After Francis: Standards & Care Quality in the NHS

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Introduction

Ensuring that NHS organisations and their staff deliver the best care possible to patients is a core aim of our health service, but how best to measure and guarantee quality care is an on-going debate. In recent months, the issue of care quality has been brought into sharper focus by the publication of the Francis Report inquiry into the Mid Staffordshire hospital scandal[1] in early February, by Secretary of State for Health Jeremy Hunt's recent focus on the issue[2] and numerous other stories relating to standards and patient dissatisfaction in the NHS.

More broadly, this debate is also taking place against the backdrop of the coalition's health reforms, which have signalled a new approach to the measurement and enforcement of standards. Most notably, there appears to be a plan to shift away from the accountability and quality control mechanisms favoured in the 2000s by the previous Labour government, which stressed centrally-set quantitative targets, alongside a lesser measure of choice and competition within the internal market.[3] The coalition government's approach, while stressing an expansion of internal competition and phasing out fixed targets, is aiming to complement this approach with new broad outcome indicators, greater information availability for patients and an emphasis on a more qualitative 'friends and family' measure of care standards.[4] [5] Debate over this new approach is on-going among health professionals and analysts.[6]

Failings in Mid Staffordshire and elsewhere have also raised questions about the effectiveness of the regulatory bodies that oversee the NHS, including the current Care Quality Commission (CQC) and its pre-2009 predecessor, the Healthcare Commission.[7] Health Secretary Jeremy Hunt has also proposed changes to the manner in which NHS managers are held accountable on care quality – new codes of ethics are being proposed and disciplinary action is potentially being

made more of an option when adequate standards are not upheld.[8] Other areas of discussion include the relationships between both Foundation Trust status and competition policy and care standards in the NHS, as well as the need for greater integration in the service.

Therefore, as the health service moves into a time of extensive challenges, it is worthwhile to assess whether the NHS is successfully meeting expectations on care quality, what specific problems exist in the system and what policy instruments are available to improve standards.

The Mid Staffordshire Scandal

On February 6th 2013, the Francis Report into the failings at Mid Staffordshire NHS Foundation Trust was released, looking at what went wrong and what can be done to prevent similar lapses (it can be accessed here). In 2005 the trust, which includes the Stafford and Cannock Chase hospitals and was originally known as Mid Staffordshire General Hospitals NHS Trust, decided to pursue Foundation Trust (FT) status, which was granted in February 2008. However, by this time it had started to become clear that death rates were abnormally high and there were serious problems with general aspects of patient care at the trust.

In 2009, it was revealed that the trust had the worst death rate in the country, with 400 to 1,200 more deaths than would be expected at an average NHS hospital occurring. Anecdotal evidence from Mid Staffordshire has also been consistently damning. Stories of understaffing, malpractice and extreme patient neglect came to light, including inadequate numbers of staff on the wards, some staff not being adequately trained to use equipment or being too junior to handle assigned duties, drugs being misadministered and patients left dehydrated without water, in pain due to failures to provide painkillers or left in soiled sheets. At times, families of mistreated patients had to take to providing them with food and washing their bedclothes. Moreover, complaints from patients and family members were seemingly ignored, and objections from staff were allegedly silenced with either formal threats of disciplinary action from managers or bullying from colleagues at their own level.[9]

In order to attain FT status, the board at Mid Staffordshire led by Chief Executive Martin Yeates determined that the trust would have to meet relevant targets, such as waiting time targets, and cut staff in order to secure the trust's financial stability. Minutes of a meeting by the trust board in February 2006 reported a "reduction in pay expenditure across most Directorates, linked to the successful implementation of cost containment measures", presumably referring to these staff reductions, which it was said were resulting in "positive movement towards year-end targets" and would likely lead the organisation to its required financial position.[10] In June 2006 the relevant regional Strategic Health Authority (SHA) confirmed its support for the trust's Foundation status application[11] and in an August 2006 meeting, Yeates "stated that the SHA did not see the Trust as a risk and was encouraging it to apply for Foundation Trust Status".[12]

In 2007, after concerns were first raised about death rates at the hospital by a research unit at Imperial College London, an investigation by the overseeing West Midlands Strategic Health Authority found nothing and concluded that the high death rates were merely a "statistical issue"[13]. In October 2008, the Healthcare Commission (the oversight organisation in the NHS at the time, replaced in 2009 by the Care Quality Commission, CQC) demanded improvements in standards in the A&E department. In March 2009, Martin Yeates was suspended as chief executive at Mid Staffordshire, and his interim replacement also tasked two officials, George Alberti and David Colin Thome, to perform two separate internal investigations, though by this

time pressure was beginning to build for a full public inquiry. In May 2009, Yeates and the board chair at Mid Staffordshire, Toni Brisby, resigned shortly before the Healthcare Commission report was due to be published, which turned out to be damning about death rates and severe neglect[14]. The new CQC subsequently announced it would launch quarterly inspections of conditions at Mid Staffordshire and in April 2009 Alberti and Colin Thome announced that they had found that staff and equipment remained issues at the trust, although they also noted improvements.[15] In July, the first CQC report reached similar conclusions and later in the year CQC reports still rated Mid Staffordshire's overall performance as "weak" and advised the hiring of more nurses. However, in November Dr Foster did praise rising standards at Stafford hospital specifically.[16] In July 2009, Health Secretary Andy Burnham announced another independent inquiry, which got underway in November 2009, but going into 2010 strange deaths were still occasionally being reported, and in June 2010, the incoming coalition government announced the full public inquiry led by Robert Francis QC.[17]

The public inquiry, which has cost £13 million and has involved 290 witnesses[18], has called into question the culture within the service and the previous government's focus on quantitative targets, which it is now widely believed led to a kind of 'box-ticking culture' rather than the promotion of genuine patient care. In Francis's words the culture was "focused on doing the system's business – not that of the patients".[19] For example, A&E targets led to manipulations in which patients were left waiting in ambulances, hallways or Stafford hospital's Clinical Decisions Unit before being brought 'officially' to A&E, all in order to 'stop the clock' and ensure compliance with the quantitative target. In other cases, patients were treated based on time priorities rather than clinical severity due to the targets, and at times, figures were just falsified outright to avoid non-compliance. The oversight failures by both the Healthcare Commission and the Care Quality Commission (CQC) were also called into focus, along with the lack of accountability and of measures for dealing with failing hospitals. This is how Francis summarised the failings at Mid Staffordshire[20]:

"the story it tells is first and foremost of appalling suffering of many patients. This was primarily caused by a serious failure on the part of a provider Trust Board. It did not listen sufficiently to its patients and staff or ensure the correction of deficiencies brought to the Trust's attention. Above all, it failed to tackle an insidious negative culture involving a tolerance of poor standards and a disengagement from managerial and leadership responsibilities. This failure was in part the consequence of allowing a focus on reaching national access targets, achieving financial balance and seeking foundation trust status to be at the cost of delivering acceptable standards of care."

Francis further identified the cultural problems at the trust as follows:

- "An institutional culture which ascribed more weight to positive information about the service than to information capable of implying cause for concern"
- "Standards and methods of measuring compliance which did not focus on the effect of a service on patients"
- "Too great a degree of tolerance of poor standards and of risk to patients"
- "A failure of communication between the many agencies to share their knowledge of concerns"
- "Assumptions that monitoring, performance management or intervention was the responsibility of someone else"
- "A failure to tackle challenges to the building up of a positive culture, in nursing in particular but also within the medical profession"

- "A failure to appreciate until recently the risk of disruptive loss of corporate memory and focus resulting from repeated, multi-level reorganisation"

Beyond Mid Staffordshire

However, while it would be easy to view Mid Staffordshire as an isolated and tragic case, the extent of the current problems in the NHS have been clearly shown not to end with it. At the time of the scandal, the UK may have had the highest preventable death rate in Europe.[21] Recently, 14 NHS hospital trusts have been reported to be under investigation for unusually high death rates, like those at Mid Staffordshire. They are: [22] [23]

1. Colchester Hospital University NHS Foundation Trust
2. Tameside Hospital NHS Foundation Trust
3. Blackpool Teaching Hospitals NHS Foundation Trust
4. Basildon and Thurrock University Hospitals NHS Foundation Trust
5. East Lancashire Hospitals NHS Trust
6. North Cumbria University Hospitals NHS Trust
7. United Lincolnshire Hospitals NHS Trust
8. George Eliot Hospital NHS Trust
9. Buckinghamshire Healthcare NHS Trust
10. Northern Lincolnshire and Goole Hospitals NHS Foundation Trust
11. The Dudley Group NHS Foundation Trust
12. Sherwood Forest Hospitals NHS Foundation Trust
13. Medway NHS Foundation Trust
14. Burton NHS Foundation Trust

Professor Sir Brian Jarman, who first drew attention to the unusual death rate at Mid Staffordshire, has estimated that the total number of preventable deaths in the NHS over the past 10 years could be as high as 20,000.[24] Dr Foster Intelligence, chaired by Professor Sir Jarman, made similar findings, reporting in 2012 that 12 trusts (including many of the above that are now under official investigation) had "worryingly high" death rates, though this was down from 20 trusts that were thought to be causes for concern in 2011.[25] The UK is also one of the worst in Europe for preventable child deaths according to a study published in *The Lancet*,[26] with between 1,600 and 2,000 child deaths occurring every year (five more per day than in the best performing nation, Sweden). It was suggested that one possible explanation for this, though not necessarily the only one, was that GPs are not being incentivised by the system to focus on paediatric care or work with paediatricians in the same way gatekeepers do in comparable nations.[27] These revelations come on top of the release of OECD Health 2012 data and the Global Burden of Disease study (see 'Empirical Performance: National Comparisons' below), both of which appeared to show the UK lagging other nations on measures of mortality.

Further, the NHS has seen past scandals. Following the Bristol Royal Infirmary scandal in the 1990s, in which babies had died at an abnormal rate following cardiac surgery and a negative culture on staff was identified, an editorial was published in the *British Medical Journal* declaring that "British medicine will be transformed by the Bristol case".[28] Although we must be mindful that any large and complex national health system will be failure-prone in instances, the fact that the NHS is again battling similar problems is something we must examine. Therefore, although the NHS still often provides excellent care, it would appear that the issues that arose in Mid Staffordshire are present in other parts of the system as well and have been for some time,

and this in turn calls for a much more fundamental debate as to what these issues are and what can be done to solve them.

Background: Current Evidence on Standards & Patient Satisfaction

First, we should review the empirical evidence we have regarding standards of patient care in the NHS to see what conclusions we can begin to draw about the current situation in the service.

Public Experiences

In December 2011 (over a year before the full publication of the Francis report) IPSOS-MORI conducted a study for the Department of Health, finding that 70% of people were satisfied with the NHS in general, the same as from one year before, albeit with a very slight fall in the number who felt "very satisfied". 75% were satisfied with their last hospital visit, 83% were satisfied with their last GP visit, outpatients reported 82% satisfaction and 75% agreed that they would feel safe in an NHS hospital. 63% felt the NHS treated people with "dignity and respect", though this could stand to be higher and only 44% were willing to say the same about social care services. 77% were satisfied that their own local NHS services were good, although only 63% said the same of NHS services nationally, suggesting a significantly stronger attachment to local services than to the national institution itself as currently designed. 73% characterised the health service as "one of the best in the world" and 69% felt it was value for money. Concerns remained about waiting times, however, with a plurality (43%) disagreeing that they seemed to be falling. The number who felt they were able to be more involved and make more choices about their own care remained static at 63%, the same as in 2009 and 2010 - about a quarter felt they wanted to be more involved, demonstrating continued demand for greater patient choice. Overall, these results would seem to indicate fairly high satisfaction with the NHS, though it should be noted that these figures come at the end of a period of high spending in the service and that higher figures have sometimes been reported from similar countries. The figures demonstrating a greater attachment to local than national services, concerns about waits and demands for greater choice also remain important to note.

In November 2012, the NHS Institute for Innovation and Improvement released online patient feedback data, also gathered by IPSOS-MORI. That showed that all trusts had offered at least some patients a chance to give feedback through standardised forms, including 67% which used questions based on the 'friends and family' test (whether people feel the service would be fit for their loved ones and would be willing to recommend it to them). However, there was still some variance in how and how often patients were offered the chance to express their views and response rates to the IPSOS-MORI study varied regionally, suggesting improvement was needed.[29] Therefore, these results suggest that writ-large, monitoring of patient care by trusts could stand to be more consistent across the board and there is still substantial room to attain higher standards.

In June 2012 the British Social Attitudes Survey (BSAS) revealed that between 2011 and 2012 there had been a drop in patient satisfaction with the NHS from 70% to 58%, a fall not seen for at least several decades and which may have been related to anxiety over the coalition reforms.[30] The previous 70% figure in 2011 tracked closely with the figure found by IPSOS-MORI and the Department of Health that year.

Staff Surveys

In the November 2012 IPSOS-MORI investigation, NHS Trusts were also asked to self-assess their performance on patient experiences in ten areas, broken down into five categories of two areas each: leadership ("leadership visibility", "strategy & investment"), culture ("empowering culture", "accountability & governance"), patient centrism ("patient centric organisation", engaged patients"), evidence ("360º drill-down evidence", "evidence drives improvements") and staff ("engaged staff", "good practice celebrated"). Trusts ranked themselves 0 to 5 on how active they are in implementing these aspects of patient experience improvement (5 being best), with a total score of 50 available. The average self-assessment score among trusts was 28 out of 50. Leadership visibility was strongest (average score of 3.2 out of 5), with good practice and evidence-driven improvement weakest (each 2.5 out of 5). Crucially, on the two 'patient' measures, trusts gave themselves 2.9 on patient-centred care and 2.8 on ability to engage patients.[31]

The NHS Staff Survey 2012 was released in March 2013. 63% of NHS staff agreed that "if a friend or relative needed treatment I would be happy with the standard of care provided by this organisation", meaning most organisations passed the 'friends and family test' in the view of their staff, although only 17% "strongly agreed", suggesting substantial room for improvement. These numbers also varied across different types of organisations and, notably, were highest (71%) within independent non-profit NHS social enterprise organisations such as Plymouth Community Healthcare, NAViGO (North East Lincolnshire) and the North Somerset Community Partnership, demonstrating a link between relative quality and provision diversity in the NHS. The overall number agreeing was essentially the same as in 2011 and 2010, suggesting improvement has so far been slow.[32] [33] 62% felt patient care was their organisation's "top priority", though again only 19% "strongly" felt this was the case, leaving room for improvement. 67% felt that their organisation acts on concerns raised by patients, 17% strongly agreed.[34]

Therefore, NHS staff appear to feel the service is performing well, though there is room for improvement. Notable is that across many categories, few agreed "strongly" with key statements and significant minorities did not agree standards or conditions were high but tended to "neither agree nor disagree" with the propositions put to them. While this may reflect genuinely mixed feelings, it could also signal reluctance among NHS staff to be clear when they have concerns.

Complaints

In June 2011, the House of Commons Health Select Committee found that the complaints system in the NHS, primarily the office of Health Service Ombudsman, was not working. It was recommended that the Ombudsman should have broader powers to independently review complaints to NHS providers and that the current requirement that investigations must have a reasonable chance of a "worthwhile outcome" be done away with, so as to allow patients more power of redress.[35]

In August 2012, it was confirmed by the Health and Social Care Information Centre (HSCIC) that the number of formal complaints against the NHS had risen by 8%. Between 2011 and 2012, there had been 162,129 complaints, approximately 3,000 a week. Some concerned staff attitudes or communication, but 50,000 regarded "all aspects of clinical treatment".[36] In

November 2012, a report by the Ombudsman attributed the rise to inadequate, "insincere" and "unclear" communication between staff and patients.[37] In January 2013 the Patients Association raised concerns about inadequate complaints procedures in the NHS, warning this presented the risk that failures similar to those at Mid Staffordshire could still go overlooked. Specifically, they warned that staff are not trained to deal with complaints, that hospitals fail to see them as "opportunities to improve" and that previous post-Staffordshire recommendations on complaints procedure had not yet been implemented[38].

Therefore, both in terms of rising numbers and the adequacy of procedures for dealing with them, complaints appear to be an area where there is significant room for improvement in the NHS.

Clinical Outcomes & Service Quality: National Comparisons

On a variety of clinical outcome measures and indicators relevant to good patient care and experiences, the UK continues to lag some other countries. Below is data drawn from three OECD documents:

- 'Mortality Amenable to Health Care in 31 OECD Countries' (2011)[39]
- 'Health at a Glance 2011 - OECD Indicators, Waiting times' (2011)[40]
- 'OECD Health Data 2012 – Frequently Requested Data' (2012)[41]

Italics denote primarily tax-financed 'Beveridgean' health systems, **bold** denotes social health insurance 'Bismarckian' systems funded primarily by social insurance contributions (the United States is categorised as neither and OECD averages are also given). [42][43]

Country	Physicians per 1,000 people	Country	Nurses per 1,000 people	Country	Hospital beds per 1,000 people
1. Chile	1.4	**Chile**	1.5	**Mexico**	3.7
2. Turkey	1.7	**Turkey**	1.6	**Chile**	1.6
3. Korea	2.0	**Mexico**	2.5	**Turkey**	2.0
4. Mexico	2.0	*Greece*	3.3	*Sweden*	2.5
5. Poland	2.2	**Korea**	4.6	*New Zealand*	2.7
6. Japan	2.2	**Israel**	4.8	*United Kingdom*	2.7
7. Canada	2.4	*Spain*	4.9	United States	3.0
8. Slovenia	2.4	**Poland**	5.3	*Ireland*	3.1
9. United States	2.4	*Portugal*	5.7	*Spain*	3.1
10. New Zealand	2.6	**Slovak Republic**	6.0	*Canada*	3.2
11. United Kingdom	2.7	**Estonia**	6.1	*Norway*	3.2
12. Luxembourg	2.8	**Hungary**	6.2	**Israel**	3.3
13. Hungary	2.9	*Italy*	6.3	*Portugal*	3.3
14. Belgium [1]	2.9	**Austria**	7.7	*Denmark*	3.4
15. Netherlands	2.9	**Czech Republic**	8.1	*Italy*	3.5
16. Australia	3.1	**Slovenia**	8.2	*Australia*	3.5
17. Ireland	3.1	**Netherlands**	8.4	**Slovenia**	4.6
18. OECD Average	3.1	**France**	8.5	**Netherlands**	4.7

19. Estonia	3.2	OECD Average	8.6	*Greece*	4.9
20. Finland	3.3	*Canada*	9.3	OECD Average	
21. France	3.3	*Finland*	9.6	**Switzerland**	5.0
22. Slovak Republic	3.3	*United Kingdom*	9.6	**Estonia**	5.3
23. Denmark	3.5	*New Zealand*	10.0	**Luxembourg**	5.4
24. Israel	3.5	*Australia*	10.1	*Iceland*	5.8
25. Czech Republic	3.6	**Japan**	10.1	*Finland*	5.9
26. Iceland	3.6	United States	11.0	**France**	6.4
27. Italy	3.7	*Sweden*	11.0	**Slovak Republic**	6.4
28. Germany	3.7	**Luxembourg**	11.1	**Belgium [1]**	6.4
29. Spain	3.8	**Germany**	11.3	**Poland**	6.6
30. Sweden	3.8	*Ireland*	13.1	**Czech Republic**	7.0
31. Switzerland	3.8	*Norway*	14.4	**Hungary**	7.2
32. Portugal	3.8	*Iceland*	14.5	**Austria**	7.6
33. Norway	4.1	**Belgium [1]**	15.1	**Germany**	8.3
34. Austria	4.8	*Denmark*	15.4	**Korea**	8.8
35. Greece	6.1	**Switzerland**	16.0	**Japan**	13.6

Figure 1: OECD rankings (Source: 'OECD Health Data 2012 - Frequently Requested Data')

Country	Potential years of life lost (PYOLL) per 100,000 males	Country	Potential years of life lost (PYOLL) per 100,000 females	Country	Infant mortality, deaths per 1,000 live births
Turkey	..	**Turkey**	..	**Mexico**	14.1
Mexico	8979.9	**Mexico**	4833.5	**Turkey**	10.1
Hungary	8851.7	**Hungary**	3948.0	**Chile**	7.9
Estonia	8720.4	United States	3592.4	United States	6.1
Poland	7763.1	**Slovak Republic**	3073.0	**Slovak Republic**	5.7
Slovak Republic	7254.3	**Chile**	3071.9	**Hungary**	5.3
United States	6152.3	**Poland**	2988.0	*New Zealand*	5.2
Chile	5855.3	**Estonia**	2879.0	*Canada*	5.1
Czech Republic	5425.7	*New Zealand*	2749.2	**Poland**	5.0
Finland	4903.3	*Denmark*	2709.7	OECD Average	4.3
OECD Average	4798.4	**Belgium [1]**	2577.0	*United Kingdom*	4.2
France	4746.4	*United Kingdom*	2534.6	*Australia*	4.1
Portugal	4738.9	*Canada*	2504.7	**Austria**	3.9
Belgium [1]	4670.6	**Czech Republic**	2473.8	*Greece*	3.8
Denmark	4653.2	OECD Average	2457.0	*Ireland*	3.8
Slovenia	4583.8	**France**	2295.8	**Netherlands**	3.8
Greece	4561.9	**Netherlands**	2276.5	**Switzerland**	3.8
Korea	4420.9	*Portugal*	2239.6	**Israel**	3.7
New Zealand	4365.8	**Germany**	2218.8	**France**	3.6

Austria	4261.4	*Ireland*	2197.3	**Belgium [1]**	3.5
Germany	4030.1	*Finland*	2191.3	*Denmark*	3.4
United Kingdom	3989.9	**Slovenia**	2185.9	**Germany**	3.4
Canada	3926.0	**Austria**	2165.7	*Italy*	3.4
Luxembourg	3872.8	*Australia*	2119.9	**Luxembourg**	3.4
Ireland	3742.8	*Norway*	2117.0	**Estonia**	3.3
Spain	3657.1	**Switzerland**	2068.5	**Korea**	3.2
Australia	3643.0	**Korea**	2059.1	*Spain*	3.2
Italy	3439.4	**Israel**	2030.9	*Norway*	2.8
Japan	3432.5	**Luxembourg**	2012.9	**Czech Republic**	2.7
Switzerland	3430.0	*Greece*	1984.3	*Portugal*	2.5
Israel	3419.9	*Italy*	1901.2	**Slovenia**	2.5
Norway	3411.1	*Sweden*	1883.7	*Sweden*	2.5
Netherlands	3192.7	**Japan**	1795.5	*Finland*	2.3
Iceland	3178.3	*Spain*	1787.1	**Japan**	2.3
Sweden	3072.8	*Iceland*	1615.7	*Iceland*	2.2

Figure 2: OECD rankings (Source: 'OECD Health Data 2012 - Frequently Requested Data')

Country	Amenable Mortality, OECD, deaths per 100,000 in 2007 (Nolte & McKee)	Country	Amenable Mortality, OECD, deaths per 100,000 in 2007 (Tobias & Yeh)
Belgium [1]		**Belgium [1]**	
Switzerland		**Switzerland**	
Turkey		**Turkey**	
Estonia	199.0	**Hungary**	206.0
Hungary	197.0	**Estonia**	190.0
Slovak Republic	188.0	**Mexico**	178.0
Poland	138.0	**Slovak Republic**	171.0
Mexico	137.0	**Poland**	138.0
Czech Republic	125.0	**Czech Republic**	128.0
Portugal	108.0	United States	124.0
United States	103.0	**Chile**	109.0
Chile	102.0	*Portugal*	108.0
OECD Average	95.0	*New Zealand*	107.0
Slovenia	91.0	*Denmark*	106.0
Denmark	87.0	OECD Average	104.0
Korea	86.0	*United Kingdom*	102.0
United Kingdom	86.0	**Slovenia**	96.0
New Zealand	85.0	*Ireland*	95.0
Ireland	82.0	**Israel**	94.0
Germany	81.0	**Germany**	88.0
Israel	81.0	*Canada*	87.0
Finland	79.0	*Finland*	86.0
Greece	79.0	*Norway*	84.0

Luxembourg	75.0	*Australia*	82.0
Canada	74.0	**Austria**	82.0
Norway	70.0	**Korea**	82.0
Spain	70.0	**Netherlands**	82.0
Austria	69.0	**Luxembourg**	81.0
Australia	68.0	*Spain*	80.0
Netherlands	68.0	*Greece*	79.0
Sweden	68.0	*Sweden*	78.0
Japan	66.0	*Iceland*	72.0
Italy	65.0	*Italy*	71.0
Iceland	61.0	**France**	64.0
France	59.0	**Japan**	62.0

Figure 3: OECD rankings (Sources: OECD Health Data 2012 - 'Mortality Amenable to Health Care in 31 OECD Countries')

Country	Waiting time of four weeks or more for a specialist appointment (2010)	Country	Waiting time of four months or more for elective surgery (2010)
Canada	59	*Canada*	25
Sweden	55	*Sweden*	22
Norway	50	*Norway*	21
France	47	*United Kingdom*	21
Australia	46	*Australia*	18
New Zealand	39	*New Zealand*	8
Netherlands	30	**France**	7
United Kingdom	28	**Switzerland**	7
United States	20	United States	7
Switzerland	18	**Netherlands**	5
Germany	17	**Germany**	0

Figure 4: OECD rankings on waiting times (Source: 'Health at a Glance 2011 OECD Indicators, Waiting times')

From the above data it is clear that although the UK doesn't perform too badly in certain areas, such as specialist appointment waiting times, nurse numbers and potential years of life lost for males, it lags most other developed nations on outcome measures and there is certainly substantial room to improve. Strikingly, on the measures where data is available for all or almost all of the OECD, in several key areas the UK is not currently among the ten best nations.

Additionally, in March 2013 a study comparing public health in the UK with 14 EU nations, the US, Norway and Australia was published in *The Lancet*:

Country	Age Standardised Death Rate (per 100,000)	Country	Age-Standardised Years of Life Lost (per 100,000)
Australia	389	*Sweden*	7296
Italy	389	*Italy*	7485
Spain	393	*Spain*	7694
Sweden	403	*Australia*	7722
France	408	*Norway*	7904
Austria	418	**Netherlands**	7988
Canada	422	**Austria**	**8401**
Norway	422	**Luxembourg**	8484
Netherlands	426	**Germany**	8512
Luxembourg	432	*Canada*	8546
Germany	433	**France**	8666
Finland	437	*Ireland*	8764
Ireland	453	*Greece*	8806
United Kingdom	**455**	*United Kingdom*	**8949**
Belgium	460	*Finland*	9050
Greece	465	**Belgium**	9381
Portugal	468	*Portugal*	9407
Denmark	504	*Denmark*	9592
United States	516	United States	11447

Figure 5: outcomes among 18 developed nations (Source: 'Global Burden of Disease Study 2010, *The Lancet*')

Country	Life Expectancy at Birth (years)	Country	Ischaemic Heart Disease (Prevention, Ranking)
Australia	81.5	**France**	1
Italy	81.5	*Portugal*	2
Spain	81.4	*Spain*	3
Sweden	81.4	**Netherlands**	4
France	80.9	*Italy*	5
Norway	80.8	*Australia*	6
Austria	80.6	*Norway*	7
Canada	80.6	**Luxembourg**	8
Netherlands	80.6	**Belgium**	9
Germany	80.2	*Sweden*	10
Luxembourg	80.2	**Denmark**	11
Finland	80.1	*Canada*	12
United Kingdom	**79.9**	**Austria**	13
Ireland	79.9	*United Kingdom*	**14**
Greece	79.6	**Germany**	15
Belgium	79.5	*Ireland*	16

Portugal	79.4	*Finland*	17
Denmark	78.9	United States	18
United States	78.2	*Greece*	19

Figure 6: outcomes among 18 developed nations (Source: 'Global Burden of Disease Study 2010, *The Lancet*')[44]

Continentally, Britain has been estimated to lag 11 other nations according an index measuring patient care. According to the Euro Health Consumer Index, in 2012 we were 12th in Europe, with Austria, Finland, Norway, France, Switzerland, Sweden, Belgium, Luxembourg, Iceland, Denmark and the Netherlands ahead.[45] Areas for improvement noted for the NHS included: access to personal medical records, portability, waiting times (especially for specialists and CT scans), heart infarction deaths, infant deaths, cancer deaths, preventable years of life lost, MRSA infections, access to caesarean sections, depression treatment, access to cataract operations, access to infant 4-disease vaccinations, long-term care for the elderly, access to at-home dialysis, novel cancer drugs deployment and access to drugs for Alzheimer's and schizophrenia.

Civitas Investigation

In March 2013, ICM conducted a representative poll of 1,000 adults on behalf of Civitas which replicated four questions previously asked by ICM about attitudes to the NHS in 2006[46] and 2008[47], allowing us to observe how attitudes have changed. In this, we discovered that:[48]

- 41% disagree with the statement "people living in European countries such as France and Germany don't receive as good a level of healthcare as we do on the NHS", with 36% agreeing and 23% answering "don't know". This compared with 49% disagreeing in 2006, while 36% agreed and 15% didn't know. Therefore, despite a slight shift, a plurality still feel continental care is as good as our own and there has been no increase in the number feeling NHS care is better

- 83% agree with the statement "it shouldn't matter whether hospitals or surgeries are run by the government, not-for-profit organisations or the private sector, provided that everyone including the least well off has access to care", with only 14% disagreeing, unchanged since 2006 despite recent attacks on the role of independent providers in health in the context of the debate over the coalition health reforms

- 56% agreed with the sentiment that the NHS is "is the envy of the world", but 38% disagreed, perhaps showing that more can be done to reform it. This is also up from 51% agreeing and 46% disagreeing in 2008. In a similar, albeit not directly comparable, poll conducted by the polling firm Harris in France in 2008, 70% of French people said they felt their system was the "envy of the world"[49]

- When asked which of five aspects of NHS inpatient care would be of most concern to them if they were in hospital, respondents replied as follows; "That you might pick up an infection in the hospital" (24% now, compared with 40% in 2008), "That you'd have to wait a long time for treatment" (26% now, 25% in 2008), "That you might have to share accommodation or bathroom facilities with the opposite sex" (7% now, 10% in 2008), "That there wouldn't be enough staff to pay attention to your needs" (16% now, 10% in 2008), "That the treatment you received might be of poor quality" (18% now, 8% in

2008), "None of these" (8% now, 7% in 2009). Given the relativity of the question, it is perhaps unclear precisely how much the public worry about their stated concerns, but this may reflect some concern about patient care, continued concern about waits and certainly some awareness on the part of the public about health affairs, given their correct perception of the improving situation with hospital-acquired infections

Conclusions

On its face, it can seem difficult to reconcile the relatively high satisfaction ratings given to the NHS by its users and staff with the evidence of lapses such as Mid Staffordshire and data showing the need for significant improvement in clinical outcomes when the NHS is compared to other developed nations, but assessments by the US-based Commonwealth Fund perhaps shed some light. They have outlined how while the NHS performs fairly well on measures such as financial access, equity, cost-efficiency, patient engagement and out-of-hours care, clinical outcomes remain the service's Achilles heel relative to almost all other nations, clearly still a problem since this should be the focus of any successful health system.[50] When nations are compared on mortality amenable to healthcare, perhaps the most specific available indicator of how effective health systems are at saving lives, the UK currently only beats the US and a few others among developed nations, for example. However, since the areas where the NHS performs most strongly are those that patients experience and perceive most directly and the performance of our system relative to other nations on measures of mortality is something most people are unlikely to be able to perceive unless specifically informed, this means the latter is likely not being taken into account by the public. Therefore, despite the strengths of the NHS in some areas, fundamental questions should be asked about how the service can be reformed and what we can learn from other nations.

Issues & Potential Solutions: The Current Debate

From the above information and from the events at Mid Staffordshire and the subsequent revelations in the Francis report about what led to them, it is clear that the NHS has far to come to improve patient care and implement changes that will tackle its problems with mortality and prevent the Mid Staffordshire scandal being repeated. However, a variety of different elements of the problem and potential solutions are now being discussed publicly.

Managerial Accountability

Managerial accountability and the possibility of the removal of managers if their organisations are failing to provide adequate care, rather than simply on financial grounds as at current, has been one theme in the debate around NHS standards recently. In November 2012 Health Secretary Jeremy Hunt spoke at The King's Fund, stating that "There's a simple test every layer of the health and social care system should be applying. And that is to ask: is this the care I would wish for myself, or for a loved-one?" (referring to the friends and family test) and arguing that "Just as a manager wouldn't expect to keep their job if they lost control of finances, why should they if they lose control of care?"[51] Robert Francis QC stressed similar themes in his report. He recommended that managers (and all other staff) be bound by a new code of ethics and standards, with compliance enforced by the possibility of dismissal,[52] in order to "Provide for a proper degree of accountability for senior managers and leaders to place all with responsibility for protecting the interests of patients on a level playing field".[53] A new professional regulator was also discussed as a possibility, along with appraisals and the

introduction of common minimum standards by the General Medical Council (GMC) and the Nursing and Midwifery Council (NMC) – feedback from patients, families and colleagues about the standard of care provided by the staff member would form a key part of these appraisals. A new leadership college was proposed to provide a better common standard of training for NHS managers, including an accreditation scheme, and it was hoped this innovation might help promote best practice in the service.

Another problem has been the perceived tendency of the NHS as a system to move failing managers 'sideways'. To address this, ministers at the Department of Health have spoken of the possibility of a "blacklist" of managers who should not return to the service.[54] Further, Mike Farrar of the NHS Confederation (which represents NHS organisations and managers) spoke favourably of such a move, in addition to making clear that he accepted many other tenets of the Francis report.[55] The Confederation has launched a consultation and published a discussion paper, stressing the creation of a positive culture of patient care, the strengthening of oversight methods, a balance between internal governance and external (national) regulation and strengthened employment practices to ensure the recruitment of quality staff. The paper also discusses calls for the formal regulation of managers, as already exists for health professionals, and some of the potential benefits of such an approach.[56]

The paper also noted that such an oversight regime would be difficult to set up and run effectively and that formal regulation was vetoed following the Bristol scandal in the 1990s and not explicitly called for in the Francis Report for this very reason.[57] However, without formal regulation, it is hard to see how the above proposals would guarantee good care. After the Bristol scandal, reforms were recommended to the General Medical Council (GMC)[58], but as scandals have continued on a large scale, it would appear that not enough has changed. Therefore, while blacklists, strengthened oversight and better training and accreditation would be wise, we should look more broadly at other ways to improve standards.

A Reformed Inspectorate

The Francis report also proposed strengthening the Care Quality Commission (CQC) after warnings from whistle-blowers that even years after Mid Staffordshire, the CQC is still not up to the task of ensuring standards across the system. Francis's main proposals to improve the CQC include making CQC inspections both more rigorous and more frequent, boosting staff numbers at the CQC and ensuring that CQC inspectors are adequately trained and that more of them have clinical experience than is the case at current. He also recommended that the CQC should collect and collate a wide variety of relevant data on hospital standards, in order to make it easier to spot failings earlier – this was a problem in the Mid Staffordshire case – and that the CQC should share information more effectively with other NHS bodies. Finally, in addition to being in charge of guaranteeing care quality, the CQC should oversee "corporate governance" and "financial competence".[59] It is hoped that if implemented, such recommendations could ensure that the CQC will not be as overburdened as before, will make better use of information and will be more rigorous.

In response to the report, Jeremy Hunt has announced that a new Chief Inspector of Hospitals and a separate Chief Inspector of Social Care will be created, that 'gagging clauses' that have tended to reinforce the culture of silence in the service will be banned, that a type of revalidation will be introduced for nurses as well as doctors and that healthcare assistants (HCAs) will have a new system of minimum standards and practices.[60] Donald Berwick, the

former Medicare and Medicaid administrator in the Obama Administration, has also been appointed to head a new advisory group on 'zero-harm' in the NHS.[61] New Ofsted-style inspections for hospitals and care homes will also be brought in, on the grounds that the CQC's current approach to inspections focuses too heavily on mere "minimum standards" and does not give patients enough idea of how hospitals compare.[62] These measures have now been included in the Care Bill, published on the 10th of May.[63] However, while the aim of a stronger and clearer set of standards is to be encouraged, a Nuffield Trust study commissioned by the Department of Health has already identified drawbacks with this approach, primarily the possibility that rankings would again be excessively quantitative and thus "too simple".[64] For example, a hospital might fail in some areas, but achieve a good ranking based on strong performance in others, disguising issues and leaving patients unaware of them, meaning that the ratings will have to assess individual departments and services in order to be effective.[65]

As with reforms in the direction of managerial accountability, scepticism therefore remains about how successful a strengthening of the NHS inspectorate will in itself be at promoting quality care in the long term. Indeed, according to an investigation by the *Health Service Journal* nearly three-quarters of chief executives at hospitals believe that the overhaul of inspections will be ineffective.[66] This is not to say that the government should not continue with efforts to find an effective way to inspect hospitals and enforce standards. Ranking hospitals and providing clear data for the public on hospital performance is a crucial prerequisite for patient choice to be properly exercised and helps underpin the German and Dutch healthcare systems, for example. But it would seem that again, more fundamental reforms will be needed to truly bring about improvements in standards.

Foundation Trust status

As discussed above, the Mid Staffordshire trust board's pursuit of Foundation Trust (FT) status has been noted as part of the background of the scandal, as the staff cuts and management style they instituted was intended to ensure that Mid Staffordshire met the financial and clinical targets required of trusts seeking FT status. Further, nine of the other trusts being investigated have FT status. This has led some commentators to blame the scandal on the policy of encouraging trusts to seek FT status[67] – *The Telegraph* criticised the trust board for wanting to be "premier league" and described the policy as simply allowing trusts "freedoms from Whitehall, including over executive pay, and [the ability to hold] board meetings in secret".[68] Some critics have called for FTs, which operate semi-independently from Whitehall as mutually-owned non-profit public benefit corporations within the NHS, to be "renationalised" (returned to full central control).[69]

There is no doubt that the Mid Staffordshire board was wrong to pursue FT status at the pace that they did without regard for proper patient care. It has also been predicted that the coalition's original plans to have most trusts achieve FT status by 2014 may have to be delayed, which is strongly recommendable if we are to avoid further Mid Staffordshire-type tragedies.[70] David Nicholson has also asked for the power to "renationalise" certain failing FTs in certain instances (as opposed to unilaterally bringing all of them under central control regardless of their current performance), a proposal worth considering.[71] Evidence on whether Foundation Trusts in practice help improve standards is mixed – one report by the York University Centre for Health Economics found that "results suggest that generally FTs perform better than non-FTs. However, these differences appear to be long-standing rather than the effect of the FT policy per se and we find some evidence of a convergence in hospital performance between FTs and

non-FTs". However, the same report also said that "Despite not being able to identify a substantial positive 'FT effect', our analysis certainly does not suggest that FTs are doing any worse than non-FTs" and that "Our analysis could not test whether FTs bring other benefits such as service innovation"[72]. Allowing trusts to break free of direct Whitehall control, take responsibility for their finances and raise extra money for their patients remains worthy of our consideration as an idea.

Therefore, although it is clear that the decision of the Mid Staffordshire board to sacrifice patient safety in order to pursue FT status was wrong and while it is wise to ensure that plans to universalise FT status by 2014 are put on hold, the idea behind FTs remains laudable in its intention to decentralise the NHS as an institution. The evidence of heightened staff satisfaction in NHS social enterprises such as Plymouth Community Healthcare and the North Somerset Community Partnership, a different type of independent non-profit organisation operating under the auspices of the public sector NHS (see 'Background - Staff Surveys' above), further demonstrates the value of experimenting with forms of local and arms-length control.[73] However, given the minimal evidence of a link between FT status and outcomes, this goal could perhaps be better pursued through a fuller devotion to localism and civil society in a manner that has been tried and tested elsewhere. On the continent, full devolution of health services to local government control and greater involvement by the non-profit sector in the management of hospitals and clinics is often seen, for example, and has at times been associated with the creation of more responsive services. This would suggest that in this area, as in others, we can still learn much from our European neighbours.

Reforms to Commissioning

The Mid Staffordshire scandal and other problems long predated the coalition reorganisation of NHS commissioning under the Health and Social Care Act 2012. Nevertheless, some commentators have included it in the post-Francis report debate about NHS standards, with supporters seeing the reorganisation as a potential way to drive up standards and detractors feeling it will either do little for patient care or undermine it.

As of April 1st 2013, 152 local Primary Care Trusts and the 10 Strategic Health Authorities were dissolved and replaced by 211 new local Clinical Commissioning Groups (CCGs) and the quasi-autonomous national NHS England board (previously known as the NHS Commissioning Board). This reorganisation is thought to be the most far-reaching in NHS history – NHS Chief Executive David Nicholson famously said it was "so large that you can see it from outer space" – and is costing an estimated £3bn. The new CCGs are intended to ensure that NHS budgets will be placed in the hands of groups of local GPs so that they can attune local decision-making to the needs of their areas and perhaps also move health spending away from hospitals and more towards the community sector, leading to a more coherent, modern and patient-centred health service. Former *Health Service Journal* editor Richard Vize has said that most of the fully authorised CCGs "have demonstrated a strong clinical focus, and are showing early signs of being ready to engage effectively with patients and communities", a promising sign if this assessment is correct.[74] In a survey by GP magazine *Pulse*, 83% of GPs reported that CCGs were pushing them to improve their performance.[75]

However, there have been criticisms of the evidence base for the reforms and therefore of their likelihood of success. The last comparable experiment with direct management of budgets by GPs was the policy of GP fundholding in the 1990s. Fundholding was not a complete failure, as in

areas where GPs involved themselves heavily in the process rises in standards and improvements in waiting times were observable. However, in areas where GPs were less engaged, fewer improvements were seen, creating somewhat of a postcode lottery effect with the policy. Furthermore, engagement was correlated with the income level of the local area, with higher-earning areas with fewer social problems tending to see greater GP engagement and resultant improved outcomes.[76] Anecdotal reports and the *Pulse* survey have suggested that GPs so far feel disengaged from the process – although 36 per cent of GPs reported being more involved in commissioning under the new regime, 55 per cent do not.[77] Admittedly it is early days and engagement could improve, but this will have to be closely monitored.

Further, though the creation of CCGs and the abolition of mid-level SHAs is intended to deliver a more localised NHS service, concern remains about the role of NHS England vis a vis the local CCGs. The NHS England board has its own responsibilities, including oversight and some commissioning functions of its own, and has a budget of £35bn, compared to a total budget of £65bn being handled by 211 separate CCGs. Therefore, there are concerns that the board amounts to further "nationalisation" and "command-and-control" centralisation in the NHS, contradicting the aim of greater localism.[78] Moreover, since only half of CCGs are currently fully authorised, the remainder will be operating under special operational restrictions from NHS England until at least June 2013 – a quarter face heavy restrictions.[79] Additionally, NHS England is a quasi-autonomous public body (some have labelled it a "quango")[80], and while on the one hand this will relieve the NHS of day-to-day interference from elected politicians at the Department of Health, this also severs the only clear line of elected accountability between the public and the NHS.

Therefore, on two fronts, there are risks that the reorganisation of NHS commissioning and accountability could fail to achieve its stated aims. Further, since the reorganisation has cost taxpayer money at a time of belt-tightening in the NHS, has led to some staff leaving rather than taking replacement jobs in the new organisations[81] and has required staff to spend time implementing the structural changes, it is feared that the net effect on the NHS and patient focus may be negative if the reforms do not yield the intended gains for patients. At present the public also seem sceptical – only 18% believe the reforms will improve the NHS in the end, according to a recent ITN poll.[82]

Target Culture

Under the previous Labour government, centrally-decided targets became a key mechanism of quality enforcement in the NHS. At the time of the 2010 election, The King's Fund listed 16 main areas Labour had introduced targets for, along with published analysis of how well the think-tank thought they had been attained[83]:

- Life expectancy ("progress")
- Health inequalities ("deterioration")
- Smoking ("met")
- Mortality rates from heart disease ("met")
- Inequalities gap in rates of death from heart disease ("progress")
- Mortality rates from cancer ("progress")
- Inequalities gap in rates of death from cancer ("met")
- Suicide ("progress")
- Four-hour wait in A&E ("met")

- Access to GP services ("progress")
- Under-18 conception rate ("limited progress")
- 18 weeks from referral to treatment ("met")
- Patient experience ("limited progress")
- Mental health services ("met")
- MRSA rates ("met")
- *Clostridium difficile* rates ("met")

Despite apparent progress by most of these measures in the targeted areas, the manner in which they were designed often led to side-effects in the form of a 'box-ticking culture' of sorts in which meeting the quantitative targets, intended to act as proxies for quality care, replaced actual patient care as a priority for staff.[84] This led to neglect, 'clock stopping' manipulations and falsifications of the kind seen at Mid Staffordshire, though such tactics did not occur only there. Recently, evidence came to light that government services contractor Serco had its operators manipulating the recording of 999 ambulance calls, again in order to 'stop the clock' and comply with targets about response times.[85] This provoked attacks from the trade union UNISON on private involvement in the NHS and demands for the scope of the Freedom of Information Act be extended to cover private contractors working in the NHS[86], but while it is certainly important that all providers be accountable and this measure should perhaps be considered, the actions of the Serco staff were also little different from those of the public sector NHS staff at Mid Staffordshire who similarly gamed results to ensure compliance, showing that targets can have this effect regardless of the type of organisation that they are imposed upon. Similar manipulations have occurred elsewhere in the public NHS, including in the devolved Scottish NHS – recently, NHS Tayside[87] and NHS Lothian[88] have both been hit by scandals after evidence came to light of waiting time figures being deliberately distorted. In his report, Robert Francis QC summarised the problematic attitude raised by these pressures as follows - "finances and targets were often given priority without considering the impact on the quality of care"[89]. This shows the limitations of using centrally-set quantitative measures to ensure patient care, an inherently sensitive, personal and highly qualitative area.

In his previous report, Francis also outlined the role that the National Institute for Clinical Excellence (NICE) should play in creating a better culture, stating that the body should provide "evidence based means of ensuring compliance" on measures such as staff numbers and skills in order to ensure "compliance with fundamental standards".[90] In the new report, Francis further recommended that the service do the following:[91]

- "Foster a common culture shared by all in the service of putting the patient first;"
- "Develop a set of fundamental standards, easily understood and accepted by patients, the public and healthcare staff, the breach of which should not be tolerated;"
- "Provide professionally endorsed and evidence-based means of compliance with these fundamental standards which can be understood and adopted by the staff who have to provide the service;"
- "Ensure that the relentless focus of the healthcare regulator is on policing compliance with these standards;"
- "Make all those who provide care for patients – individuals and organisations – properly accountable for what they do and to ensure that the public is protected from those not fit to provide such a service;"
- "Provide for a proper degree of accountability for senior managers and leaders to place all with responsibility for protecting the interests of patients on a level playing field;"

- "Enhance the recruitment, education, training and support of all the key contributors to the provision of healthcare, but in particular those in nursing and leadership positions, to integrate the essential shared values of the common culture into everything they do;"
- "Develop and share ever improving means of measuring and understanding the performance of individual professionals, teams, units and provider organisations for the patients, the public, and all other stakeholders in the system"

Politicians on both sides have already begun responding to the recommendations. Labour, who implemented the targets and were in power at the time the failings at Mid Staffordshire began, have acknowledged the issues with targets. Current Shadow Health Secretary Andy Burnham has said that "in places the response [to targets] was a tendency to focus on numbers, not people. Francis is right to say targets, properly constructed and implemented, have a place. But he is also right to warn of an over-reliance on targets. This is a lesson Labour is learning. If we don't, the NHS won't be able to rise to the complex challenge of caring for older people".[92]

Meanwhile, for some time the coalition government have had a concept of how they will go about replacing the New Labour-era targets with a more qualitative compliance model, first outlined by the Conservatives in opposition under the slogan "Outcomes Not Targets"[93] and then subsequently fleshed-out by former Health Secretary Andrew Lansley in government. This is centred on the drawing up of 60 new 'patient outcome measures', providing better information to patients via the NHS Choices website and gearing the service's ethos towards the 'friends and family test' mentioned previously.[94] Crucially, these measures are intended to function as benchmarks, rather than hard targets.[95] It has been claimed that if implemented, the measures could save 10,000 or 20,000 lives a year.[96] A full list of the NHS Outcomes Framework 2012/13 measures is available here.

Reactions to the new framework have been mixed, however. The figures on life saved have been questioned by fact-checkers.[97] GPs have criticised what they see as the imposition of a larger number of new 'targets' on an already-pressed service.[98] Further, while this approach will hopefully allow us to track outcomes without the resultant managerialism and perverse incentives associated with the previous target regime, in itself it of course carries the potential drawback of making accountability less clear.[99] In November 2012, new Health Secretary Jeremy Hunt redesigned Andrew Lansley's NHS Mandate, "[tearing] up plans to force the NHS to meet specific targets on increasing patient satisfaction, reducing premature deaths and improving the quality of life for those with long term health conditions… suggesting instead that the health service should show "measurable progress" in a whole range of areas."[100]

In any case, given the more qualitative approach to targets, accountability and compliance will now instead have to be achieved by simultaneous patient empowerment, which it has been made clear will require not just greater information availability but also genuine choice for patients. This requires us to examine the place of patient choice in the NHS at current.

Competition and Patient Choice

Patient empowerment and choice, coupled with commissioning and competition to create accountability and push up standards, have essentially defined the last twenty-five years of British health policy. In 2005, patients were given the right to choose between five hospitals, in 2007 the website NHS Choices was launched in order to provide patients with detailed information on different hospitals and from 2008 the choice was extended to all eligible English

NHS or independent providers ('free choice'), all of which were important steps.[101] However, continuing problems in Mid Staffordshire and elsewhere perhaps show that these reforms have not yet gone far enough, as patients are clearly not able to vote with their feet and speedily demand better care from an alternative provider. Expanded information, Ofsted-style ratings and detailed outcomes frameworks may help in this regard, but it is arguable that competition and provider diversity is also needed to complement it and ensure that patients do not simply have a choice between a list of standardised or underperforming hospitals.

According to data from the British Social Attitudes Survey 2007 (cited in a 2011 Department of Health publication), 96% of the public feel they should have choices over what kind of treatment they receive - 76% felt they should have "a great deal" or "quite a lot" of choice. Respondents also stated how much choice they felt they had in practice and from this, researchers writing in *The Lancet* calculated that 61% of the public felt they deserved more choice than they had at current.[102] In a 2009 survey by The King's Fund of 5,997 NHS patients, 49% reported being offered a choice of hospital and it was found that patients offered the choice were somewhat more likely to travel to a non-local hospital (29%) than those who were not (21%). 49% were given between two and five options and 2% were given more. Only 8% reported being given any private sector options, though based on their answers some patients being treated at Independent Sector Treatment Centres appeared to be unaware that they were privately run – this perhaps further makes clear that the lack of public preoccupation with who specifically runs their health services that the ICM/Civitas poll uncovered in March 2013. Only 4% had made use of the NHS Choices website, with past experience, advice from their GP and advice from loved ones tending to top it as sources of information.[103] Dr Foster, a leading provider of consumer information for healthcare, has published research showing that 97% of patients who had been offered a choice were glad they had been and also cited evidence suggesting that 65% of patients chose to be treated in alternate hospitals when offered and that 71% supported the NHS paying for treatment in private hospitals. In 2005, only 8% of people had been aware of the new government policy on hospital choice, though this may have risen since then.[104]

A 2011 study at the London School of Economics by health economist Dr Zack Cooper and three others found that when they used 30-day mortality rates for Acute Myocardial Infarction (AMI) as an indicator of service quality and compared areas of the NHS that had more competition with areas that had less, they found the following:

"after the introduction of [hospital choice] reforms in 2006, our marker for service quality (AMI mortality) improved more quickly for patients living in more competitive hospital markets. Compared to the mean, AMI mortality has fallen approximately 0.31 percentage points per year faster in places that were one standard deviation higher on our market structure index (on a base mortality of 13.82% during the 2002-2008 period. As a result we conclude that hospital competition within a market with fixed prices can improve patient outcomes"[105]

The Cooper study built on past studies in both the UK and the US which showed a correlation between fixed-price competition and improved clinical performance in hospitals, when the latter was measured by AMI (AMI was therefore used by Cooper as a measure in order to allow comparison with other studies). His evidence could appear to make the case for more uniform implementation of competition reforms in the NHS, as at current the variance in the extent to which competition is being allowed to drive up standards is creating an unjust 'postcode lottery' in the system. However, while his study did also show that competition between NHS providers unambiguously raised standards, Cooper also warned that stronger regulation of independent

providers will be needed if they are to become a greater part of the system in order to guard against "cherry-picking", as when the main competition to a local NHS hospital was an independent provider it tended to be younger and better-off citizens that received private treatment. Cooper also said it was important to ensure that NHS funding was structured in a manner that ensured that "it is not more profitable for [hospitals] to avoid treating certain potentially more costly patients."[106]

In a more recent piece for the Nuffield Trust, Cooper also pointed to a study that the Nuffield Trust commissioned with the Institute for Fiscal Studies, the findings of which "[buttressed] our earlier work on competition" in his view.[107] That study, 'Choosing the Place of Care', examined the role of patient choice and Independent Sector Treatment Centres (ISCTs) between 2003 and 2011. It found that though the numbers of elective operations not undertaken at the most local NHS trust had risen little, the usage of ISCTs by patients had increased year-on-year. By 2010/2011 there were 161 ISTCs and they were accounting for "3.5% of all outpatient attendances in the English NHS".[108] A study in the *British Medical Journal* by Martin Bardsley and Jennifer Dixon into quality of care at ISTCs found that "adjusting for health status and other factors on admission, the outcomes of patients treated in NHS providers were marginally worse", relieving earlier concerns that the use of the independent sector and competition in the form of the ISCTs would be bad for patient care.[109] Another study of outcomes of the use of ISTCs in the *British Medical Journal* in 2011 by Chard, Kuczawski and Black found that there was relatively little evidence of extensive "cherry picking" of healthier patients by ISTCs and that rates of complications and reoperation among patients treated in ISTCs were lower when compared to NHS providers – Chard *et al* overall concluded that their findings supported "the idea that separating elective surgical care from emergency services could improve the quality of care".[110]

Finally, another study in the UK by Bloom, Propper, Seiler & Reenen in 2010 at the Imperial College London Business School comparing health outcomes in politically marginal areas of the UK (which tend to have higher concentrations of hospitals, a negative side-effect of centralised political control) suggested both that "management quality was robustly associated with better hospital outcomes across mortality rates and other indicators of hospital performance" and that "more hospital competition appears to cause improved hospital management (and lower death rates)", again suggesting that competition between NHS hospitals at least tended to be correlated with improvements in management and clinical quality.[111] Professor John Van Reenen, one of the report authors and a former Health Department advisor and executive committee member of the Fabian Society, has argued that although he does not believe the GP commissioning element of the current NHS reforms will work, there is a "growing evidence base" supporting the use of competition in the NHS and that undermining competition "would ignore evidence and leave us with the elements of [the Health and Social Care Act 2012] least likely to succeed".[112]

Furthermore, it is also worth remembering that the NHS is not a politically unified national service – it has devolved Welsh and Scottish branches, in addition to the Health and Social Care in Northern Ireland (HSC) service – and the 2000s-era NHS reforms instituted by the Blair government in Westminster only affected the NHS in England. It has therefore been possible to observe relative outcomes in the four different services and perhaps relate them to systematic differences. The National Audit Office (NAO) has provided helpful data on how the four UK nations are performing:[113]

	England	Scotland	Wales	Northern Ireland
Life Expectancy at birth, men (2008-2010)	78.6	75.9	77.6	77.1
Life Expectancy at birth, women (2008-2010)	82.6	80.4	81.8	81.5
Spending per person on health services, 2010-2011, £	1900	2072	2017	2106
Number of GPs (headcount) per 100,000 people, 2009	70	80	65	65
Day cases as percentage of all hospital admissions, 2008-2009	41.0	36.4	36.8	41.8
Average hospital length of stay (acute beds only), 2008-2009, days	4.3	5.7	6.3	5.5
Standardised Mortality Ratios (accounting for age & gender differences)	98	117	103	107

Figure 7: selected measurements of healthcare performance in the four UK nations (Source: National Audit Office, 'Healthcare across the UK: A comparison of the NHS in England, Scotland, Wales and Northern Ireland', 2012)

From the above table, it would therefore appear that patients in England are healthiest, despite receiving less spending per capita, having slightly fewer GPs than Scotland (access to GPs has been associated with good population health) and not being entitled to some service elements specific to the Welsh, Scottish and Northern Irish services, such as free prescriptions.[114] Professor Nicholas Mays of the London School of Hygiene & Tropical Medicine also noted that in the English NHS, length of stay and hospital mortality have both fallen faster over time than in Scotland and that when Foundation Trusts in England (which do not exist in Scotland) were compared to the Scottish NHS, this distinction was slightly stronger still.[115] These differences are of course not purely related to the design of the health system – it is well known that socio-economic, environmental and public health differences between England and the rest of the UK create deep pre-existing health inequalities (this should also be borne in mind when the UK and other nations are compared internationally). However, health system design and relative patient empowerment are by no means irrelevant either.

Competition and choice reforms have also been a trend in similar foreign health systems, such as those in nearby Scandinavia. In Denmark from 1993, patients earned the right to choose to be treated at another state hospital, even across local county lines, creating competition for elective patients.[116] Similar policies were also implemented in Norway and Sweden, though studies have suggested that as in the UK, information asymmetries make it difficult for patients to exercise these rights fully as of yet.[117] In Sweden, a few former public hospitals are now run by private health firms under the auspices of the taxpayer-funded Swedish health system, similar to the role the Circle Health Partnership is now playing in Hinchingbrooke Health Care NHS Trust[118], and managers in private sector-run Swedish hospitals claim to have reduced waiting times and increased hospital capacity through efficiency gains.[119] A 2004 book assessing the impact of market reforms in Sweden, while noting that other factors had certainly been at play and that marketization had had some negative side-effects, found that "the market programs contributed to a shift in outlook and behaviour among hospital managers and professionals, whose efforts were critical to sustaining improvements in efficiency and effectiveness. Increasingly, hospital providers recognised the necessity of cost containment and the importance of attracting and satisfying patients."[120] Independent sector providers also play a large role in health provision in

much of the rest of the continent. According to the international Independent Hospital Federation (IHF), the independent sector accounts for 60% of hospital beds in Luxembourg[121], 64% in Belgium[122] and 42% in Austria[123] (it also accounts for 32% of beds in Australia).[124] The IHF also states that 138 hospitals in the Netherlands are run by non-profit private entities, while the public sector only runs 8[125]. In Israel, the government reportedly runs 11 hospitals with 6,774 beds, while the non-profit sector runs 24 hospitals (7,319 beds) and the for-profit sector runs 11 (489 beds).[126] In Germany, 30.5% of hospitals are public sector, 36.6% are non-profit and 32.9% and are for-profit private, although in terms of bed numbers this breaks down as 223,385 public beds (48.3%), 164,337 non-profit beds (35.6%) and only 74,735 for-profit beds (16.1%).[127]

Therefore, current available evidence on the impact of public-private cooperation, competition and increased patient choice would suggest that a fairly compelling case can be made for the continued use of competition to drive up standards. In light of Dr Zack Cooper's caveats about some of the mixed impacts of increased independent provision in the NHS and in particular the risk of 'cherry-picking', it is of course important that payment structures are organised in a way that does not incentivise such behaviour and Monitor takes its regulatory role seriously[128], but there is also potentially a partial justification for some "cherry-picking", in the sense that allowing independent sector providers to handle more of the routine elective procedures could free the NHS of these procedures, preventing the cancelled operations and inconvenience for elective patients that sometimes results from the clash between the emergency and elective workloads faced by NHS surgeons[129]. Overall, current evidence suggests that competition can be a net positive for NHS patients if it is organised properly.

Integration

The NHS and social care in the UK are not currently set up in a way that is conducive to good patient care, as the system remains fragmented and provision for social and community care is inadequate. This has meant that despite repeatedly restated aims to restructure health and social care in order to make them more seamless, elderly and chronically-ill patients who would be better treated in the community remain in overwhelmed NHS hospitals, a situation that is good neither for them nor the health service. Over 65s account for 60% of NHS admissions, 70% of bed days, 65% of emergency readmissions and 75% of hospital deaths. Over 85s account for 25% of bed days.[130] The strain placed on the acute system by the inadequacy of outside arrangements is thought to be a key reason why NHS hospitals were recently reported to be over their safe 85% capacity level and Dr Foster has estimated that 29% of NHS inpatients should be treated elsewhere.[131] Some observers, including dementia campaigners, have related the lack of integration and resultant lack of focus on elder care to the problems at Mid Staffordshire and other hospital trusts.[132] Norman Lamb MP, the Minister for Care and Support, has rejected the notion that competition reforms will be the cause of the fragmentation in services, arguing that:

> *"We have got completely fragmented care already. It's institutionally fragmented between health and social care, mental and -physical health, and -primary and secondary care. It's a remarkably irrational system."*[133]

Both Health Secretary Jeremy Hunt and Shadow Secretary Andy Burnham have stressed seamless integrated care as a priority. Coalition efforts in this direction have included the creation of CCGs and Health and Wellbeing Boards under the current reforms, a commitment to a version of the Dilnot cap on individual social care costs (to be set at £72,000) and the

establishment of a £50m fund to encourage the creation of "dementia friendly environments" in which NHS trusts, local authorities and social care providers collaborate to provide better care for dementia sufferers.[134] A more specific aim for full integration by 2018, starting with the formation of several "pioneer" areas by September 2013 and the introduction of new indicators of patient experience to measure whether integration was being felt, was announced on the 14th of May 2013 by Norman Lamb.[135] Responses from key stakeholders, including community care organisation Think Local Act Personal, the Association of Directors of Adult Social Services, the Patients Association and the Local Government Association, were generally positive, although the government will have to learn from difficulties with past integration pilots.[136] In the 2013 Comprehensive Spending Review, a fund of £3.8 billion intended to begin the integration process and help move older people "trapped" in hospital care into social care was announced.[137] Current Labour policy ("Whole-Person Care") is exploring bringing about integration by merging the NHS and council social care budgets, putting the majority of this unified budget under the control of the new Health and Wellbeing Boards, moving CCGs into a more "advisory" role and using a national social insurance system to pay for social care – a private commission led by GP and system change expert Sir John Oldham has been established towards this goal.[138] [139]

Several case studies of more fully integrated health and social care systems are already available, both within the UK and abroad:

- **Health and Social Care in Northern Ireland (HSC):** Northern Ireland's non-NHS healthcare service has been structurally integrated since 1972, with five integrated trusts providing comprehensive care (acute, primary, mental and adult social care, but not education or housing) from a single funding system and in pursuit of unified aims. Health teams are integrated and multi-disciplinary. There is a unified commissioning body, the Health and Social Care Board. As with the English NHS, the system is sometimes criticised as being too health-centric, with more weighting towards the social care side needed in some respects, but overall it is thought to provide care that is comparatively less episodic than treatment on the UK mainland. This is thought to lead to a more seamless, patient-centred experience and perhaps fewer waits[140]
- **Torbay Care Trust:** Collaboration between the local NHS trust and the local council in Torbay has been widely noted as a case study of how we can reach a more integrated NHS. The large retiree population locally (23% of Torbay residents are over 65) and failures in local adult social care were key drivers of the decision to integrate services in 2005 and it is believed that care standards and satisfaction have risen since integration.[141] Several favourable studies have been published on Torbay. A report by The King's Fund however stressed that "There is no textbook to guide the process because local context (especially the interplay of people, relationships and processes) is a key variable". Joint governance, engagement and mutual agreement on expectations and aims for patients were seen as key determinants of success[142]
- **Veterans Health Administration (VHA), US:** the VHA, perhaps the part of the America's healthcare infrastructure that is most comparable to the UK NHS, offers another respected example of decentralised integration. In the 1990s, a round of reforms focusing on integration and increased managerial accountability transformed a once-failing public service into one with satisfaction ratings of over 80%.[143] A previously complex bureaucratic structure in which there were 4 regions, 33 networks and 159 independent centres was condensed into 21 joined-up integrated networks tasked with "budgeting and planning health-care delivery for veterans over a particular area" and

moving the system from hospital dominance and toward primary care. The publication of information on quality and performance incentives, including financial rewards and the granting of additional powers to high-performing hospitals, were used to hold managers accountable.[144] A world-class electronic records system was implemented, making health records instantly available to staff.[145] Moreover, the VHA manages to achieve high standards despite its average patient being older, poorer and sicker than the US population as a whole

- **Regionale HuisartsenZorg Huevelland (RHZ)[146], Maastricht, the Netherlands:** the Nuffield Trust cited RHZ in a study of organisations "relatively young in their development of integrated care".[147] Established in 2006, the RHZ unifies 89 GPs and covers a population of 170,000, organising care for people with diabetes and some other long-term chronic conditions. Payment is integrated, a move encouraged by Dutch national government policy. RHZ negotiates contracts with private insurers (who handle financing of care in the Dutch public healthcare system) and they pay a pre-paid sum attuned to the severity of the case. As a result, primary care GPs in Maastricht are more heavily involved in the management of diabetes care than in other areas, with reliance on hospitals somewhat reduced. Interestingly, the Nuffield Trust noted that one of seven features they described as an "enabler of integration" was a "planned increase in provider competition by developing a competitive market in diabetes care, which is stimulating GPs to act together to improve care", demonstrating how under the right circumstances competition can not only be compatible with integration but can actually help drive it. Nuffield did however caution in their analysis that one of the challenges facing the RHZ was fragmentation with regard to certain incentives and difficulties with the treatment of people with multiple, complex conditions[148]
- **Kaiser Permanente (KP), US:** Kaiser Permanente is a non-profit private integrated managed care organisation founded in 1945. Based in California, it has 8.9 million members and operates in nine US states. It is often cited as a model for the NHS to follow as a successful example of a "mature" integrated care provider.[149][150] KP's Colorado arm has been used as a case study by Southport and Ormskirk Hospital NHS Trust for how to integrate effectively with the community sector.[151] Like the Dutch RHZ, KP also offers an example of an integrated care network that has been improved, rather than undermined, by competition, again showing that under certain circumstances the two aims are compatible. A 2002 study in the British Medical Journal argued that KP performed better than the NHS on certain measures despite somewhat similar per capita costs, concluding that in addition to better integration and use of information technology, the presence of competition and consumer choice may have been a driver of KP's relative cost-effectiveness[152] (although the population profiles and nature of coverage in the two systems are still different)[153]

Therefore, given the current fragmentation in health and social care services in the mainland UK and the turnarounds of failing services that integration has at times enabled, such as in the US with VHA and in Torbay within the NHS, it appears that there is a case for further integration in the NHS. However, examples such as RHZ and Kaiser Permanente are of particular interest in light of the current debate over NHS reform, as there is sometimes a tendency to speak of competition and integration as mutually exclusive or inherently contradictory policy options (for example, a recent British Medical Association press release called for "further explanation on whether commissioners would be able to prioritise integration over competition and choice without leaving themselves open to a challenge from Monitor").[154] The RHZ provides a particularly interesting example in this regard, as while Kaiser Permanente is a long-standing

institution and no comparable equivalent exists to it in the UK independent health sector at current, RHZ is an example of a recently-formed and fledgling integrated care organisation operating under conditions of competition in a European health system.

This is not to say that competition and integration are compatible in every instance or that the specific government plans to combine the two are necessarily adequately structured at current. For example, a 2011 report by Loraine Hawkins at The King's Fund noted that although the competition law parts of the Health and Social Care Act 2012 are unlikely to be problematic in themselves, the sections that "that regulate how commissioners purchase and pay for services" could be, especially since they leave "considerable latitude" for a wide range of different actors to interpret them in different ways over time, which Hawkins noted "will not be conducive to [either] competition or integration of service delivery".[155] Similarly, the Chief Executive of The King's Fund Chris Ham has said that while the coalition's 'any willing provider' pro-competition rule could have positive effects on patient care and cost-efficiency in planned and elective care and there is "no inherent contradiction between competition and integration" (the latter of which he has stressed as a major priority), in unplanned care the introduction of more providers could lead to fragmentation if the rule is not implemented in the right way.[156] However, this presents a case for more nuanced examination of how these two stated goals can be best put together, rather than an 'either/or' approach.

System Model

Ultimately, another factor we must consider is the overall design of our health system. Data from the OECD, *The Lancet* and the Euro Health Consumer Index (see 'Empirical Performance: National Comparisons' above) makes clear that on a variety of measures, the UK is outperformed by two broad groups of nations; countries that have developed more decentralised variants of our tax-financed (TF) Beveridgean model (including the Scandinavian nations, Canada, Australia, Italy and Spain) and countries that employ Bismarckian Social Health Insurance (SHI) systems (including the Netherlands, Germany, France, Switzerland, much of continental Europe, Japan and Israel).[157] These models differ substantially, with the former model retaining substantial similarities to the UK NHS model in terms of the fact that insurance (and depending on the nation, provision) remain firmly public sector, but both find ways to put users more in control of the health services they receive and the money that is spent on them. Some commentators have tied the differences between our model of healthcare and others to the Mid Staffordshire scandal. For example, following the publication of the Francis Report, former NHS nurse and Labour Party general secretary Peter Watt wrote the following:

"We say things like "the NHS is the envy of the world." And seem to actually believe it! The truth is that virtually no other country has copied it as a model. What is true is that [while] many countries rightly envy the fact that we have universal free health care, they don't though envy the way that we have chosen to deliver it…Shouldn't we be demanding the full integration of health and social care provision and an NHS that is more local and locally managed? Are we really saying that the very best way of delivering health to 60,000,000 people is a service directed from Whitehall?"[158]

It could be said that the decentralisation option is attractive for the UK in the sense that while the devolution of responsibility for the financing and provision of healthcare from Whitehall to local government level would represent a radical break from decades of UK health policy, relatively speaking it would be an incremental step within the existing institutional structure of

our system. In Scandinavia, where health systems are premised on the same social democratic ethos as our own, this structure has meant that healthcare can be directly voted on – in Sweden, for example, health constitutes 90% of the activity and spending commitments for many of the local councils, meaning that health is a key issue in the local elections every few years.[159] If taxation powers were also to be devolved, it would mean that people's individual contribution to the health system would be somewhat more hypothecated and would directly fund services in their local area[160] – in Sweden, approximately 70% of health financing comes from local taxes, with the remainder coming from central block grants.[161] It has been contended that keeping funding and ownership closer to the people in this way may make them more willing to pay more for services, making it easier to fund them adequately, while the secondary block grants can still be used to ensure a degree of central redistribution from the richest areas of the nation to the poorest.[162] BBC health correspondent Nick Triggle noted that a representative of the Swedish Association of Local Authorities, Roger Molin, argued that this system means that council-run Swedish health services are "more responsive to patients' needs than a more centrally-controlled system such as the NHS".[163]

Further, there is an existing base in the UK for considering local control in health. Municipal control of government hospital services was the norm prior to the founding of the NHS and during the post-1945 Labour government, local councils and Deputy Prime Minister Herbert Morrison originally fought to amend the specific element of the National Health Service Act 1946 that sought to place council-run hospitals under direct Whitehall control.[164] Recently, a Labour-affiliated health association published an article stating that "Public and patient engagement in the NHS has been weak ever since Bevan's centralised model trumped Morrison's municipalism", suggesting either the Morrison model of council control, an elected element within CCGs or the adoption of a strengthened version of the foundation trust model by CCGs as ways in which the NHS could be genuinely democratised. A commitment to an NHS in which the scope of the central Department of Health is reduced and powers are devolved to elected local boards of some description has also been a feature in the health policies of both the Liberal Democrats[165][166] and UKIP[167], and the two main parties would be well-advised to give similar policies some consideration. Senior Conservatives have praised the concept of strengthened localism in the NHS and the current coalition reforms are in part intended to bring about this aim[168] and Labour have begun to acknowledge previous failures to place adequate trust in local government.[169] However, while they would strengthen local governance, most of these existing proposals would not appear to move control of taxation specifically to the local level. Also, although health continues to be a high priority issue for voters according to opinion polls[170], it should perhaps be cautioned that if local elected health boards or direct council control were to be implemented, lessons would have to be learnt from the low-turnout 2012 Police and Crime Commissioner elections about how to ensure that voters are adequately aware of the new elections and of the issues being discussed.[171] It should also be noted that the best tax-financed systems, such as those in Scandinavia, are premised upon public support for high general tax rates (and are supplemented by oil funds, in the case of Norway). Moreover, although there is generally little on which to tell the decentralised TF and SHI nations apart in terms of empirical indicators of health system performance, according to the OECD's 2011 study of waiting times, Norway, Sweden, Australia and Canada had higher elective surgery waiting times than Germany, Switzerland, France and the Netherlands.[172]

The other class of high-performing health systems, the Social Health Insurance (SHI) systems, would involve a much larger systemic shift away from our current healthcare model. However, if a transition route could be found and a uniquely British version of the model could be forged,

such a switch could perhaps pay dividends. Norwich Union Healthcare (now part of Aviva)[173], the Civitas Health Consensus Group[174][175] and David Laws's chapter in *The Orange Book*, '*UK Health Services: A Liberal Agenda for Reform*'[176], all made suggestions in this direction. More recently, Conservative MPs John Glen and Jeremy Lefroy suggested in a ConservativeHome post that the NHS could be funded mainly from "ring-fenced [National Insurance] contributions" and secondarily from general revenue, in order to re-establish a contributory social insurance principle in the health service[177], which could be a first step towards a full SHI system. In a similar vein, Labour MP Frank Field argued the following in the *New Statesman* in November 2012: "Let's openly finance the NHS from a new insurance fund with a proper contribution from general taxation to cover those who do not or cannot pay National Insurance. The switch must be matched by cuts in that part of direct taxation that covers current NHS expenditure. Once the switch is made, we will see that our ceaseless demands for a better NHS come at a price that would have to be met from the new NHS insurance fund."[178] This would re-establish the contributory principle in British healthcare, as is already being discussed by politicians with regard to other parts of the welfare state[179], and would help clarify our debates over healthcare funding by making the funding mechanism for the NHS more transparent.

In full SHI systems, citizens are required by law to register with one of a number of tightly-regulated non-profit social insurance funds (sickness funds), which are funded via payroll taxes or a system of premiums levied proportional to income to ensure progressivity (this replaces the 'single-payer' tax-financed approach seen in Beveridgean nations, in which a single government fund effectively acts as the sole insurer for everyone).[180] Sickness funds compete to provide a government-mandated treatment package that all citizens are entitled to and are usually bound by law to accept all applicants without discrimination and cannot make sicker enrolees pay more or seek to avoid paying their costs. Citizens often have the right to choose between funds and can switch every year. It is these sickness funds that purchase care on behalf of their members from healthcare providers, which in turn may also be under public, non-profit or for-profit ownership (see 'Competition and Patient Choice' section above).[181] If people are not in work or are low-income, the universal right to care is still maintained by law and specific provision may exist for people with chronic conditions – additional financing from general tax, secondary to the hypothecated social insurance contributions that fund the bulk of the system, is used to ensure this. In much of Europe and in Israel, statutory sickness funds often have civil society roots, having been founded by mutual societies, trade unions, charities, regional government, employer or professional groups, political organisations or religious groups.[182] In essence, these systems situate competing non-state social organisations within the framework of a universal public system, accessible to all, and are often able to harness the diversity of markets and civil society and marry this with the aim of social solidarity, thus creating a social market in healthcare.[183] The strength of SHI systems is therefore their ability to guarantee care to all (including the unemployed, low-paid and chronically ill) while allowing service users to direct their own contributions, choose their own insurers and service providers and demand value for money and high standards from their healthcare system, something which more monopolistic systems may not always allow them to do as effectively.

Conclusion

Overall, the severity of the Mid Staffordshire scandal and the revelation that numerous other trusts are under investigation for similar problems presents a huge challenge for the NHS. Moreover, these events occur against a broader backdrop in which we can see that the NHS, while often able to perform well in some 'front-facing' aspects of patient care and to maintain

decent satisfaction ratings as a result, is not doing as well on actual clinical outcomes as other comparable nations.[184] This means we must be looking seriously at options for reform.

Proposals for a strengthened inspectorate and measures to lift staff standards and engender a sense of managerial accountability should certainly be implemented, but the NHS can be difficult to change and similar measures in the past have failed to lift standards. The fact that almost three-quarters of hospital chief executives are reported to be doubtful that reforms to the NHS inspectorate will yield much impact, for example, is not an encouraging sign.[185] Meanwhile, though the current government's GP commissioning reforms could be effective, this will be only be the case if there is sufficient engagement on the part of GPs, something which past and present evidence creates substantial cause for scepticism about at the current time.

Given the past problems with centrally-set quantitative targets, a new approach to targets and a perhaps less direct system of qualitative benchmarks is certainly worthy of consideration. However, while such a system could inform the government and patients alike of how individual NHS hospitals are performing if designed correctly, it will nevertheless need to be buttressed by a replacement accountability mechanism. This is where competition and strengthened patient choice could come in - the information from the new benchmarking regime could be used by patients to assist their consumer decisions within the system. Despite frequent attacks on competition and the role of independent provision in the NHS, a fairly convincing evidence base is already making clear the generally positive role that competition can play in the NHS and similar health services under right circumstances. There also appears to be public support for this kind of diversity. However, going forward it will be important to structure NHS competition regulations in a manner that will avoid any negative side-effects, maximise benefits for patients and ensure that competition complements rather than contradicts the aim of greater integration of health and social care services, as this too should remain a high-priority goal for the health service as it seeks to better face the care challenges of today.

Finally, events at Mid Staffordshire and the NHS's clinical performance relative to other systems in international rankings raise questions about the current design of our healthcare system and whether it is still the best model to use if our intention is to empower patients, strengthen accountability and push up standards while providing healthcare on a universally accessible basis. Given the plethora of other universal models that exist, some of which are currently attaining better clinical outcomes and appear somewhat more patient-centric by design, thorough examination of local government control, social health insurance systems and other models would appear recommendable.

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