and high cost (such as

intensive care, transplantation and some cancer services), areas that are the subject of National Service Frameworks (such as coronary heart disease), or areas of public or professional concern (such as cardiac surgery). To help with the enhancement of existing clinical databases and the development of new ones, it would be helpful if a national network was formed, which could spread good practice and explore the potential for collaboration.

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Confident about efficiency measurement in the NHS?

Technical problems must be overcome if the new reference cost indices are to make a contribution to measuring and encouraging NHS performance.

Andrew Street

INTRODUCTION

The new performance indicators published as part of the Performance Assessment Framework include a set of cost indices that attempt to shed light on the cost of service provision.

The cost indices are designed to replace the discredited purchaser efficiency index, which failed to capture fully the diverse activities of the health service and introduced incentives that were contrary to efficient service delivery.[1] The Government's original intention was to produce comparative information allowing trusts, health authorities and primary care groups to consider the costs of local service provision in the light of national data.[2] Evidence of higher costs was to be interpreted as indicating poor performance, necessitating remedial action.

In order to make fair comparisons, it is important that efforts are made to compare like with like. This implies that activity and costs are measured similarly, and factors influencing costs that are outside managerial control are accounted for. This is not a simple matter and, thus far, five indices have been devised, differing according to the extent that they achieve these aims. The next section describes these indices. This is followed by a discussion of whether it is possible to interpret the indices as indicating poor performance. It is concluded that we cannot be confident that the indices have successfully identified differences in efficiency.

THE COST INDICES

Between November 1998 and March 1999 five different indices were produced purporting to measure the unit costs of service provision in English acute trusts. A brief description of each index appears in Box 1. The five indices fall into two groups. The *reference cost indices* (RCI and RCI+) measure in-patient activity using finished consultant episodes (FCEs) and are based on non-routine data provided by trusts to the NHS Executive (NHSE) in 1998. The Department of Health (DoH) led development of the *casemix cost indices* (CCI, 2CCI and 3CCI). These indices measure in-patient activity using hospital spells, are based on routine activity and financial data, and have been adjusted for a range of factors deemed influential in explaining variations in unit costs among trusts. The construction of each index is described in more detail below.

BOX 1: THE NHS COST INDICES

Reference cost indices

- **RCI.** The national reference cost index is compiled using data provided by trusts about their unit costs by healthcare resource group (HRG) for their main surgical specialties. The RCI is a weighted average of all HRG costs in each trust relative to the national average. The market forces factor (MFF) is then added to account for differences in local factor costs. The index was published in November 1998 and covers around 50 per cent of trust expenditure.
- **RCI+.** The RCI covers only acute activity. The RCI+ is more extensive and covers expenditure and activity in general, acute and maternity specialties and in A&E. The RCI+ covers around 70 per cent of expenditure.

Casemix cost indices

- **CCI.** The casemix cost index (CCI), unlike the RCI, includes mental health services and day care costs. The index is a ratio of actual to expected costs, taking into account hospital casemix. Activity in the CCI is summarised as a weighted combination of HRG-based in-patient spells, out-patient first attendances and A&E first attendances.
- **2CCI.** The casemix costliness cost index (2CCI) builds on the CCI, incorporating adjustments for other variables hypothesised to explain cost differences among trusts. These variables include hospital transfers, multi-episode spells, the proportion of elderly or female patients, student numbers, research revenue and the MFF. The extent of the adjustment for each of these variables is estimated through regression analysis.
- **3CCI.** The 3CCI – the casemix costliness and configuration index – attempts to take into account differences in hospital configuration, over and above the adjustments made in the 2CCI. These include the costs of multi-site working, hospital size and capacity utilisation.

The reference cost indices

The 1997 White Paper, *The New NHS: modern, dependable*, announced that trusts would be required to publish and benchmark the costs of the treatments they provide.[2] The intention was to develop a national schedule of reference costs, based on an allocation of accounting costs by healthcare resource groups (HRGs). The first version of reference costs was published in November 1998 as the National Schedule of Reference Costs (NSRC), with a second set released in January 2000. The two schedules suggest that the cost of providing similar treatments varies considerably among trusts. This variation might stem from differences in efficiency, but other explanations should be considered. For instance, clinical coding and accounting practices are highly influential in determining the costs reported for individual treatments.[3] There will always be a substantial element of discretion in how to allocate the majority of hospital costs to specific activities.

As well as providing a list of HRG costs, the data used to create the NSRC were aggregated to provide a summary of each trust's overall costs, reported as the reference cost index (RCI).[4] The RCI is a weighted summary of all HRG costs in each trust relative to the national average and is adjusted for the differences in the cost of land, building and labour in the NHS using the market forces factor (MFF).

There were grounds for scepticism in regarding the original RCI as a valid measure of hospital unit costs. The fact that, even though it purported to adjust for casemix, the two trusts providing the most and least complicated procedures were respectively least and most 'efficient' according to the index suggests that factors explaining cost differences were not adequately dealt with.

Criticism focused on three major deficiencies. First, the RCI related to surgical activity and failed to account for out-patient, A&E and non-acute activity. Second, it used FCEs to measure activity, a measure with known deficiencies in view of the amount of local discretion over what constitutes the time spent in the care of a consultant.[5] Third,

although there was an attempt at clustering similar hospitals into family groups, the index itself failed to take into account factors known to influence costs, such as the severity of cases treated and hospital configuration.

THE CASEMIX COST INDICES

Attempts to deal with these problems resulted in three cost indices produced by the DoH and the Audit Commission in early 1999. The three casemix cost indices (CCIs) use patient 'spells' rather than FCEs as a measure of hospital activity, with spells corresponding to hospital admissions. Furthermore, they are based on data from the hospital episode statistics rather than the non-routine returns used for the RCI. The three new indices were derived by calculating an index of expected to actual costs and then regressing this index against a succession of explanatory factors. The 3CCI includes the most comprehensive set of adjustments.

Full details about the construction of the cost indices are provided elsewhere,[6, 7] but a brief overview is presented here. The casemix cost index (CCI) is calculated for each hospital by dividing expenditure by the number of patients treated. Activity is weighted to take account of casemix, so if a hospital admits patients with above average care requirements this is taken into account.

Casemix is not the only factor that might influence the level of costs. The casemix costliness cost index (2CCI) builds on the CCI, incorporating adjustments for other variables hypothesised to explain cost differences among trusts. These variables are listed in the top half of Box 2. Hospital transfers, multi-episode spells and the proportion of elderly or female patients are included to account for cost differences over and above the HRG casemix adjustment. In addition, the 2CCI makes allowance for possible cross-subsidisation between patient care and teaching or research, which may not be adequately dealt with in the funding allocations, and for differences in local factor costs, assessed using the MFF.

The 2CCI is described as a long-run cost index in that it implies that hospital reconfiguration is feasible in the long term. In reality, hospitals may appear relatively inefficient on the 2CCI because of factors beyond immediate managerial control. The 3CCI attempts to take some of these factors into account, over and above the adjustments made in the 2CCI. These include the costs of multi-site working, measured by the number of sites with more than 50 beds; hospital size, measured by the number of beds; and capacity utilisation, reflected by the number of patients treated.

BOX 2: EXPLANATORY VARIABLES USED IN THE CONSTRUCTION OF THE 2CCI AND 3CCI

2CCI

- the proportion of spells transferred into the trust
- the proportion of spells transferred from the trust
- the proportion of inter-specialty transfers
- emergency admissions as a proportion of total spells
- finished consultant episodes per spell
- out-patient re-attendances per spell
- an index of unexpected emergency admissions
- an index of within-HRG casemix complexity
- the proportion of in-patients under 15 years
- the proportion of in-patients over 60 years
- the proportion of female in-patients
- student whole time equivalents per spell
- the percentage of total income from research
- the market forces factor

3CCI

- the number of in-patient spells
- the number of first out-patient attendances
- the number of first A&E attendances
- average number of beds
- heated building volume per bed
- the number of sites with more than 50 beds
- an index of specialisation

EVIDENCE OF POOR PERFORMANCE

The publication of multiple indices has meant that trusts appearing 'inefficient' on one index can

emerge as relatively 'efficient' on another. To some extent, some movement is to be expected, as trust 'league positions' (or ranks) reflect the differential impact of the various explanatory factors that each index takes into account.

However, while these adjustments will lead to some changes in rank, what is surprising is the extent of movement experienced by individual trusts. Of the 213 trusts for which full data are available, only ten remain in the same decile across all indices. In contrast, trusts move an average of 80 places across indices – equivalent to a third of the 'league'. At the extreme, the Queen Victoria Hospital Trust moves from near the bottom of the RCI (206/213) to third most 'efficient' on the 3CCI. Clearly, this has the potential to create confusion.

So which index is the most appropriate measure of unit costs? There are good economic reasons for believing that the 3CCI should be a much better rough indicator of short-term relative performance than the other indices because it better isolates the things over which management may have influence. Management has little control over size, mergers reflect national policy, diseconomies of scale should not be confused with managerial 'slack' and adjustment of the capital stock associated with multi-site working takes time and depends on regional capital priorities. By attempting to control for these factors, the 3CCI is more likely to reflect the performance of the trust rather than the environment in which it operates.

However, in order to judge whether the efficiency scores represent true differences in performance, it is necessary to calculate confidence intervals around each trust's score. A method to do this is described in Street, 1999.[7] Respectively, Figures 1 and 2 present the 2CCI and 3CCI efficiency scores and confidence intervals surrounding these scores for 217 acute trusts, ordered according to the estimated efficiency score. All of these confidence intervals overlap. The figures suggest that no significance can be attached to the differences observed among trusts. In other words, we cannot confidently claim that the trusts that appear among the most efficient under the 2CCI or 3CCI are actually any more efficient than those trusts that appear among the least efficient.

DISCUSSION

The 1998/99 financial year saw the publication of five indices designed to measure the unit costs of NHS acute trusts in England. These indices differ in various respects, and these differences lead to very different conclusions about the relative performance of most trusts. To avoid confusion it is important that users are aware of the construction and relative merits of each index.

Of the five indices, the RCI is the least satisfactory. It is based on non-routine returns, the accuracy of which cannot be verified. It has only partial coverage of the range of hospital activity and militates against moves to offer more care on an out-patient basis. In-patient activity is measured using FCE rather than spells. Finally, it fails to adjust for known influences on hospital costs. Some of these deficiencies are addressed in the latest version of reference costs, but this still succeeds in covering only 60 per cent of acute hospital expenditure.

The CCIs are a considerable improvement on the RCI and their use should be encouraged in preference to the RCI. Trusts under pressure from their local health authorities or Regional Offices to justify their apparently 'inefficient' performance on the RCI should refer to the CCIs before engaging in detailed analysis of their cost structures. It may be that the other indices present a different picture of their relative performance.

However, the differences in the unit costs observed among acute trusts are not statistically significant. As such, differential targets set on the basis of the efficiency scores produced by the CCIs cannot be considered fair: the indices have failed to isolate true differences in efficiency. There are two main reasons why there appear to be no significant differences in unit costs among trusts.

First, when the CCI is calculated, data on in-patient activity are trimmed to exclude outlier patients, those with 'exceptionally' long lengths of stay. Trimming typically removes around 5–10 per cent of cases but, because the outliers are those with long stays, the exclusion can result in 20–30 per cent of bed days being lost to the analysis.[8]

Figure 1

MULTIPLE COMPARISON 95 PER CENT CONFIDENCE INTERVALS BASED ON 2CCI

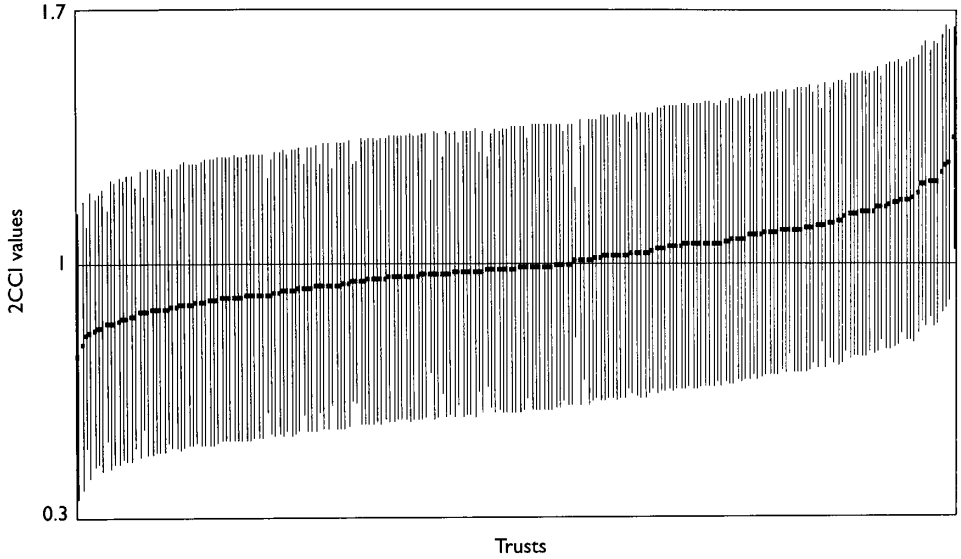
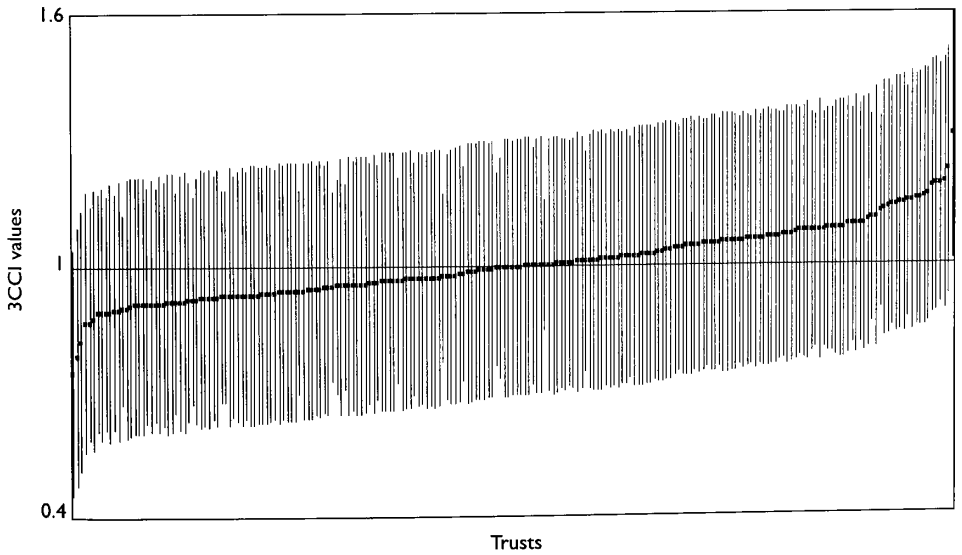


Figure 2

MULTIPLE COMPARISON 95 PER CENT CONFIDENCE INTERVALS BASED ON 3CCI



Trimming has the advantage of stability, in that comparisons among providers are less influenced by extreme cases. However, it is possible that by excluding outlier cases from the analysis, we have removed one of the main reasons why trust costs might differ. It may be that we can learn more about trust efficiency by studying how exceptional cases are managed than we can from focusing on more common cases. The implication of trimming is that we may have already removed much of the

difference among trusts before undertaking any comparative analysis.

Second, to a large extent trust income (and therefore, by definition, expenditure) is determined not by the performance of the trust but by the NHS resource allocation formula. The formula attempts to allocate resources on the basis of the needs of the population. If the formula is a true reflection of population needs, the main differences in trust income would be explained by local populations accessing services differently (either less frequently or seeking care from other sectors). Assuming that differential access is not substantial, it should come as little surprise that the unit costs of service provision do not vary significantly. After all, they are largely the outcome of a managed process of top-down resource allocation.

In view of the lack of statistical significance in their unit costs, the attention accorded to supposed differences in the relative efficiency of acute trusts must be questioned. Putting pressure on trusts to identify methods to improve their unit cost performance diverts attention from other non-quantified matters.[9] Moreover, external organisations (Regional Offices or health authorities) might interpret above average unit costs as 'evidence' of poor performance and set efficiency targets on this basis.

In practice, cost improvement targets are likely to be set after consideration of a range of information, rather than merely the analysis of unit costs. The NHS reforms, in which the internal market was introduced, were founded on the belief that substantial inefficiency existed among NHS providers. Moreover, it was felt that efficiency would be improved by issuing general policy directives aimed at all providers. Whether further gains are to be made from this approach is arguable in the light of evidence that differential performance in terms of unit costs is not substantial.

In future, two further courses of action might be considered. First, it may be possible to produce more focused indices. There may be differences in efficiency, but it might not be possible to capture these with an indicator aggregated at hospital level. Attempts have been made to produce specialty level indices, but at present these are of limited value primarily because of the vagaries of cost allocation. Second, attention might be directed at the balance of spending within hospitals or across sectors. There may be no differences in technical efficiency but this does not imply that current spending patterns are appropriate. It is not enough to do things well, we also need to do them right.

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Accounting for clinical governance: rethinking performance management

Important progress towards establishing accountability for improvement that helps rather than hinders could be made through implementing clinical governance.

Steve Dewar and Alison Hill

The NHS is being inundated by performance indicators – but what chance is there that they will help the service consistently deliver quality services? This is not going to be achieved through another battery of figures – but important progress might be made through the implementation of clinical governance. So, what role can performance indicators play in clinical governance? And what are the chances that clinical governance might make it out of the starting blocks when traditional approaches to performance managing change are unsympathetic to the task of developing individuals, teams and organisations?

PERFORMANCE INDICATORS AND PERFORMANCE MANAGEMENT IN A NEW CONTEXT

Indicators are part of a drive for accountability to government, to health service managers and to the public. Government reforms of quality in the NHS aim to establish accountability for performance, improvement and quality assurance in all that the NHS does.[1, 2, 3] They seek to ensure that people can access the same services provided to the same high standards anywhere in the country.[4] To achieve this aim a more centralised approach is being taken to the management of clinical services, the performance of individual clinical professions[5] and health care trusts. These reforms hinge on the implementation of clinical governance. For the first time, clinical governance makes managers and clinicians accountable for improving and demonstrating quality.

The implementation of clinical governance is the big picture of which performance indicators are but one piece. All parts of the NHS will take up new roles in ensuring that they are delivering the structures and processes necessary to reduce variation in the quality of service across the country. Information, particularly on performance, is a key part of this task – information will catalyse clinical governance work, show progress on clinical governance implementation, and be part of the process for improving and demonstrating quality.

Using performance indicators as part of this drive to implement new accountabilities raises a number of problems:

- available indicators are limited and currently lack credibility
- trusts are not fully engaged in a culture that promotes the free sharing of information

- the data to drive quality improvement is expensive to collect without better and more sophisticated IT systems
- one size does not fit all – comparative data may be insensitive to valid differences between places or may not be accepted by those whose performance is being measured.

On the ground, such data will need to be supplemented by other measures of service delivery if quality is to be meaningfully considered in the round.

Getting clinical governance to work will require a seismic shift in NHS culture. Clinical professionals need to take part in a process that enables them, and the health care managers with whom they work, to account for clinical quality. Chief executives and managers who have in the past been judged only on the financial bottom line have to ensure that they have systems in place to assure patients and the wider NHS of the quality of their services and of their ability to protect patients from potential poor performance. Meanwhile, the NHS Executive, Regional Offices, health authorities and primary care groups all need to assure the Government and the public that working systems to achieve these ends are being put in place.

Government policy is usually implemented by the NHS Executive setting targets for Regional Offices and/or health authorities, who in turn pass on responsibilities to trust chief executives and managers. Each party then manages the performance of the person or organisation further down the ladder in order to check that change is happening. Information is the lifeblood of the process.

This approach to managing change in the NHS is often called 'performance management' and traditionally it involves the clear setting of targets and specifying the data that would demonstrate achievement. It may work well in simple environments where accountabilities are less complex, but it is more difficult in the NHS.

The common accountability of employee to employer is not the only accountability upon clinicians. Clinicians work with multiple accountability – to their profession, to their employer and to the public. Some professional groups jealously guard their independent professional accountability. These different lines of accountability mean some clinicians can maintain a certain freedom. It is possible for some professionals to be relatively unaccountable to NHS management by relying on their professional accountabilities to define their obligations.

Using traditional performance management approaches to direct and monitor the changes required to ensure consistent services of a consistently high quality might bring problems:

- clinical professionals might not respond to traditional forms of performance management that seek to implement more national control over service quality and access
- the task of achieving quality assurance and improvement as part of clinical governance will require changes in attitudes and behaviours that can only really be 'facilitated' through a combination of approaches that mark a departure from traditional performance management
- accountability for quality must reflect patients' experiences. Often that means it should not be confined to one organisation and one line management structure but needs to span organisational boundaries.

PERFORMANCE INDICATORS: UNCOMFORTABLE FACTS

A host of performance indicators seeks to provide comparative data between trusts. Foremost among these are the High Level Clinical Indicators (HLCIs). These indicators have the potential to provide a bridge between clinical governance activities and clinical outcomes, but currently some well known problems remain. Respondents in a recent London Regional Office stock-take of clinical governance in trusts commented on the difficulties of knowing about and interpreting these data, as well as questioning their relevance:

> *The problem is knowing about external information and then disseminating it appropriately ...*[6]

Interpreting national data in order to make meaningful comparisons is difficult ...[6]

These limitations are well known and questions of validity and dissemination are a high priority within the NHS Executive. Despite these difficulties, however, many trusts have used the HLCIs to stimulate much-needed work to improve the quality of clinical data. What is more worrying is that trusts across London are still finding an unwillingness to share information. To understand the performance of the clinical team or the individual professional will require information to be shared – but this is not always happening. The following illustrative comment is from another respondent to the recent London stock-take:

A more timely and meaningful assessment of services would be greatly facilitated by the availability of key clinical information in addition to routine activity data. We need relevant routine benchmarking with other organisations.[6]

The difficulty of collecting data is well documented. NHS guidance accepts that 'present NHS information systems are not of an adequate standard to meet these needs for information on quality',[3] and this is an important step towards necessary improvement. Problems of data collection are partly problems of cost and capacity in relation to IT. Many of those working in trusts and PCGs acknowledge the limitations of current IT capacity but are acutely aware of the large costs of manual data collection.

The problems are that data collection is expensive. Current data generated via IT only contain crude quality data ... . It is likely that this situation will be resolved with the introduction of the electronic patient record ... . In the interim, we have to attempt to develop a routine monitoring system, which identifies variance using largely manual and thus high cost methods.[6]

To be meaningful, performance indicators need to be agreed, understood and owned by those who are being made accountable. Many trust directorates and their clinical staff are taking up this challenge and considering what clinical parameters they themselves would measure performance against. Other trusts recognise that active clinical involvement in the process of establishing and using performance indicators will have to wait until clinical directorates or teams have an organisational structure that allows them to address such questions. Of course, the danger in such an approach is that teams may find themselves drawn to what can be measured rather than what should be addressed. Two senior trust staff showed awareness of these dangers when interviewed last year as part of a survey to gauge early progress on the implementation of clinical governance:

Some groups are only on the first rung of organisational working while taking on clinical governance may not really be possible until rung ten.[7]

Directorates focus on issues for which data is available ... but this shouldn't really dictate our priorities ...[7]

PERFORMANCE MANAGEMENT: NEW CHALLENGES

Establishing accountability for quality and performance is the central new feature of clinical governance and the whole new quality framework within which it sits. But where are these accountabilities located? There is a statutory duty of quality on trust chief executives.[8] Regional Offices performance manage clinical governance in trusts. Health authorities performance manage clinical governance in PCGs. Trust chief executives and medical directors performance manage clinical governance in clinical directorates or clinical teams.

The traditional approach to performance management is to set consistent and explicit future targets for all – complete with concrete measures of progress along a pre-ordained path to policy implementation. The implementation of clinical governance does not lend itself to this highly structured approach. The appropriate way to think about the performance management of clinical governance would be to recognise the importance of the organisational development aspect of the task. This is the sort of work where 'ownership' and 'participation' are to the fore; it is the sort of work that needs to be nurtured through a more flexible approach to managing change – see Box 1 below.

BOX 1: CONTRASTING APPROACHES TO PERFORMANCE MANAGEMENT

There is tension between the traditional approach to performance management and the need to adopt a new way of accounting for clinical governance. The old approach is deeply rooted in a scientific and rational approach to management. The newer thinking stresses the evolutionary nature of these tasks, sees the organisations involved as living systems and emphasises the importance of organisational and personal feedback to achieve change.

Performance management has often been based on traditional models of management, which emphasise the following components:

- a clear prescription of the problem and a 'well understood' goal
- pre-planned stages and milestones to the implementation process
- centralised leadership to manage the process of implementation.[9]

New approaches to the management of change are based on a different approach – one that emphasises:

- the unclear and partial nature of the problem and the goal of intervention
- the need to allow milestones and partial objectives to emerge and evolve during the implementation process
- the need to support and encourage dispersed leadership throughout the organisations involved in implementation.[9]

Currently, Regional Offices are using the requirement for trusts to submit and agree development plans for clinical governance as a way of obtaining a framework of objectives against which they can fulfil their performance management obligations. However, there are examples of a new approach to the task being taken. The London Regional Office, for example, has acknowledged that trust development plans for clinical governance will need to be specific to each organisation and should not be written to a national or regional framework.

Clinical governance leads need to stress local priorities and organisational development if they are to win hearts and minds. Setting targets, milestones and objectives may be appropriate for monitoring the implementation of a top-down national clinical framework (as with National Service Frameworks), but will not necessarily help trusts manage organisational culture change or personal and team development.

The traditional form of performance management may not be sympathetic to the nature of the implementation task. We know, for example, that the process of managing evidence-based change is messy, non-linear and evolutionary. Experience and research emphasise the complexity of the change management task.[10, 11, 12] Converting national guidance to local programmes addressing educational, financial and organisational support for change has been found to be a more evolutionary than linear process.

The danger is that performance management becomes limited to those inputs and outcomes that can be easily counted. In practice attention is often focused on easy to measure categories. These might bear little relation to outcomes, may provide only a narrow snapshot of a dynamic process and may reinforce the status quo by focusing on those areas where efforts have already been put into indicators of 'good practice'. When there is insufficient overlap between the formal accounting mechanisms and the complexity of the system, the accountability framework can find itself reduced to merely a 'tick box' exercise. If this occurs staff are more likely to feel alienated by such simplification than actively engaged in the process.

Trust chief executives and clinical governance leads recognise that particular sensitivity is required to make performance management work without threatening to undermine the very conditions that encourage ownership. One chief executive interviewee from a study of clinical governance implementation early in 1999 commented:

One major challenge to effective clinical governance will be ensuring management sensitivity in the use of often-unreliable data – the real task here is to try and ensure maximum professional participation in the generation of the data in the first place.[7]

Similarly, there is a greater acknowledgement of the need for a range of information if quality is really to be assessed. Some trusts and the Commission for Health Improvement are, for example, looking to ensure that user perspectives are captured and considered in conjunction with harder data. Other commercial organisations with a foothold in the market for benchmark data are also addressing the need for more sophisticated and meaningful approaches to the task of assessing performance.

CONCLUSION

To get effective clinical governance in action will require a change in approaches to performance management. This adjustment will aim to ensure a better fit between the model of accountability and the nature of the change management task. It will seek to ensure effective local ownership and sustainable organisational development.

The use of performance indicators to assess quality and drive the implementation of clinical governance is currently limited by the perceived poor validity of national and local data. Data needs to be robust if it is to influence the development of clinical governance without damaging confidence and participation. At a practical level, this problem is acknowledged and improvement is being actively sought by the NHS Executive and local trusts. But there will always be a need to acknowledge that performance indicators must be 'blunt instruments' if they are to trawl through an ocean of information in a way that is not too labour intensive.

Clinical governance is about quality and accountability for quality. Quality is a multifaceted concept and quality improvement is a complex organisational and personal task. Accountability arrangements need to respect the complexity of the task and performance indicators can be only one piece in the picture. Learning about how to improve services has been a major task. The next step is for the NHS to learn about how to establish a meaningful accountability for improvement that helps rather than hinders progress.

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Performance measures: the public's choice

The challenge for the future will be for the NHS to give the public a greater role and say in health service performance.

John Appleby and Jo-Ann Mulligan

The public's involvement in the development of the Performance Assessment Framework (PAF) – the six key dimensions designed to try to capture the multiple 'bottom lines' of the NHS and the performance measures to support these – has been minimal. Although – as Clive Smee has noted in his editorial – a key principle guiding the design of the PAF and its indicators was relevance to the users of the NHS, and while indicators suggested by the Department of Health were published for consultation,[1] it is not immediately clear that the public would have suggested the measures contained in the High Level Performance Indicators (HLPIs) and the Clinical Indicators (CIs).

But more important perhaps than the particular measures themselves is the lack – currently, at least – of public involvement in the use and understanding of the PAF and its attendant indicators.

'Involvement' in this context does not just mean having a say as to the measures of performance the public would like the NHS to compile and use. Although, in addition to waiting times and deaths in hospital, the public may also want to see standardised measures of hospital food quality or a consultant 'smile index', this is not to suggest that users are concerned only with what health care professionals may view as somewhat peripheral or marginal performance issues. Indeed, some of the things that can change patients' experiences of the NHS from bad to good can often be traced to such things as the quality of food or the attitudes and behaviour of NHS staff.

There is, however, an additional aspect of public involvement in the new performance management process, which touches on the move towards the 'balanced scorecard' approach the PAF has adopted. Crudely put, what exactly is the right 'balance'? The multiple objectives of the NHS are not mutually exclusive. Doing well on one dimension – 'fair access' for example – may mean not doing so well on other dimensions – efficiency, say. Such trade-offs are all too familiar to the NHS. And these trade-offs percolate down to the supporting indicators, illustrating economists' dismal message about opportunity cost: using scarce resources to reduce deaths in hospital means *not* using those resources to, say, reduce waiting times for first out-patient appointments.

The problem is that there is no particular 'balance' between measures that can be justified objectively: whether the 'scorecard' for one trust or authority is better than another or whether one set of performance indicator values in one year can be said to be an improvement on previous years' scores, as this cannot always be judged unequivocally. Indeed, performing at the national average on different dimensions superficially suggests that some sort of balance has been achieved – but of course, the average is no real guide in this context.

The key to this apparent problem is to address the essentially *subjective* nature of these trade-offs and to inject some value judgements into the process. The most obvious group to turn to for judgements about value is the current and potential users of the

NHS. If health service professionals have no reference points to judge whether doing well on waiting lists is better than doing well on hip operations, or if there is no ready reckoner to equate trade-offs in one performance area with those in another (are 100 more hip operations equivalent to a 1 per cent fall in the proportion of people waiting over 12 months for admission to hospital?), then any decision about performance (and all that this implies) is essentially arbitrary. If the NHS is to be less random and more logical in its decision-making then it needs to find ways of incorporating or tapping into public opinion.

But in the absence (for good reason) of the normal economic process that allows individuals to bring their own value judgements to bear on resource allocation and consumption decisions – the market – how are the public's values to be measured? There are also some prior conceptual problems about the nature of consumerism in the NHS and the way that traditional principal–agent roles are (or ought to be) played out.

Leaving aside questions about how consumerism should or will develop within the NHS, if the market's approach to encouraging people to reveal their preferences brings too many costs and distributional failures, then what are the alternatives? In particular, how can the NHS get real (i.e. subjective) value out of the PAF and its performance indicators?

A COMPOSITE PERFORMANCE INDICATOR

As a practical part of a strand of work on performance management and public involvement, the King's Fund produced a composite or aggregated performance measure for health authorities and boards in England, Wales and Scotland. A programme (*The Sick List*) based on the resulting list of authorities was broadcast on Channel 4 in February 2000.

The composite performance indicator was based around six indicators, which covered various aspects of the performance of the NHS and which were published by the Department of Health in England:

- deaths from cancer (per 100,000)
- deaths from heart disease (per 100,000)
- total number of people on hospital waiting lists (per 1000)
- percentage of people on waiting lists waiting over 12 months
- number of hip operations (per 100,000)
- deaths from 'avoidable' diseases (TB, asthma, etc.) (per 100,000).

The first three indicators cover the recent changes in the Government's priorities in the NHS – switching emphasis from reducing the length of the waiting list to reducing deaths from cancer and heart disease. We were interested to see whether the public supported this change.

The fourth indicator – the percentage of people waiting over one year – has traditionally been a significant and well understood process measure of how well the NHS performs. It was also suggested by many health care experts that it would have been a more appropriate measure than the Government's manifesto pledge to reduce the numbers on waiting lists.

The final two indicators – hip operations and deaths from 'avoidable' diseases – cover the performance of the NHS in two areas: quality of life and saving lives. It is sometimes argued that the NHS should concentrate on saving lives and not do so much about the quality of people's lives. Again, we wanted to know what the public thought about this value judgement.

ELICITING VALUES

Having chosen the performance indicators, the next stage was to find out what weight or value the public would attach to each one. How important is it for the NHS to reduce waiting times compared to reducing deaths from cancer? Would the public want the performance of their health authorities and boards to be judged more on the number of hip operations carried out than the size of the waiting list?

One way of finding out the relative importance of the different indicators is to ask a sample of the public to simply rank the six measures – the most desired at the top and the least favoured at the

bottom. However, this does not give people the chance to say how much *more* they value one measure over another.

Another approach is the 'budget pie' technique. This is more realistic in that it emphasises that resources for health care are not infinite and that, therefore, choices must be made about how much should be spent on different health care services.

There are numerous other approaches to eliciting relative values – single and multiple voting, simple scoring and scaling, as well as more complicated and elaborate methods such as analytic hierarchy process and conjoint analysis. Different methods have different advantages and disadvantages.

We decided to use three methods: ranking, budget pie and conjoint analysis. Between 26 November and 2 December 1999, the polling organisation MORI carried out a ranking, budget pie and conjoint analysis survey of 2000 people across the country (all 2000 carried out the conjoint analysis, with one-half also being asked to complete the ranking exercise and the other half the budget pie). For the production of the final composite indicator we relied upon the results from the budget pie survey. The ranking of the indicators and the results of the conjoint analysis produced very similar overall rankings of health authorities in the final composite indicator. But here we just concentrate on the budget pie analysis – less sophisticated than the conjoint analysis, but more realistic than the simple ranking method.

For the budget pie, respondents were asked to distribute a fixed sum of 60 'chips' to some or all of the six performance indicators – the more chips spent in an area, the greater the improvement on that indicator. From the survey results we produced average weights for the six indicators (see Table 1).

Interestingly, we found that there was little difference in the distribution of the chips depending on respondents' sex, social class, age or the area of the country where they lived.

These results show that, on average, the public give over three times as much weight to reducing cancer deaths as they do to increasing the number of hip operations. These weights were multiplied by the actual values recorded by every health authority and board in England, Wales and Scotland, and then summed for each area to produce a composite score.

Table 1

WEIGHTS BASED ON DIVIDING OUT 'CHIPS'

Performance measure	*Weighting*
Reducing deaths from cancer	1.00
Reducing deaths from heart disease	0.75
Reducing the number of people on hospital in-patient waiting lists	0.63
Reducing the number of people waiting over 12 months for admission	0.56
Reducing the number of 'avoidable' deaths	0.50
Increasing the number of hip operations	-0.31

The weights were then applied to the real performance data for all health authorities and boards in England, Wales and Scotland, so that the different indicators could be added together to produce the composite indicator for the list (see Box 1).

BOX 1: HOW THE COMPOSITE INDICATOR WAS CALCULATED

The composite indicator is the weighted sum of a health authority's actual performance across the six indicators. So for Enfield & Haringey Health Authority, for example, we multiplied the actual value of the indicators (cancer death rates, hip operations, etc.) for the authority by the various weights we derived from the survey of the public (see Table 1):

Composite = $(1.00 \times 124) + (0.75 \times 139) + (0.63 \times 31) + (0.56 \times 9) + (0.50 \times 76) + (-0.31 \times 295) =$ **199.37**

The hip operations weight is *negative* because increasing hip operations indicates good performance, whereas increasing any of the other measures indicates bad performance.

DISCUSSION

Broadly, the list showed that, from the point of view of the public, some health authorities and boards are performing better than others. Table 2 shows the top and bottom five health authorities in terms of their composite performance indicator ranking. In fact there is a six-fold variation in the scores of the authority at the top of the list and the authority at the bottom. This suggests that if the NHS takes the public's views seriously, there is room for improvement in its performance.

So why do some areas do better than others? This is a crucial question, but one which is inevitably very hard to answer. Research into variations in health service performance suggests that there is no single answer, but that there is a range of factors that go some way to explaining differences.

Perhaps one of the most important questions is whether all the differences can be laid at the door of the NHS. For example, is the way the NHS budget is distributed partly responsible for the ability of different health authorities to deal with the health problems of their populations? Or is it that there are variations in doctors' performance? Or does the age of the hospitals make a difference?

If some or all of the variations arose from factors outside the control of the NHS, then it would be perhaps wrong to blame authorities and boards near the bottom of the list for performing badly. And, equally, it would be wrong to congratulate those near the top for doing well.

Clearly, there are factors that influence the scores in the list that are outside the control of authorities and boards. For example, areas with higher numbers of elderly people will record higher numbers of deaths. Also, death rates vary between men and women, as does the need for hip operations. However, the data used to construct the list has taken factors such as the age and sex structure of the population into account, so to some extent like is being compared with like.

Other factors such as the level of social and economic deprivation (unemployment levels, etc.) are known to be associated with ill health. These have not been taken into account directly in the list. However, the NHS distributes its budget among health authorities and boards according to a formula that goes some way to taking account of these factors (as well as age structure and levels of death rates), so that every area of the NHS receives different amounts of money according to the relative need for services in each area. This means that Manchester, for example, receives 60 per cent more NHS money per head of population than, say, Oxfordshire. Whether this difference is big enough to enable Manchester to reduce cancer death rates to levels seen in the better-off areas of the country is, however, arguable.

There is considerable variation in the amount of money per head allocated to health authorities. Currently, the Department of Health is engaged in an ongoing review of the resource allocation formula in England (and Scotland) to examine the possibility of changing the method in order to contribute to a 'reduction in avoidable health inequalities'.

Table 2

COMPOSITE INDICATOR RANKINGS

Top five health authorities (rank)	*Bottom five health authorities (rank)*
Oxfordshire (1)	Wolverhampton (116)
North & East Devon (2)	St Helens & Knowsley (117)
Herefordshire (3)	East London & The City (118)
Somerset (4)	Liverpool (119)
Dorset (5)	Manchester (120)

But there is also a deeper issue about the ability of the NHS – or any health care system – to grapple with the many determinants of ill health in the population. For example, smokers know that their habit is bad for their health (and many of the cancer and heart disease deaths are directly due to smoking) but smokers also know how hard it is to stop, and the NHS has only limited powers of persuasion. Furthermore, smoking levels are linked to unemployment and other socio-economic factors. To what extent is the NHS able to deal with these issues without the co-operation and resources of other government departments?

More generally, this work raises questions about the involvement of the public in performance measurement. Yet the call for a debate on the role of the consumer in assessing the performance of public services is not new. Over the years commentators have wrestled with what consumerism actually means in the context of publicly provided services. In the 1980s Pollitt made the case for finding ways of performance measurement that are participative and which are negotiated between the NHS, users and the wider community.[2] In terms of progress, the national surveys of NHS patients represent a good start, but we have yet to really engage the views of the wider public.

As the editorial by Clive Smee suggests, the Department of Health wants to explore methods of aggregating performance across the six domains of the Framework and the potential trade-offs between the PAF domains. Our work suggests one approach to eliciting values from the public and incorporating these weights into a composite performance indicator for the NHS. The challenge for the future will be not only exploring trade-offs between, say, efficiency and equity, but also to develop ways of using the resultant indicators to change behaviour and service delivery for patients.

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DATASCAN

Tony's billions: where will he find the money for the NHS?

The NHS is to receive significant real increases in funding. But where will the money come from?

John Appleby and Seán Boyle

For the first time ever, the guiding principle for deciding NHS funding levels is to be based not just on spending levels in other European Union countries, but on the *proportion of their GDP* they devote to health care. This is a remarkable break with tradition, and sets the NHS aside among public services as truly favoured.

Government ministers have often committed to increased levels of expenditure – but conditional on real growth in the economy as a whole. This new pledge – as a proportion of GDP – is to an extent independent of the performance of the economy: no matter how well the economy does, health spending must grow much faster to meet the pledge target.

Since the Prime Minister indicated that total (public *and* private) health care spending will reach the EU average over the next five years or so, many have queried the arithmetic rigour of the PM's calculations and the financial feasibility of hitting the target he has set.

The commitment to substantial extra funding for the NHS has, however, been welcomed. But what exactly does the commitment – literally – amount to, and what are the options open to the Government in order to fulfil its pledge?

WHAT ARE THE CORRECT FIGURES?

There are many sources of uncertainty (and dispute) about health care spending levels. Total health care spending as a proportion of GDP for the UK has been variously quoted as 6.8 per cent (the Government), 6.6 per cent (the King's Fund) and 6.7 per cent (the Office of Health Economics). The differences are sometimes due to different years, outdated GDP figures and different estimates for private health care spending (see Justin Keen's article on p.27).

Further differences have arisen in terms of the EU average spend. The Government suggests 8.0 per cent (based on an *unweighted* average of all EU countries – including the UK). The OECD's own Health Data File suggests a *weighted* average of 8.6 per cent. Both figures are for 1997. Leaving out the UK, the weighted average for the rest of the EU for 1997 is nearly 9.0 per cent. Since the UK is part of the EU, increases in UK spending boost the target

EU level as well. In fact the UK would have to reach the EU average *excluding* the UK for the target to be achieved, i.e. 9 per cent.

The position now (1999/2000) across the EU is difficult to determine. However, it is extremely unlikely that the EU average will be lower than in 1997. Experience across Europe over many years has been for health care spending to rise as a proportion of GDP. Although France and Germany may get their spending under control, many other countries will not (nor, for many, do they want to contain spending – at least while they too find themselves below the average).

So it seems unclear where the UK is starting from and where it has to get. But, using the latest figures for UK GDP, NHS spending, best estimates of private spending and the Treasury's own forecasts for the economy over the next few years, it is possible to set out a truer picture of the scale of the funding mountain the Government has set itself to climb.

The Treasury estimates that UK GDP will be £870.2 billion for 1999/2000 – at 1998/99 prices (all figures here take account of inflation; any differences are therefore 'real', i.e. over and above the GDP deflator). The Treasury's November 1999 Pre-Budget Report[1] suggests that GDP will grow in real terms by 2.25 per cent up to and including 2004/05, to reach £972.5 billion.

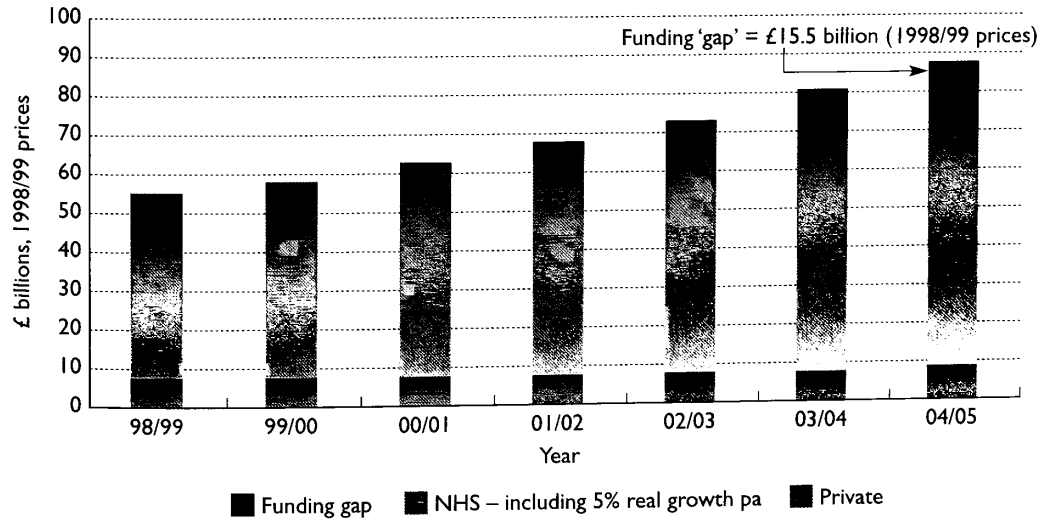
If, by this date, the share of GDP devoted to health care is to reach the EU average of 9 per cent, total health care spending must reach £87.6 billion (9 per cent of £972.5 billion).

Currently, in 1999/2000, we estimate that total health care spending in the UK is £57.5 billion (6.6 per cent of GDP). The funding 'gap' is therefore £30.1 billion in real terms.

It is clear from Figure 1 that even if private spending were to grow at the same pace as the economy as a whole, an increase in NHS funding of 5 per cent a year in real terms from 2000/01 to 2004/05 will not be enough to raise total health care spending to the EU average of 9 per cent of GDP. The shortfall will be £15.5 billion. In fact, it would take a real increase of 9.7 per cent in NHS spending every year from now to 2004/05 to meet the EU average spending target. This is equivalent to an extra £29.2 billion spending on the NHS (assuming that private spending will increase in line with GDP growth, providing an additional £940 million).

Figure 1

WILL TOTAL HEALTH CARE SPENDING REACH 9 PER CENT OF UK GDP BY 2004/05 WITH ANNUAL REAL GROWTH IN NHS SPENDING OF 5 PER CENT PER YEAR?



The enormous increases in public or private spending needed to reach the EU target have far-reaching implications for government spending as a whole, and raise questions about the feasibility of meeting the target.

HOW CAN THE PLEDGE BE FUNDED?

Increasing health care spending faster than the growth rate of the economy means that there are limited options for funding this expenditure. The choices for the Government are to:

- increase total government expenditure by increased taxation or borrowing
- shift public spending to the NHS
- expand the private sector.

Below we examine each of these options.

INCREASING TOTAL GOVERNMENT EXPENDITURE

Assuming private sector health care spending increases at the same real rate as the economy (2.25 per cent per year), NHS spending will have to increase by 9.7 per cent in real terms over the next five years if the EU target is to be met by 2004/05. This implies a real increase of just over £29 billion in NHS funding – nearly 60 per cent more than what is currently spent.

If other government spending is not to be affected by extra spending on the NHS, then the latter must remain a constant proportion of all government spending – that is, 14.4 per cent. This means that total government spending (TME – total managed expenditure) must also grow at 9.7 per cent, increasing from an estimated £343.1 billion this year to over £545.1 billion by 2004/05. Box 1 illustrates some of the taxation implications of this increase.

But increasing total government spending at this rate means that its share of GDP will also increase – from around 39.7 per cent this year to over 56 per cent by 2004/05 (see Figure 2). Such a share is unprecedented in the post-war UK economy and, as the sole solution to increasing spending, is likely to be politically and economically unacceptable.

Similar problems arise if the Government were to increase its borrowing rather than increase taxation. Moreover, at best this would only ever be a short-term solution.

BOX 1: WHAT WOULD IT MEAN IN TAX TERMS?

Raising another £29.2 billion over five years is equivalent to increasing the basic rate of income tax each year by over 2p in the £ (assuming 1p gives £2.65 billion in tax revenue). Alternatively, an immediate increase in VAT from 17.5 per cent to nearly 27 per cent would have a similar effect. And an increase in tobacco duty of around £2.00 per packet each year would raise around £29.2 billion by 2004/05.

Increasing taxation is of course a particularly sensitive political issue. The apparently paradoxical views of the public – willing to be taxed more to increase NHS spending, but traditionally unwilling to vote for parties with such a manifesto commitment – may possibly arise from the public's scepticism that, when in office, politicians may tax but not spend (on health care). A more radical tax solution – which could go some way to connecting the taxpayer with NHS spending – could be a form of hypothecated tax.

However, it is difficult to see how this would bypass political and Treasury influence without incurring problems such as variations in revenue linked not to the need for health care but to broader macroeconomic changes in the economy. Someone has to set the rate for the tax, and if this is not done through an accountable political process, then how is it to be done?

SHIFTING GOVERNMENT EXPENDITURE

A second option is to shift public expenditure to health care from some current use. If the overall level of total government expenditure as a proportion of GDP is to stay constant at the current level of just below 40 per cent, the proportion of this spent on health care will have to increase from the current 14.4 per cent to over 20 per cent of TME (see Figure 3).

Figure 2

HOW MUCH WOULD PRIVATE HEALTH CARE SPENDING HAVE TO INCREASE TO CLOSE THE FUNDING 'GAP' IF REAL NHS SPENDING INCREASED AT 5 PER CENT PER YEAR?

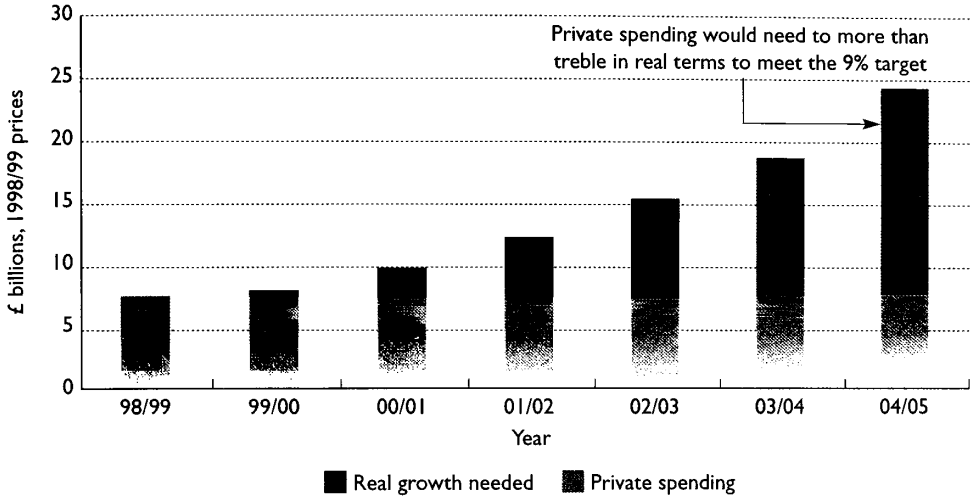
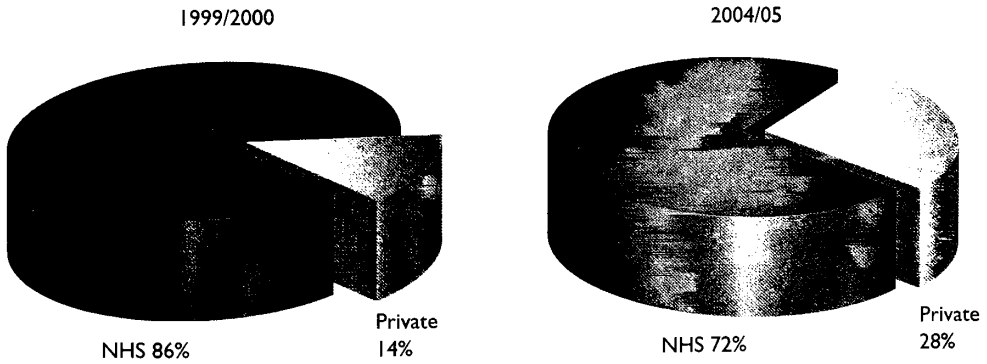


Figure 3

PRIVATE/NHS SHARE OF TOTAL UK HEALTH CARE SPENDING



This could be done, but is likely to require a combination of real reductions and no (or minimal) real increases in other spending areas. If TME is to remain at a constant proportion of a GDP that is growing in real terms, then TME will also grow in real terms – by around £41 billion between now and 2004/05. The extra spending needed for the NHS – £29.2 billion – could be funded from this TME growth, but this does not leave much for other departments. NHS spending apart, it would leave TME growing at just under 0.7 per cent in real terms for the next five years. Apart from a period in the late 1980s, at no time in the last 35 years has TME (minus health spending) grown so slowly for such an extended time.

Box 2 illustrates the problem of shifting resources away from non-NHS spending areas.

BOX 2: WHAT OTHER PUBLIC BUDGETS COULD BE RAIDED?

For 2000/01, total managed expenditure (TME) is set to consist of departmental expenditure limits (DEL) – education, health, defence, etc. – of £189.7 billion and annually managed expenditure (AME) – social security, payment of government debt interest, etc. – of £179.1 billion, a total of £368.8 billion. The top seven spending departments account for 82 per cent of DELs.

At one extreme, the £5.3 billion annual real NHS increase needed over five years to bring total health care spending up to 9 per cent of GDP could be found by reducing, for example, defence, the Home Office and culture, media and sport budgets to zero by 2004/05.

A less painful solution would be to fund NHS expansion out of the £41 billion real increase in TME, leaving other departmental budgets to grow at around 0.7 per cent per year in real terms. To this extent, achieving the health spending target would be made more difficult if the economy did not grow as fast as expected.

EXPANDING PRIVATE EXPENDITURE

A third way of increasing the overall spend on health would be to encourage increased spending within the private sector: essentially through more out-of-pocket payments or by increased private insurance. Currently the proportion of total spend that is private is low by European standards: 15 per cent compared with an average across the European Union of around 24 per cent (1997).[2]

However, to match overall EU levels purely by increased private expenditure would require an immense increase in this part of the total over the next five years. Even assuming that NHS funding increased at a real rate of 5 per cent per year, private spending would need to increase from current levels of around £8 billion to over £24 billion (see Figure 4). This would imply an unprecedented rate of real growth of over 25 per cent per year, and would bring the proportion of total health expenditure funded privately up to nearly 28 per cent, a level currently matched by Germany, Italy, The Netherlands and Portugal (see Figure 5).

Figure 4

HOW WILL GOVERNMENT SPENDING CHANGE IN TOTAL AND AS A PROPORTION OF GDP IF GROWTH IN NHS SPENDING IS TO REMAIN A CONSTANT PROPORTION OF GOVERNMENT SPENDING?

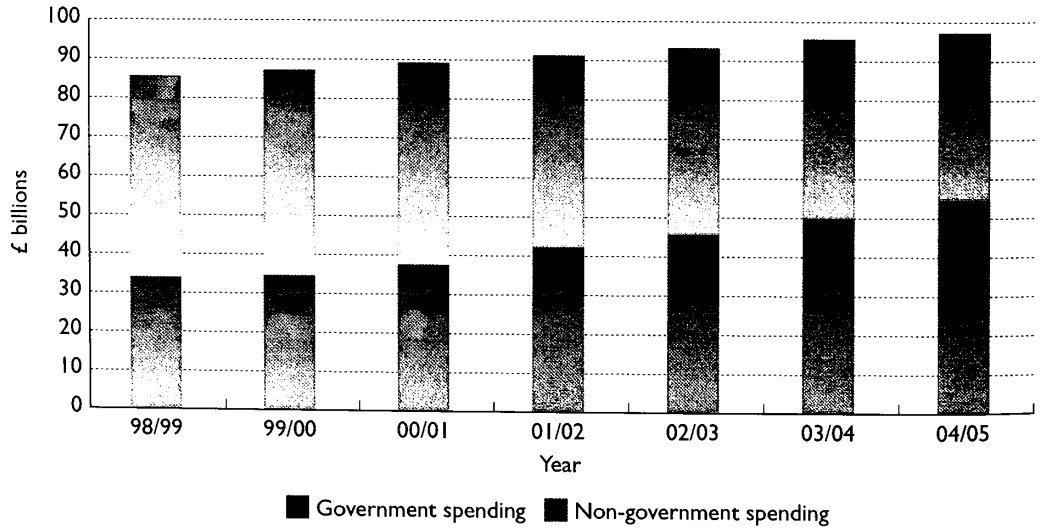


Figure 5

SHARE OF NHS SPENDING OUT OF ALL GOVERNMENT SPENDING

BOX 3: HOW WOULD PRIVATE SPEND INCREASE?

The first problem with funding increased health care spending through the private sector is how this can come about. Currently, UK citizens are free to buy many forms of private medical insurance and to pay directly out-of-pocket for health care from private providers. How are the public to be persuaded to spend over three times more on private health care than they do at present?

Subsidies from government, which effectively lower the price of, say, private medical insurance are a rather roundabout way of doing this. It makes more sense for the Government to spend taxpayers' money directly on health care through the NHS, rather than risk wholly or partly subsidising private health care providers' earnings (through increased prices) without much impact on the volume of care provided.

Providing an opt-out from the NHS by reducing income tax payments for those who go private merely increases private spending at the cost of reduced NHS spending, at one extreme leaving total health care spending neutral.

If these problems were not enough, there is also a distributional or equity issue that needs to be addressed. Over 75 per cent of current public expenditure is for people over 65 years and for children. In other words, just £12 billion of the current NHS budget is spent on adults of working age. If this is where most of the growth in private spend can feasibly occur, then this could mean an end to a universal health care service and a very overt split between those who contribute to NHS funding (but use the private sector) and those who use the NHS.

CONCLUSION

Although we have presented each option separately, the Government could use a combination of these – raising taxes and shifting public spending for example. However, we have illustrated the extent of the Government's pledge to the NHS over the next five years. It means greater public spending, a shift away from other traditional areas of public spending or a massive increase in private expenditure on health care.

All options have attendant problems and knock-on effects. And while there seems no question that there is a popular desire to spend more on health care – and primarily to spend more through the NHS (preserving a commitment to inequality in

funding favouring the poor), the scale of spending increases raises difficult choices, of which the public may not be fully aware.

More radical solutions for bridging the funding gap – such as a form of hypothecated tax – may well bring benefits (not least additional money for the NHS) but also raise questions: who sets the tax rate? How are fluctuations in the tax yield dealt with so as not to create uncertainty for NHS planning? Will identifying each taxpaying individual's NHS contribution undermine the universal (and essentially altruistic) nature of NHS funding and provision? To what extent will taxpayers' expectations and use of the NHS be raised as they begin to make connections between their personal contribution and their own use of the NHS?

Although there may be uncertainty as to where the UK is starting from and where it has to go in terms of health care spending, it is certain that the NHS will receive significant real increases in funding over the next few years. One question remains: whatever we spend on health care, will we ever be satisfied?

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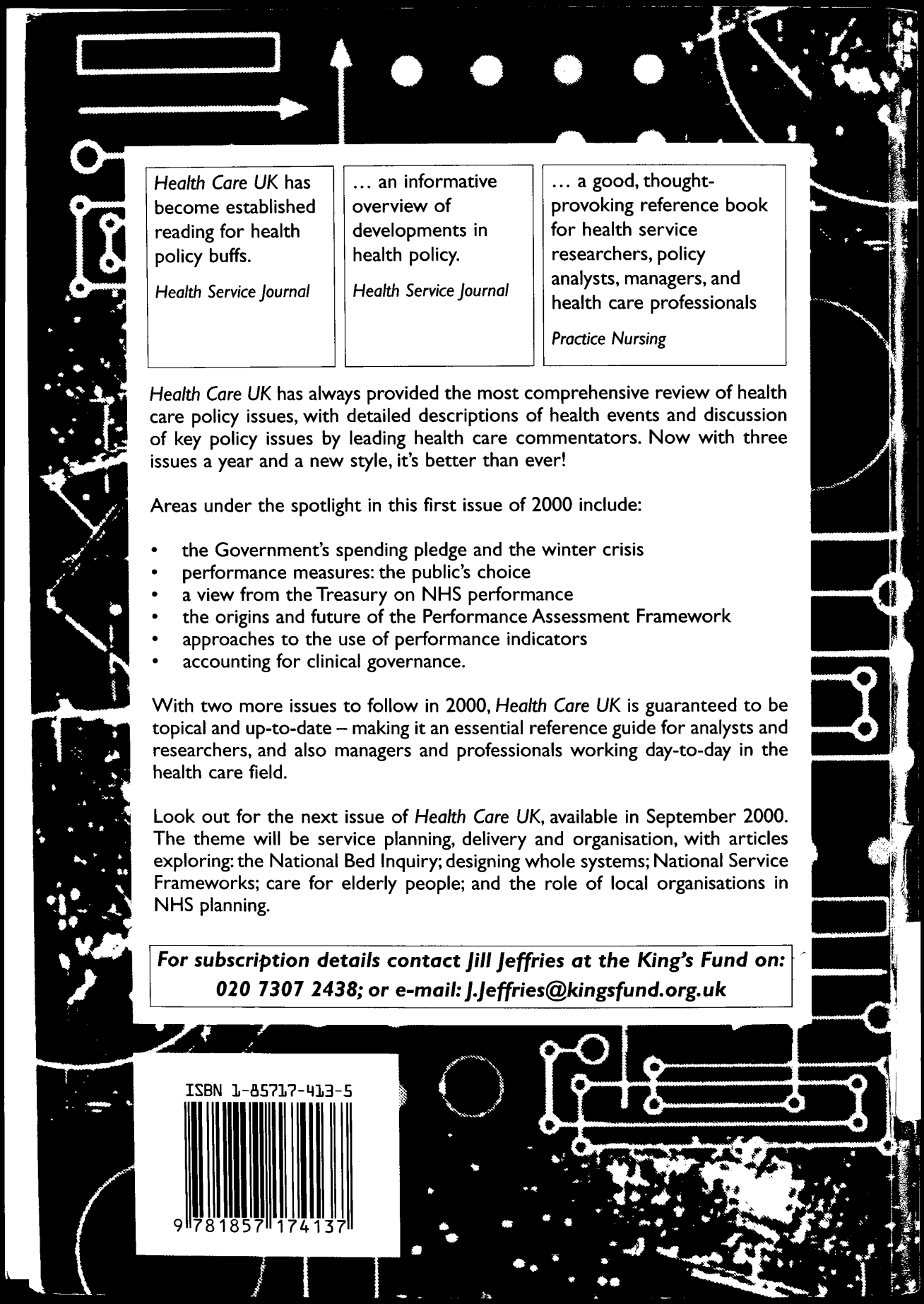

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ISBN 1-85717-413-5