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If you would like more information about the Observatory please contact: European Observatory on Health Care Systems, WHO Regional Office for Europe, 8 Scherfigsvej, DK-2100 Copenhagen Ø Denmark.

Telephone: +45 39 17 14 30
Fax: +45 39 17 18 18
E-mail: observatory@who.dk
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Extra money for the United Kingdom National Health Service

Walter Holland

The promise of a plan for investment in the UK NHS and the intention that expenditure until 2004 will grow "by 6.1% per year over and above inflation, by far the largest sustained increase in NHS funding of any period in the 50 year history of the Health Service" (Chancellor's budget speech 21 March 2000) is wonderful, and should be welcomed by all. This has been followed up by the *NHS Plan*, published in July 2000, on what the government intends to do. Its publication sets out the government's intentions for improvements in the NHS, in which perhaps the most important assertion was that "the NHS will provide a universal service for all based on clinical need, not ability to pay", i.e. a continuation of the basic principles which governed the foundation of the NHS in 1948.

In a short review of the government's plans it is impossible to make more than a few comments. In addition, the various pronouncements of the government are somewhat vague, thereby making it difficult to comment in any detail. For example, the statement that there will be an additional 2 100 beds in general and acute wards is welcome, especially given the continuous inexorable decline in the past 15–20 years. However, it should be noted that there are about 200 acute hospitals in England, so this means that there will only be about 10 "new" beds in each hospital by 2004, while about 10 000 beds have been closed each year between 1984 and 1994. Also, the problem about such political statements is the consequent rise in public expectations. For those working in the NHS, the expression of commitment and concern is a boost to morale after the experience of a continual reduction in resources over the past 20 years. The danger, however, for both the public and the NHS is the inability to meet the necessary and desirable changes rapidly. After a long period of reduction in staff, new methods of organisation and management were simultaneously introduced, which increased bureaucracy and demands, e.g. through "patient charters", without a concomitant resource addition. Nevertheless, it is worthwhile considering some of the constraints which are bound to influence the desired expansion and the proposed improvements of services.

Almost all the plans published to date concern the provision of clinical care services. Although both patients and staff desire an improvement in prevention, it is unfortunate that the main emphasis in the *NHS Plan* under this heading is on the extension of routine screening, the identification of high risk groups, the assessment of new medicines and the provision of occupational health services to industry. This sounds seductive until one considers what is meant. The NHS already has a body responsible for promoting effective screening services. Screening is a complex problem, and may do as much harm as good. For such services to be effective, a variety of organisational matters, as well as the tests themselves, have to be considered; merely identifying abnormalities is insufficient. Similarly, the identification of high-risk groups is unlikely to have much effect on population health. The modification of population risk is needed. The provision of health services to employers is praiseworthy, but the NHS has

little expertise in this field, and is grossly deficient in providing such a service to its own staff. It has been calculated that to provide such services to the NHS alone requires about 200 additional occupational health physicians. It is difficult to see how the assessment of new medicines can improve prevention – and the use of medicines to improve lifestyles, as suggested, is unlikely to meet with the approval of those concerned with health promotion.

In primary care the major development envisaged is in the provision of 'NHS Direct' a nurse-led telephone help-line. This is already available in some areas, but the evaluation of the current model does not suggest that expansion will enable a more cost-effective service to be provided. Well-tried general practitioner services would, if adequately funded, be able to provide the necessary services in a similar manner to NHS Direct.

The intention to provide an electronic medical record is very desirable if the envisaged continuity of care is to be delivered. But this has been promised, in one form or another, since about 1970. A prerequisite to such a system is a method of identifying each individual in the population, so that records can be linked. This exists in Oxford (since 1968) and in Scotland. Some of us are in despair as to why it cannot be used universally. Recent General Medical Council and European Union (EU) regulations and pronouncements on "patient-record-confidentiality" would, if implemented, make such a system virtually impossible to introduce – at least not without enormous effort. The proposals of the former are likely to prevent accurate assessments to be made of treatments for such diseases as cancer, and could threaten the future of public health research.

It is fascinating how every government considers that improvements in quantity and quality of primary health care health services will reduce demand on hospital services. Aneurin Bevan, in 1948, was the first to promise this; most recently it was suggested by the Thomlinson Enquiry under the last government, which recommended the reduction in hospital beds in London of the order of about 3 000. Yet, no evidence for this has ever been produced, in fact the opposite has always been found. Reductions in need for in-patient facilities have come about because of changes in practice, changes in technology, and changes in the incidence and pattern of individual diseases due to environmental, social and other non-medical factors.

The *NHS Plan* proposes the expansion of intermediate care services, though it is not clear what is meant by this. But it should be noted that community hospitals have been with us since the inception of the NHS in 1948. Many of the services likely to be provided in intermediate care are those originally provided in such institutions. Between 1980 and 1990 alone there was a reduction from about 600 such institutions to 400.

These are only a few remarks about some of the proposed growth areas which are intended to highlight the scale of the problems which need to be tackled.

Turning to the NHS itself, it is a labour-intensive service with between 70% and 80% of its costs for the payment of staff. If services are to be improved then there is an obvious need to increase the number of nurses, doctors and other staff. The *NHS Plan* does take this into account and promises 7 500 more consultants, 2 000 more general practitioners, 20 000 more nurses and 6 500 more therapists and other health professionals. It is in this aspect that the lack of detail is most worrying.

The time between commencement of medical education and exit as a fully-qualified general practitioner or consultant is at least 10 years, and for some areas of practice 15 years. Even for nurses a minimum of 3–4 years elapses between entry to training and qualification. It should thus be obvious that the target for the expansion of staff is likely to be a very difficult one to attain. The suggestion that more health care personnel should be recruited from overseas is likely to meet opposition from developing countries, from where most such staff are likely to come. It is also of doubtful ethical propriety and may engender even more dissatisfaction with the NHS services provided, unless the immigrant staff are trained to deliver services of an equal level of proficiency as those trained locally. The Plan does envisage increasing the number of training places and medical and nursing schools, but clearly it will take some time for the effect to become evident.

It is surprising that other solutions for the personnel requirements have not been addressed more imaginatively and fully. For example, the United Kingdom loses about 25% of its 4 000–5 000 medical graduates from the NHS within the first five years of qualification. An increasing proportion of nursing staff leave the service shortly after qualification. If conditions of work, pay scales and the introduction of more flexible employment conditions were addressed more seriously, it might be possible to meet the government's targets from "local" resources. But this requires major changes in the attitudes of staff, professional groups as well as managers and government to meet some of the well-known concerns and aspirations of those who currently work in the NHS. It is suggested that better and more incentives are needed, including financial ones. There is no doubt about this, but perhaps the most important incentive for NHS staff is that others appreciate their work, value it and consider it important. Many changes in organisation and practice are desirable and needed, but they will take time to implement and the continuous clamour of concern with the unacceptable poor performance of a few staff – without concomitant praise for the activities of most – is unlikely to help in introducing the needed changes.

It may thus be seen that the proposed reversal of the decline of the NHS is very welcome and to be desired. But there are dangers that the promises cannot be fulfilled within a short time-scale. The Prime Minister recognises that the changes will take a long time to be enacted, it is to be hoped that others will too!

Nonetheless, there are also important gaps. For example, cancer, coronary heart disease and mental health are identified as priorities for action. But this could mean that the services for conditions that are the major sources of

disability and diminution of quality of life, e.g. stroke, arthritis, asthma, rather than the former that cause premature mortality, will be neglected. In addition, major concentration in these areas may identify large gaps in current need which could, in the short-term at least, make things worse.

Of equal concern is the apparent neglect in the proposals of research that needs to be done to improve the prevention, care and cure of common conditions in the future. The only mention of increase in research resources is for trials of cancer treatment. Further promises are included to improve the quality of services, but there is no statement that the necessary funds for the development of methods of audit will be provided in order to assure this.

To conclude on an optimistic note, it is however worth considering what can easily be achieved with the extra money in the short-term. Health authorities and Trusts will be able to pay their bills promptly and repay the debts many have accrued. A freeze on the new appointment of staff to vacancies – a common situation in the last 20 years – is unlikely. Authorities are far more likely to be able to fund the purchase of expensive, effective drugs, for example those used in the treatment of cancer or mental illness, ending the 'post-code' lottery of uneven policies.

Funds will be available to purchase new items and replace out-dated equipment. It should be possible to increase inadequate pay scales for all types of health service staff, perhaps improving the attractiveness of the NHS as an employer, and retaining current staff to reverse the current trend of premature retirement. It should be possible to improve the quantity and quality of food consumed in the NHS, even though more radical measures are needed to change the nutritional status of the patients often due to inadequate nursing.

These are only some of the features which can be implemented quickly. Building new premises, training new staff and above all changing attitudes, is likely to take longer. It is a pity that politics works to short time-scales and expects fast results. It is equally unfortunate that it is considered necessary to give concrete promises – for if they are not kept, will lead to further disillusionment. One hopes that the change in policy to expand the NHS and correct its deficiencies will serve as an inducement to change morale, as well as to provide a better service. It is unfortunate that so few realise how much damage has been done to the NHS by twenty years of cut-backs and "efficiency-savings". It is even worse that our civil servants and leaders of the health professions have not been able to prepare realistic plans for expansion which could have been "taken off the shelf", but instead have had to put forward a series of measures in a great hurry – some of doubtful effectiveness or unrealistic aspirations.

Finally, there is also a major danger: satisfaction with NHS services has been diminishing, stimulated by the media. New promises for improving investment and services have been made continuously in the past three years, but only since March 2000 has there been a concrete commitment for increased investment. As I have tried to show, improvements will take time to be evident. There is little appreciation of the damage that has been done to the NHS in the last twenty years and the time required to correct this. Unless the population is willing to accept that change can only come about slowly and gradually, the disillusion with the NHS may become even worse.

Walter Holland is Chairman of the European Health Policy Research Network and Emeritus Professor of Public Health Medicine at LSE Health & Social Care.

Kyrgyzstan: 'trialling' reforms

Judith Healy

Kyrgyzstan gained its independence from the former USSR in August 1991. Its 4.6 million population lives mainly in the fertile highland valleys and in the capital, Bishkek. The President, Askar Akaev (first elected in October 1990), was re-elected in 2000 for another five-year term. In its first years of independence Kyrgyzstan began to dismantle its Soviet structures, laid the foundation for a civil society, and began to shift towards a market economy. The country is largely dependent on agriculture, but hopes to develop its mineral and hydroelectric resources. The economy suffered badly after the collapse of the Soviet Union and growth only resumed in the late 1990s. Poverty has increased alarmingly over the last decade, with more than half the population now living below the poverty line. Against these severe social and economic crises, Kyrgyzstan is looking for ways to stabilise and reform its health care system. The Ministry of Health embarked upon plans for reform from the mid-1990s with assistance from the World Health Organization (WHO) and other international organisations. The government has wisely chosen to pilot most changes before rolling them out to the rest of the country.

Kyrgyzstan has an extensive health care system but no longer has the money to run it. The share of health care expenditure is around 3% of GDP and real per capita health expenditure has continued to drop; for example, from US$ 13.1 in 1995 to US$ 12.4 in 1998. In an effort to supplement the state health budget, the government introduced compulsory health insurance in 1997. Based on payroll tax plus state transfers for children and pensioners, it currently provides nearly 5% of the state health budget. Given very limited public revenue, the health system increasingly depends upon out-of-pocket payments by patients, amounting to perhaps half of total health

care expenditure and thus causing further inequities and poverty.

The health care system remains state-owned and administered. The Ministry of Health is developing its national policy-making role and also administers republic level institutes and hospitals. Meanwhile oblast (regional) and city administrations run most other health services. Ways are being sought to reduce duplication, offer fiscal incentives to improve cost-efficiency, and allow more flexibility in reorganising services. In some oblasts, several hospitals (general and specialist) are being merged under one management and budget. The oblast level Health Insurance Fund will soon become a 'single payer', disbursing pooled budget and insurance health care funds. Also, separate specialist clinics in urban areas are being merged into integrated polyclinics.

Primary health care is being reorganised and the staff gradually retrained. From an initial pilot, the family group practice model is spreading throughout the country. The three basic types of physicians (therapeutists, paediatricians and obstetricians) are being retrained and encouraged to work more cooperatively. Primary care providers in some pilot projects are to be partially funded through patient capitation payments.

Hospital expenditure has remained high, accounting for nearly 70% of the health budget, despite attempts to reduce excess hospital capacity. (There were 8.3 beds per 1 000 population in 1997). Although over one-quarter of hospital beds were closed between 1990 and 1996, the number of hospitals increased so that few detectable savings were made in fixed costs.

A broader view of population health, signalled in the 'Healthy Nation' national programme, aims to improve health status in several priority areas. Another challenge will be to coordinate the efforts of clinical medical services with the Sanitary Epidemiological Service (SES). The latter has traditionally concentrated on controlling infectious disease and monitoring environmental health; both of which remain considerable problems.

Kyrgyzstan has substantial natural and human resources, including strong cultural traditions, and remains optimistic about its capacity to reform its extensive health care system in line with the needs of its population and the constraints of its revenue base.

T*he HiT on Kyrgyzstan was written by A. Sargaldakova (Ministry of Health, Kyrgyzstan), J. Healy (EOHCS), J. Kutzin (WHO/Euro) and G. Gedik (WHO/Euro) and is available via the Observatory's website: www.observatory.dk.*

Health care in Austria:

System fragmentation inhibits cost containment and reform

Stefan Meusburger

According to the World Health Report 2000, the Austrian health care system is performing well. It ranks ninth for "overall performance of health care system" out of the 187 WHO member states surveyed in 1997. Nevertheless, this should not permit complacency. For the highly fragmented structure of the system – from the national down to the operational level – poses a threat to the system's performance in the future.

The Austrian health care system is based on social insurance and its development has been a gradual evolution rather than the result of a series of fundamental strategic changes. About two-thirds of total expenditure for health care is publicly funded, and one-third via private payment. This high rate of public payment makes the system particularly vulnerable to changes in the macro-economic development of the country.

Since the 1970s, cost containment has been a major focus of political interest, especially amongst the stakeholders. Austrian accession to the European Union in 1995 meant that the Treaty of Maastricht – with its obligation to keep the national budget under tight control – increased the priority of this topic. Quality of health care has also became a theme of some importancein Austria, and recently, therefore, the question of how to pursue cost containment measures without a resulting loss in quality of service has become a major topic in both the public domain and on the political agenda.

Development of clear aims for the health system and the introduction of efficient mechanisms to reach such aims is now necessary to deal with this challenge successfully. However, the historically low priority accorded health care by the federal government, and the fragmentation of competencies between offices of similar stature makes it difficult to develop a consistent national health care strategy. Quite simply, efficient instruments to implement such a strategy are missing.

Structure

Austria's administrative structure comprises the national government and governments of the nine regions. The national parliament sets up the legal boundaries for regional parliaments to develop detailed legislation. The regional governments are responsible for the implementation of legislation concerning health care. Districts and municipalities

meanwhile are responsible for controlling the quality of care. On the regional level as there is scope to interpret national legislation, this has led to the development of nine slightly different regional health care systems with sometimes conflicting aims, and different mechanisms of funding and quality assurance. It is difficult to achieve economies of scale and scope within these small sub-systems.

Until 1997, the three competencies necessary to positively influence the future development of expenditure for health care – setting of aims, development of an appropriate system of funding and incentives to achieve these aims, and the regulation of supply with medical professionals – were dispersed between different federal ministries. The development of health policy used to be the responsibility of the Ministry of Health, while health care funding was traditionally the responsibility of the Ministry of Social Affairs. Health was merged into social affairs in 1997, becoming the *Bundesministerium für Soziale Sicherheit und Generationen*. The training of medical students meanwhile, is a competence of the Ministry of Science. Part of the regulations concerning doctors are delegated to the Austrian Medical Association. Twenty-seven social and several private insurance bodies are the other important stakeholders. Thus, any initiative by the Ministry of Health to contain costs for health care is at the risk of being opposed and obstructed by one of the many groups within the systems, as all more or less wield similar influence.

Health care: low priority

Not only this fragmentation, but also health policy has traditionally been of low priority to the government. Between 1979 and 2000, ten different ministers or secretaries of health were responsible for the development of national health policy. Since 1985, only one minister has ever been in charge for more than two years. During the same period, the ministry responsible for the development and implementation of federal health policy changed three times; accordingly, it is difficult to identify goals for a national health policy over the last 20 years. Nevertheless, the integration of the ministries of health and social affairs is a first step into the development of a comprehensive health policy.

As regards health training and medical education, access to university is unhindered. At present, 18 000 medical students are in training in Austria's medical faculties. Since 1978 the number of doctors per thousand inhabitants has doubled, from 1.5 in 1978 to 3 in 1998. The number of physicians (general practitioners, specialists, and doctors in training) is expected to increase by 13% from 2000 to 2004; from 33 780 to 38 155. By 2020, therefore, the Austrian Medical Association expects some 9 500 doctors to be unemployed. Such pressure on the medical labour market is likely to increase supplier-induced demand for health care and thus expenditure on health care.

Paying doctors

The behaviour of doctors concerning the amount and type of services they provide is crucial to the future development of a comprehensive health care spending plan. Currently, doctors in the public primary care sector are paid by social insurance on the basis of a modified 'fee-for-service' system. Meanwhile, for services provided in hospital out-patient departments, doctors are paid on a yearly 'one off' payment scheme via social insurance, irrespective of the number of patients treated. Over the last two years the deficit of all Austrian social insurance bodies increased dramatically from 254 million Euro in 1999 to 363 million Euro in 2000. As a consequence, primary care doctors have an incentive to refer patients to the hospitals instead of treating them in the primary care sector; the deficit of public hospitals is not paid by the social insurance agencies. That way, the insurance bodies reduce their own financial risk, albeit at the cost of increasing overall expenditure for health care.

Heads of department in public hospitals are allowed to treat private patients in their departments. Private insurance pays doctors directly on a 'fee-for-service' basis. A catalogue of different services is negotiated between the national association of private health care insurers and the regional medical association. According to agreements between doctors within a department and the hospital trust, private income is usually pooled, and all doctors in the department then get a share. The hospital trust in turn gets a share of the pool as well, along with a flat rate payment directly from private insurance for every day the client stays in hospital.

Usually the share of income for the head of the department out of private sources is much higher than the salary he gets from the employer. It is thus in the interest of doctors, as well as hospital trusts, to provide a high number of services on a fee-for-service basis. This is of course in conflict with national level efforts to contain overall expenditure on health care. New mechanisms for the payment of doctors could thus be one way to limit the amount and type of services they provide.

Conclusion

Health care has until recently been of low priority for the national government. Pressure on the Austrian health care system to contain costs and provide good quality of services is growing constantly. The development of a consistent national health policy with clear aims and a set of efficient instruments to enforce this policy on all levels of the system is crucial to dealing with this challenge successfully. There are finally some signs that the government is willing to take on this challenge, and to implement the right measures so as to put health policy higher on the political agenda.

Recalling the WHO report cited at the outset, it is only via similar international comparisons of health care systems in the future, that we will be able to see if the combined efforts of politicians, administrators and health care providers can lead to an more integrated health care system in Austria that is able to maintain the present standard.

Stefan Meusburger is specialist for Anaesthesia and Intensive Care Medicine at the Krankenhaus der Barmherzigen Schwestern Linz BetriebsGmbH.

The demand for private health insurance in Germany

Sarah Thomson and Elias Mossialos

Most countries in the European Union (EU) require mandatory participation in the statutory health care system. In Germany, the Netherlands and Spain, however, certain groups of people are either not covered by the statutory system (high earners and civil servants in the Netherlands, and civil servants and the self-employed in Germany) or are allowed to opt out of it (individuals earning above an income threshold in Germany, and civil servants in Spain). This leaves them free to purchase private health insurance (PHI) as a substitute for statutory protection.

A comparison of the take-up of PHI among this latter group reveals significantly lower demand for PHI in Germany than in Spain: whereas as many as 85% of Spanish civil servants (95% in the Ministry of Health) choose to opt out of the statutory system and join a quasi-private scheme known as *MUFACE*, less than a quarter of Germans with earnings above the income threshold choose to purchase PHI. Although the German statutory health insurance scheme *Gesetzliche Krankenversicherung* (GKV), covers 88% of the population, 16% of its members (equivalent to 14% of the population) are high earners who have chosen not to purchase PHI. Some 9% of the population is privately insured, but this figure also includes individuals who are not eligible for GKV membership. In total therefore, only about 23% of those who have a choice between statutory and private health insurance choose the latter option.

Why is the demand for PHI in Germany so low? The German PHI industry argues that low demand is partly due to a regular increase in the statutory income threshold, which means that the number of people eligible to switch from statutory to private health insurance remains fairly stable from year to year.[1] However, the demand for PHI in Germany seems more likely to be affected by other statutory rules and by the performance and cost of PHI.

A key factor in explaining the low demand for PHI may be that those who opt out of the statutory health sector cannot return to it. With the exception of borderline situations such as a change in economic status, the decision to leave is irreversible.[2] The recent Reform Act of Social Health Insurance 2000 has tightened the rules even further, by stipulating that privately insured persons over the age of 55 may not return to the statutory system at all – even if their earnings fall below the statutory ceiling – and this is likely to increase reluctance to leave the GKV.[3]

Cost is another important factor in explaining the low demand. The private insurers' main marketing strategy is to highlight the better facilities they provide, but many people regard PHI as expensive compared to the GKV.[4] The GKV provides comprehensive benefits and cover for dependants, whereas private insurers do not automatically cover dependants or offer family policies. Private subscribers must pay separate premiums for spouses and children, making family size a critical factor when choosing between statutory or private insurance.[5] As a result, PHI is more attractive to single people and double income couples.[2]

Not only is the GKV better value for money in terms of providing comprehensive benefits and covering dependants, it is also cheaper in the long term. Contributions to the GKV are proportionate to income and the contribution rate has not increased significantly over time: in 1975 it was 10.5%, rising to 13.5% in 2000.[1] In contrast, PHI premiums are calculated according to the extent and level of cover required, in addition to risk, age at entry, gender and health status at the time of underwriting. Because premiums often rise steeply with age, since July 1994 private health insurers have had to offer policies at a standard rate (*Standardtarif*) to individuals aged 65 and over who have been privately insured for a qualifying period of at least 10 years. This tariff provides for benefits which match the benefits of statutory health insurance and guarantees that premiums will not exceed the average maximum contribution to statutory health insurance .[6] However, very few people choose this option (only 1 161 people at the end of 1998) because, as with all PHI, it does not cover dependants and is therefore expensive compared to the statutory scheme.[1] The Reform Act of Social Health Insurance 2000 actually stipulates that private health insurers must inform potential subscribers of the likelihood of increasing premiums .[3]

Access may be another cause for low demand. Unlike GKV subscribers who receive benefits in kind, privately insured people generally have to pay providers directly and are subsequently reimbursed by their insurer. Although insurers claim that this payment system encourages a more 'responsible' attitude to claims for medical benefits,[5,6] it has not stopped costs from rising; partly because doctors are able to charge their privately insured patients 1.7 or 2.3 times the reimbursement values set in the price list for private medical services issued by the Federal Ministry for Health.[2] Consequently, cost increases in the private sector are almost two-thirds

higher than in the statutory system, and twice as high for ambulatory care.[2]

In the mid-1990s the number of voluntary GKV members switching to PHI declined in comparison to previous years (only 66 000 switched in 1996, compared to a peak of 329 000 in 1992), possibly as a result of public debate concerning increases in PHI premiums in old age.[1] Since 1997, however, there has been a stronger rise in the number of individuals switching from statutory to PHI, which the industry argues is partly due to benefit cutbacks in the statutory system.[1]

Overall, the evidence suggests that the demand for PHI in Germany is low because PHI does not provide good value for money when compared to the statutory system, and that the high price of PHI premiums, combined with stringent statutory rules, are a significant deterrent to the take up of PHI.

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An experiment in health care regulation:

The UK Commission for health Improvement

Julian Le Grand and Matt Tee

The aim of the Commission for Health Improvement (CHI) is easily stated: to improve the quality of care patients receive in the National Health Service of England and Wales.

The CHI was established by the current Labour Government in 1999. It is overseen by a board of 14 part-time Commissioners. None of the Commissioners are part of the Government and the majority do not work in the health service. This reflects an important aspect of CHI. It is independent both of the NHS and the Government. This independence is important, for there will be times when what CHI says will make uncomfortable reading for the health service and whatever government is in power.

The Commission was created partly to restore public confidence in the health service. In light of a number of recent and serious failures in the service which received widespread publicity, along with a growing perception that the quality of health services varied across the country. The public needed reassurance that someone was checking that patient care was as good as it should be, and indeed, getting better. However, there was also a structural issue in the health service that needed to be tackled. At the time of the CHI's inception, the NHS was judged very much on financial and activity targets, not on how well it treated patients. This is now changing and there is now a statutory duty on the NHS to improve the quality of care as well as concentrating on how much care it provides and what it costs. The CHI is a lever by which the culture of the health service can be changed so that the care for patients is truly at the centre of its work.

In its mandate the Commission for Health Improvement has four basic functions. The first of these is the so-called *Clinical Governance Review*. This is a routine but rigorous assessment of every health service organisation at least every four years. The assessment has three phases: data collection and analysis, an on-site visit, and a report. The visit is carried out by a team which includes a doctor, a nurse, a therapist and a manager, all of whom are currently employed in the NHS. The team also includes a member of the public recruited by advertisement. They are coordinated by a review manager who works permanently for the CHI. The visit takes a week and involves the team interviewing and observing staff in the organisation being assessed. The report is a public document and is accompanied by an action plan, written by the organisation which spells out what they intend to do to improve patient care as a result of the Commission's visit.

The second function is *investigation*. When things go seriously wrong in the health service, the CHI can be asked to find out why it happened, how it can be prevented from happening again and what needs to be done to restore public confidence. The methods for carrying out an investigation are similar to those for a Clinical Governance Review, but the team are selected for their particular

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The Government of Spain
The European Investment Bank
The Open Society Institute
The World Bank
The London School of Economics and Political Science and
The London School of Hygiene and Tropical Medicine

experience in the area under investigation. To give a flavour of the sort of issues the CHI is asked to look at, the first two investigations covered the appalling abuse of elderly patients in a mental hospital, and an incident in an acute hospital in which a man had a healthy kidney removed rather than the diseased one. Investigations are very high profile and it is important that the way they are reported reflects the Commission's identity. *The Health Service Journal*, a respected health service management magazine, described the CHI's first reports as 'tough but fair' which, in our view, was an encouraging start.

The CHI's third function is to undertake *national studies* of health service standards. As part of the modernisation of the service, standards and guidelines are being drawn up to apply across the country. These may specify how services for a particular condition, for example heart disease, should be organised and provided, or they may give guidance on the most cost effective way of carrying out a procedure, for example the best artificial hip to use. The Commission's first study of this kind is into the implementation of the Calman-Hine guidelines on cancer services which, when published some years ago, set the framework in which cancer services should be provided.

The CHI's final function is to provide *leadership and best practice* to the health service in its efforts to improve patient care. It is a commonly held belief that there are many examples of excellent practice in the country, but relatively little sharing of good practice. Thus, the CHI intends to develop a database of excellence which everyone in the health service will have access to. One example of this will be guidelines for the health service on how to run an investigation when things go wrong; for the Commission is often asked to investigate after an internal inquiry has been held. The standard of such enquiries is variable, precisely because there are no national guidelines.

Through the exercising of these four functions in an ambitious work plan, the CHI is confident that it will be able to demonstrate an improvement in patient care across the health service.

Julian Le Grand is a Commissioner on CHI, and Matt Tee is its Communications Director. For those interested in the Commission on Health Improvement, please contact the CHI's website at: www.doh.gov.uk/chi, or send an email to: info@chi.nhs.uk for more information.

***Euro Observer* is looking for individuals wishing to act as national correspondents, to contribute on a regular basis.**

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8 Scherfigsvej, DK-2100 Copenhagen Ø, Denmark.

Telephone: +45 39 17 14 30, Fax: +45 39 17 18 70

E-mail: observatory@who.dk
or visit the Observatory's web site: http://www.observatory.dk

Editor
Govin Permanand
Tel: +44 20 7955 6342
Email: g.permanand@lse.ac.uk

Editorial Team
Phyllis Dahl
Josep Figueras
Elke Jakubowski
Martin McKee
Elias Mossialos
Richard Saltman

To join the mailing list, please contact
Anna Maresso
Observatory – London Hub
Tel: +44 20 7955 6288
Fax: +44 20 7955 6803
Email: a.maresso@lse.ac.uk

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