

Is it time to set out more clearly what is funded by the NHS?

# Rationing health care

*Research report*

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February 2012

## Acknowledgements

The authors are grateful for the contributions of Dame Carol Black, Jennifer Dixon and Judith Smith at the Nuffield Trust; Andy McKeon (Chair) and members of The Quest for NHS Efficiency steering group; and Aileen Clarke, University of Warwick. All these reviewers have provided valuable comment and insights during the drafting of this report. We are also grateful to those individuals who agreed to be interviewed as part of our research. The views expressed in the report are however our own.

We would also like to thank Rachel Posaner and colleagues at the Health Services Management Centre Library, Birmingham, for their invaluable assistance with the literature review.

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# Executive summary

The National Health Service (NHS) in England is facing a significant financial challenge. Between 2011/12 and 2014/15, NHS spending will increase by only 0.4 per cent in real terms (House of Commons Health Committee, 2010). To put this into perspective, between 1950 and 2000 the NHS' net spending increased in real terms at an average of 3.48 per cent per year, rising to 6.56 per cent between 1999/2000 and 2010/11 (Appleby and others, 2009a). The NHS therefore now faces what has been dubbed 'the Nicholson challenge': to derive by 2015 an estimated £15–20 billion more value from the overall budget in order to meet rising demand without a corresponding increase in funding.

At the same time, the NHS is going through a series of large-scale reforms, as set out in the Coalition Government's Health and Social Care Bill 2011. Responsibility for commissioning patient care is set to be transferred from primary care trusts (PCTs) to consortia of general practitioners in 'clinical commissioning groups'. Each clinical commissioning group will purchase care for the patients registered with its constituent general practices (excluding highly specialist and primary care), and clinical commissioning groups will control around £60 billion of the NHS budget.

The drive to devolve greater responsibility for decision-making to local clinicians is expected to result in variations in the funding and purchasing decisions made by local clinical commissioning groups for the populations they cover. Some fear that this will result in greater inequities in access to care across areas, while others regard this as a necessary way of allowing clinicians to respond to the different needs of their local populations.

The NHS has in the past responded to the need to constrain expenditure growth by attempting to increase productivity, reconfiguring services, restraining staff numbers and pay, and letting waiting lists for elective care grow. However, despite considerable debate in the past on 'rationing' and interest in the experiences of other countries in this regard, ending the availability of whole services has been rare.

The Nuffield Trust has argued elsewhere (Smith and others, 2010) that efforts should in the first instance be devoted to achieving greater efficiency in the NHS before considering the abandonment of previously available services. But, anticipating debate in this area, the Trust has conducted a review into the feasibility, advantages and disadvantages of introducing an explicit, nationally set benefits package in the NHS in England. This report outlines the case for and against introducing such a package, and draws out learning for the NHS from other countries that have attempted to do so.

The intention is to examine whether drawing up an explicit account of what health care is and what is not funded by the NHS could help to promote the main objectives of the NHS, such as maintaining a comprehensive service based on need, being free at the point of use regardless of ability to pay, while spending within a global budget.

## Funding health care: how are decisions made?

In all publicly funded health systems, choices have to be made over who is covered and for what services. In the NHS, all citizens are covered, but there are in practice limits to the health care benefits paid for by the state. The inclusion or otherwise of services in the main ‘benefits package’ is open to contest and debate, and may shift over time.

Currently, the set of health care services paid for by the NHS (what we call the ‘NHS benefits package’) is arrived at implicitly, as a result of decisions made by national, regional and local decision-makers, working within a context of laws, duties, policies, budgets and financial incentives that change over time.

This implicit approach to the development of the NHS benefits package has some advantages:

- It allows doctors to respond, where necessary, to the needs of individual patients and not be unduly constrained by rigid national rules.
- It allows local commissioners to set local priorities for spending within a fixed budget.
- It diffuses what might be unmanageable political and public pressure in response to difficult spending decisions.

But it also has disadvantages, for example:

- It may be inconsistent with promoting national strategic objectives such as cost-effectiveness and equity of access.
- It can lead to a tendency to maintain historical patterns of care.
- It gives rise to variations in health funding decisions across the country (the ‘postcode lottery’), with resulting perceptions of unfairness.
- There is a lack of transparency about how spending decisions are made.

## The experience of international health systems

Some countries seek to describe explicitly the health care benefits that are paid for by their publicly funded health system. Such benefits packages may be *inclusive*, setting out a positive list of what will be funded, or *exclusive*, setting out a negative list of what will not be provided, or will only be offered under some circumstances. In practice, benefits packages often lack the detail necessary to be more than a guide to local clinical practice, and they rarely set out ‘appropriateness’ criteria to indicate which specific patients should qualify for receipt of a treatment. In some countries, regions have considerable autonomy over what is actually funded, albeit within a national framework of entitlements.

## Should a national NHS benefits package be specified?

Given the financial pressures faced by the NHS, the idea of setting out explicitly the limits to what patients are entitled, in the form of a nationally specified NHS benefits package, may seem superficially attractive. This report examines three main questions:

1. Is it feasible in practice to define explicitly a list of benefits?
2. What would be its likely impact in three key areas: containing costs and improving efficiency; equity of access to care; and transparency?

3. If setting a national benefits package is not feasible or desirable, can improvements to the existing implicit system nevertheless be made?

The review concludes that developing a detailed national benefits package for the NHS is likely to be unworkable, and implementing it may lead to adverse consequences. It would:

- prove technically challenging to develop and enforce
- limit necessary local autonomy of commissioners in adhering to budgets
- limit necessary local autonomy of providers in adapting to variations in patients' needs
- be vulnerable to arbitrary departures from consistent decision-making, in the face of lobbying and other political pressures
- possibly compromise the solidarity principle on which the NHS relies.

### Alternative options

While this report recommends against the introduction of an explicit national benefits package, the motivation for examining this option remains pressing. The report therefore makes a number of recommendations for changes that could be made to improve the way the current implicitly set NHS benefits package is shaped, without going as far as specifying a national set of NHS-funded services. The recommendations are as follows:

1. **A set of principles should be established that can shape how public money is spent in the NHS** and, conversely, inform decisions about what will no longer be paid for. These principles could be enshrined in the NHS Constitution and restated in the annual Secretary of State for Health's mandate to the NHS Commissioning Board (and in turn to the new clinical commissioning groups), reminding NHS commissioners of what should underpin their decision-making about resources and services. The principles are likely to be based on existing NHS criteria such as clinical effectiveness, cost-effectiveness and equity.
2. **Acting on the mandate set by the Secretary of State, the NHS Commissioning Board should perform a crucial role in setting the scope of funding and service provision in the reformed NHS, and working with the National Institute for Health and Clinical Excellence (NICE) to determine a Commissioning Outcomes Framework** that will guide the activities of local commissioners, against which they will be held to account. The NHS Commissioning Board should commission core standards for NHS care from NICE – these must incorporate information about cost-effectiveness, best evidence-based clinical practice, and advice on efficient service provision.
3. **The NHS Commissioning Board should use NICE guidance for producing, as a starting point, a national list of the treatments that public money should not be spent on in the NHS**, unless there are exceptional circumstances. Local clinical commissioning groups should be required to report publicly on their progress in following this 'do not do' advice, explaining any exceptions where such procedures are funded. More generally, clinical commissioning groups should be expected to report on departures from national guidance.



4. **The standards developed by NICE and set out in the Commissioning Outcomes Framework should be aligned with the structure and level of the NHS tariff.** Hospitals and other providers would therefore be paid by commissioners in a way that upholds an NHS benefits package that is affordable, clinically effective and cost-effective.
5. **Wherever possible, providers and clinicians should be ‘nudged’ towards clinical and cost-effective care** through: public exception reporting of services that are funded outside of Commissioning Outcomes Framework standards; the use of information technology-based clinical prompts for general practitioners and specialists at the point of diagnosis and treatment; and other information technology solutions such as monitoring adherence to guidelines.
6. **The NHS Commissioning Board should provide the public with information about the relative performance of local commissioners against selected outcome indicators** from those set out in the NHS Constitution and the Commissioning Outcomes Framework. In this way, the NHS Commissioning Board will help to inform the public about what is in the *de facto* NHS benefits package and what they should expect from their local NHS, and encourage stronger local challenge and accountability in respect of funding decisions and how these decisions are made.
7. **Decision-making in clinical commissioning groups should be made transparent, so that departures from certain national guidelines, and from NHS commissioning principles, are subject to proper scrutiny before they are finalised.** Relevant information should be made available to local authorities, the media and citizens, and mechanisms put in place to permit representations to be heard.
8. **Patients should be ‘nudged’ towards preferred use of NHS services**, through the provision of clear information and making it easy for patients to make the ‘right’ choices. We consider it unlikely that policy-makers will seek to apply additional user charges in the NHS in the foreseeable future.

# 1. Introduction

The NHS is facing a significant financial challenge. Between 2011/12 and 2014/15, NHS spending will increase by only 0.4 per cent in real terms (House of Commons Health Committee, 2010). To put this into perspective, over the past 39 years the NHS has received funding increases of an average of 3.9 per cent a year above inflation, and between 1997/98 and 2010/11 the English NHS budget grew in real terms at an average of 5.7 per cent per year. The NHS now faces what has been dubbed ‘the Nicholson challenge’: to derive, by 2015, £15–20 billion more value from the overall budget in order to meet rising demand and improve the quality of services without a corresponding increase in funding. This equates to the need for approximately 4 per cent efficiency gains per year.

The NHS is also going through a series of large-scale reforms, as set out in the Coalition Government’s Health and Social Care Bill 2011. At the time of writing (February 2012), commissioning responsibility is set to be transferred from PCTs to consortia of general practitioners in ‘clinical commissioning groups’. Each clinical commissioning group will purchase care for the patients registered with its constituent general practices (excluding highly specialist and primary care), and clinical commissioning groups will control around £60 billion of the current NHS budget. The clinical commissioning groups will be held to account by a new NHS Commissioning Board, which will, in turn, be held to account by the Secretary of State for Health. The NHS Commissioning Board will also commission specialist and primary care directly from providers.

These proposed new arrangements pose major challenges for the NHS. It is likely that variations in funding and purchasing decisions will arise as clinical commissioning groups seek to remain within their allocated budgets while offering a good-quality service for their populations. Clinical commissioning groups will, however, operate within a new national Commissioning Outcomes Framework that will comprise a set of standards of care with associated indicators (developed by NICE) (DH, 2011a). This framework will seek to promote a degree of national consistency in relation to local spending decisions by clinical commissioning groups.

But as pressures on budgets in the NHS increase, and limitations to what can be funded become evident, it is likely that inconsistencies across geographic areas in the services provided by the NHS will become more visible. Historically, there has been considerable public discontent with any suggestion of a ‘postcode lottery’, so policy-makers may wish to examine the virtues of setting a national benefits package that sets out entitlements to NHS care explicitly at a national level.

The logic is easy to understand. First, by specifying the services funded by the NHS (the NHS benefits package) at a national level, geographical variation in the provision of care might be reduced. Second, by establishing an explicit benefits package at a national level, the scope and limitations of the services offered by the NHS would be more transparent to the public, who could then better hold to account those who defined, commissioned and delivered the package. Third, the package could be chosen so as to maximise the benefits to the population (subject to the health care resources available) by limiting

the package to services that are thought to deliver the maximum benefit in relation to expenditure. A single, national body (such as the NHS Commissioning Board) might be better placed than local organisations to evaluate, establish and enforce 'best practice'.

There is already a vehicle for setting out the broad entitlements offered by the NHS to the population, and the corresponding responsibilities of the public. The NHS Constitution sets out in very broad terms some guarantees, such as that people should not wait more than 18 weeks from referral to hospital treatment. But it does not currently set out a benefits package.

However, there are also strong arguments against setting a more explicit benefits package at national level. For example, the need to adhere to a standard package might undermine local autonomy. In particular, it might remove the local managerial and clinical discretion needed to maximise benefits for patients within a fixed local budget. And it may threaten the discretion of clinicians to respond flexibly to variations in the needs and circumstances of individual patients.

In this report, we examine the case for and against introducing an explicit, nationally set benefits package funded by the NHS in England. The intention is to examine whether setting an explicit benefits package could help promote the main objectives of the NHS, such as maintaining a comprehensive service based on need, and being free at the point of use regardless of ability to pay, while keeping expenditure under control. Also, to what extent would it enhance the quality of care and equity of access to care for a given budget?

It is important to keep in mind the distinction between services that are promised (stated perhaps as entitlements) and services that are actually received by patients. The performance of any health system should be assessed with respect to the scope and quality of services actually received by patients. The specification of a benefits package is merely an instrument for specifying desired levels of attainment, which may or may not be translated into services received. The effectiveness with which an explicit benefits package would lead to the right services being delivered to the right patients at the right time with a high level of quality is, of course, a crucial consideration that we touch on throughout the report.

The next chapter of the report, Chapter 2, discusses how the current package of benefits provided by the NHS is arrived at. It explains the influence of many different organisations and actors that (to a greater or lesser degree) affect which services and treatments the NHS funds, and under what circumstances. Chapter 3 discusses how different countries have gone about setting benefits packages at a national or regional level and their experience in doing so. It identifies four different dimensions to such national benefits packages: whether the package is inclusive or exclusive, its scope, its depth/level of detail and the extent to which it is enforced.

Chapter 4 assesses whether setting a comprehensive, explicit, national benefits package is feasible, and whether it would be helpful in addressing the challenges confronted by the NHS. In Chapter 5 we examine some alternative options for improving the way the package of benefits funded by the NHS is shaped. Chapter 6 concludes the report.

## 2. The package of benefits currently funded by the NHS

In this chapter, we provide a framework for understanding what constitutes a health system's 'benefits package'. We then look at how the benefits package funded by the NHS is currently derived, identify the various advantages and disadvantages of this system and outline whether a nationally set benefits package might remedy some of the problems identified.

### The three elements of a benefits package

All publicly funded health systems offer – either implicitly or explicitly – a constrained bundle of health services to which citizens are entitled (Busse and others, 2005). Even those systems that profess to offer 'comprehensive' benefits in practice place some limitations on what is funded. Furthermore, all systems exhibit both systematic and random variations in the care provided to patients that cannot be explained by variations in patient needs or preferences.

Once any issues of eligibility for care have been settled (for example, nationality, right of abode, income levels, employment), a health system's funded benefits package is made up of three broad elements:

- the categories of service funded
- the rules and protocols that govern their use (appropriateness)
- any financial limitations placed on the coverage.

These are discussed in turn. Throughout, reference is made to the statutory system of health care (in England the NHS), and not services purchased privately, or financed from voluntary sources.

- **Categories of service** refer to the treatments and services funded by the statutory health system as a whole. Each category included within the benefits package is made up of a number of specific services. For example, orthopaedic surgery would normally include knee arthroscopy and meniscectomy, shoulder arthroscopy and decompression, carpal tunnel release, hip replacement, lumbar spinal fusion and so on. Each of these services is comprised of multiple treatments, from pharmaceuticals to diagnostics to rehabilitation. Together, these treatments and services provide the basic contents of a health system's benefits package. Hence, if a service is included (say, hip replacement) then (subject to the caveats below) it will be funded by the statutory health system, whereas if it is not (say, spa treatments), it will not be funded.
- **Appropriateness criteria** govern when and for whom a treatment or service included in the benefits package is funded. Appropriateness criteria may entail clinical criteria that a patient has to meet before a given treatment is deemed appropriate and therefore funded. For example, bariatric surgery may be offered only to patients who exceed a certain body mass index.

- **Financial limitations** dictate which services within the benefits package are provided entirely free of charge and which require a payment from the recipient. The NHS has historically placed little reliance on such user fees, although it does levy a prescription charge, payable by adults who do not meet exemption criteria (related to income, age or health status).

Before setting a national benefits package, it would be important to determine the criteria by which the contents of the package would be selected. Without such criteria, the contents could develop arbitrarily or implicitly and might become subject to unwarranted influence from interest groups. The principal criterion used by NICE in its assessment of new treatments is cost-effectiveness – the costs of an intervention relative to the health gain it secures, measured in terms of length and quality of life. This criterion is, of course, open to challenge, and has in practice been augmented by additional considerations such as equity. Furthermore, NICE has found that it cannot rely on a single measure, especially in the presence of uncertainty (Appleby and others, 2009b).

In this report we shall assume that, if the NHS is to set a benefits package at a national level, the body charged with developing it has been given clear principles on which to base its deliberations. It might be thought that the main criterion would be cost-effectiveness, but there is no reason why that should necessarily be the sole objective. In particular, it might be complemented by other clearly articulated national objectives such as cost containment, equity of access or some notion of just reward.

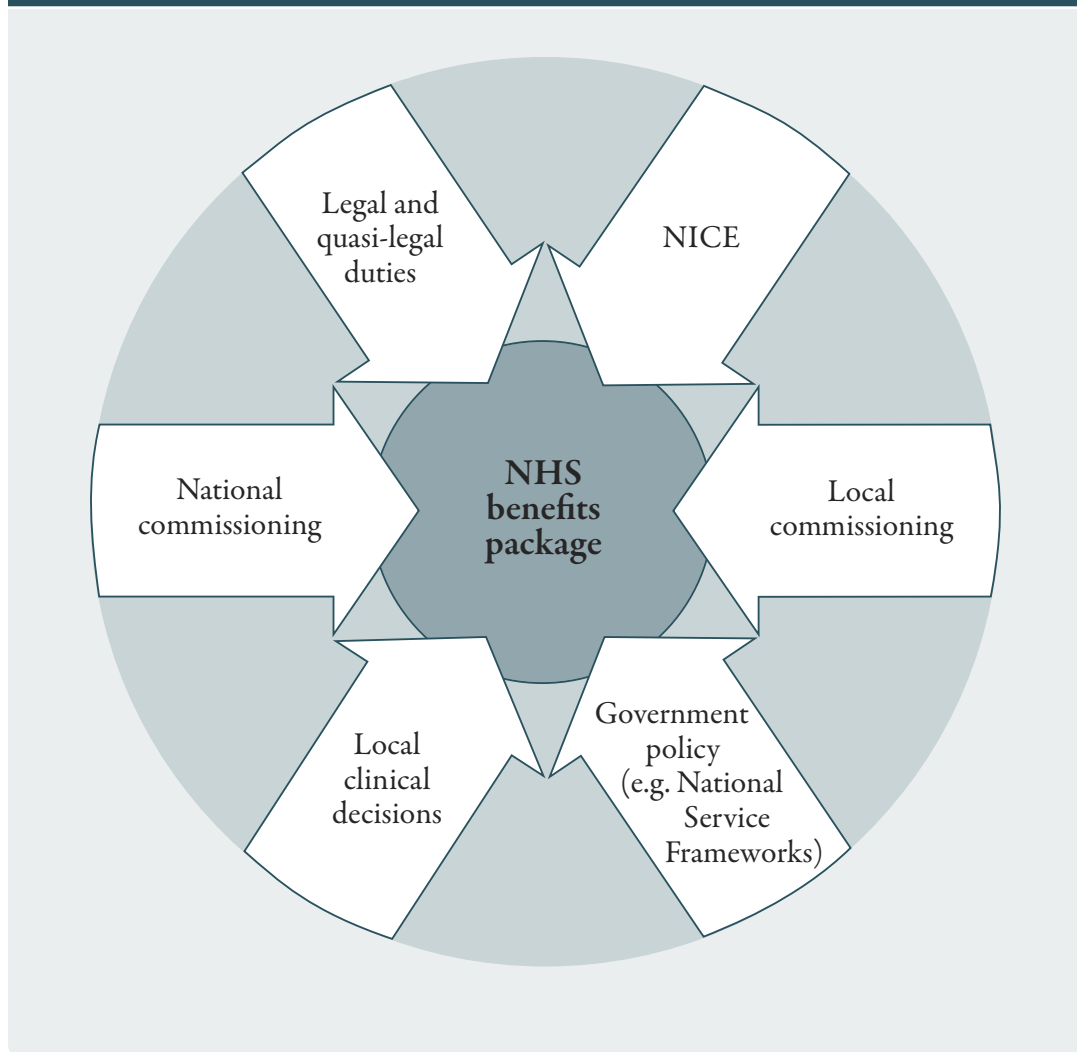
### How is the NHS benefits package presently derived?

At present, the NHS benefits package is the implicit outcome of a series of decisions made by a range of national, regional and local decision-makers. This process is complex, with many influences acting individually, in concert and (sometimes) in conflict with one another. In this section we describe the main influences and assess the possible impact of current proposals for reform. In turn, we consider the various legal and quasi-legal duties in place, government performance management and policy, NICE decisions and guidelines, commissioning decisions at different levels, and local clinical decisions (see Figure 2.1 on page 12).

#### Legal and quasi-legal framework

Legislation relating to the NHS in England makes little attempt to prescribe which services and treatments are funded and which are not (Mason, 2005). English law has put the government – and, in particular, the Secretary of State for Health – under a duty to promote a comprehensive health service. The language of these duties relates more to the provision of services than strictly what must be funded. Some services must be provided (such as hospital accommodation, medical dental, ophthalmic, nursing, ambulance, diagnostic and treatment services). However, the National Health Service Act 2006 does not seek to establish the extent of that obligation. Rather, the Secretary of State for Health needs to ensure the provision of health care services ‘to such extent as he [sic] considers necessary to meet all reasonable requirements’ (National Health Service Act 2006, Section 3(1)). At the time of writing (February 2012), there is considerable public debate about the wording in the Health and Social Care Bill 2011 of clauses related to the duty of the Secretary of State for Health and the provision of NHS care (House of Lords

**Figure 2.1: Principal factors influencing the shape of the NHS benefits package**



Select Committee on the Constitution, 2011). The extent of this debate bears witness to the perceived importance of this duty.

Towards the end of its tenure, the Labour Government did make some moves to spell out more fully in law a citizen's 'right' to health care and what those rights amount to, notably through the creation of the NHS Constitution, which came into force in 2010 (see Box 2.1 opposite for key clauses). The Constitution establishes a number of citizen entitlements with respect to the NHS, including:

- the right to a 'comprehensive service' (DH, 2010a, p. 3)
- the right to be treated 'with a professional standard of care by appropriately qualified and experienced staff' (2010a, p. 6)
- the right to 'drugs and treatments that have been recommended by NICE' (2010a, p. 6).

Nevertheless, given the lack of specificity in the NHS Constitution in terms of what counts as a ‘comprehensive service’, it has not in practice been a strong influence on what the NHS actually funds or provides.

### Box 2.1: Key clauses of the NHS Constitution

- The ‘right to receive NHS services free of charge, apart from certain limited exceptions sanctioned by Parliament’.
- The ‘right to access NHS services’.
- The ‘right to expect your local NHS to assess the health requirements of the local community and to commission and put in place the services to meet those needs as considered necessary’.
- The ‘right, in certain circumstances, to go to other European Economic Area countries or Switzerland for treatment, which would be available to you through your NHS commissioner’.
- The ‘right not to be unlawfully discriminated against in the provision of NHS services, including on grounds of gender, race, religion or belief, sexual orientation, disability (including learning disability or mental illness) or age’.
- The ‘right to access services within maximum waiting times, or for the NHS to take all reasonable steps to offer you a range of alternative providers if this is not possible.’
- The ‘right to be treated with a professional standard of care, by appropriately qualified and experienced staff, in a properly approved or registered organisation that meets required levels of safety and quality’.
- The ‘right to drugs and treatments that have been recommended by NICE for use in the NHS, if your doctor says they are clinically appropriate for you’.
- The ‘right to expect local decisions on funding of other drugs and treatments to be made rationally following a proper consideration of the evidence. If the local NHS decides not to fund a drug or treatment you and your doctor feel would be right for you, they will explain that decision to you’.
- The ‘right to receive the vaccinations that the Joint Committee on Vaccination and Immunisation recommends that you should receive under an NHS-provided national immunisation programme’.

The NHS also commits:

- ‘to make decisions in a clear and transparent way, so that patients and the public can understand how services are planned and delivered (pledge)’
- ‘to inform you about the healthcare services available to you, locally and nationally (pledge)’
- ‘to offer you easily accessible, reliable and relevant information to enable you to participate fully in your own healthcare decisions and to support you in making choices. This will include information on the quality of clinical services where there is robust and accurate information available (pledge)’
- ‘to provide you with the information you need to influence and scrutinise the planning and delivery of NHS services (pledge)’

Source: DH (2010a, pp. 5–8)

There are other laws and elements of secondary legislation that help to set out aspects of the benefits package. For example, there are legal limitations that govern the ‘eligibility criteria’ that a patient must meet in order to receive care from the NHS, such as residential status. Secondary legislation also sets out some of the ‘financial limitations’ to what the NHS offers, for example who qualifies for free prescriptions, and limitations to dentistry services and ophthalmology. Furthermore, some legally enforceable NHS contracts set out certain ‘appropriateness criteria’ attached to sets of services.

#### Government performance management and policy

While – compared with other countries – legislation has not shaped in any detail the benefits package provided by the NHS, government policy has had a profound influence, enforced through ‘performance management’ by the Department of Health. For example, the previous Labour Government set a range of targets following *The NHS Plan* (DH, 2000), against which the performance of management was carefully monitored. The most recent performance management framework, *Vital Signs*, had three levels of targets: national priorities; national priorities for local delivery; and local priorities. National priorities for 2008/09–2010/11 included:

- lowering the number of MRSA infections
- a maximum wait of 18 weeks for a patient from general practitioner referral to specialist treatment
- a maximum of a two-week wait from general practitioner referral to first specialist appointment for suspected cancer (DH, 2008).

Of all the NHS reforms undertaken by the previous Labour Government, performance targets appear to have had the greatest impact on raising standards of care in the targeted areas, in part because of the sanctions applied to managers who failed to achieve them, and in part because of the public ‘naming and shaming’ of underperforming organisations (Bevan and Hood, 2006; Propper and others, 2008). The use of targets has been criticised for distorting clinical priorities (Barber, 2007), however it has been effective in some areas, for example the reduction of waiting times (Bevan and Hood, 2006). From the perspective of the benefits package, targets serve to channel resources to certain parts of the NHS in preference to others. They may therefore have had an important indirect effect on the benefits package provided by the NHS.

National service frameworks and other national initiatives have also been instrumental in shaping the NHS benefits package by setting clear protocols and quality requirements for the treatment of people with certain clinical conditions. For example, *The National Service Framework for Long-term Conditions* (DH, 2005) defines 11 ‘quality requirements’ (QRs) that providers of such services must meet. According to these requirements, those with neurological conditions should be offered an integrated assessment and plan of their health and social care needs (QR1); if they require hospital admission they should be assessed and treated in a timely manner by teams with the appropriate neurological and resuscitation skills and facilities (QR3); and they should have access to appropriate vocational assessment, rehabilitation and ongoing support, to enable them to find, regain or remain in work and access other occupational and educational opportunities (QR6).

While there is no statutory obligation on health care organisations to implement national service framework standards, as Mason (2005) explains, the Health and Social Care (Community Health and Standards) Act 2003 gives the Secretary of State for Health



powers to publish standards for health care – including those informed by national service frameworks. NHS bodies are bound to take national service frameworks and other guidance into account when making decisions about which services to fund, and to what extent (Mason, 2005).

The Coalition Government has sought to reduce this kind of central influence on the shape of care provided by the NHS. Many of the national service frameworks created under the previous government have not been refreshed. Furthermore, the government has abandoned the use of many targets – such as guaranteed access to a primary care professional within 24 hours and to a primary care doctor within 48 hours – arguing that they were both ‘bureaucratic’ and without proper clinical justification (Ramesh, 2010; DH, 2011b). Instead, under current proposals, the NHS Commissioning Board will be made responsible for developing a national NHS Commissioning Outcomes Framework. The Board has commissioned a set of ‘quality standards’ for care from NICE, which it will use within the framework (NICE website, 2012a). The Board will use this framework to hold clinical commissioning groups to account for planning, funding and delivering local services that meet national health priorities. Hence, national guidance will continue to shape the benefits package. What is not yet clear is the intended strength of national performance management, or the autonomy envisaged for clinical commissioning groups.

On rare occasions there have been cases of direct intervention by government ministers in decisions about the NHS benefits package. For example, in 2005, Patricia Hewitt, then Secretary of State for Health, intervened in a dispute between North Stoke Primary Care Trust and a patient over the funding of the drug Herceptin for early-stage breast cancer, which had not yet received its European licence or been considered by NICE. Although Ms Hewitt regularly emphasised that the decision on whether or not to fund the drug remained with the Primary Care Trust, she brought pressure to bear on the PCT, by stating her concern and requesting to see the evidence on which the PCT had made the decision. This appears to have influenced North Stoke’s decision to reverse its original ruling. According to commentators at the time, whether or not there was a direct instruction from Ms Hewitt was irrelevant. As one unnamed PCT chief executive told the BBC, ‘After the health secretary took that position, the trust had no option’ (*BBC News*, 2005).

#### The National Institute for Health and Clinical Excellence (NICE)

The organisation that probably receives the most publicity for its role in shaping the NHS benefits package is NICE. NICE was originally created in 1999 both to reduce the regional variation in the NHS by creating a national list of approved drugs and health care technologies, and to improve the allocative efficiency of the NHS as a whole by assessing the cost-effectiveness of such treatments. As a body at ‘arm’s length’ from the government, it was also hoped that NICE would be able to remove the media focus from ministers on decisions about funding treatments. At present, the work of NICE is split across many different aspects of care that currently contribute to the implicit NHS benefits package. This includes development of guidance in the following areas:

- clinical guidelines
- diagnostic technologies
- interventional procedures
- medical technologies

- public health
- technology appraisals.

NICE's technology appraisals apply to only a relatively small number of services in the overall package of services purchased by the NHS, and to a relatively small proportion of the overall NHS drug budget of £12 billion. However, through its assessments and guidance, NICE exerts a strong influence on the contents of the NHS benefits package, whether in terms of the inclusion or exclusion of certain treatments or the establishment of appropriateness criteria set out in clinical and other treatment guidelines.

Local NHS organisations are required to take NICE's public health guidance into account when developing public health strategies with local authorities and others, and to review current management of clinical conditions in light of clinical guidelines. They also have a legal duty to fund and resource medicines and treatments recommended by NICE technology appraisals (usually within three months of NICE issuing guidance) (Secretary of State for Health, 2001; Newdick, 2005).

NICE's work focuses on questions of cost-effectiveness and allocative efficiency. For example, it has produced a 'do not do' list of 555 individual clinical interventions that it recommends should not be carried out. The list varies from recommendations not to undertake major surgery unless other options have been exhausted (for example hysterectomy for heavy menstrual bleeding), to smaller-scale recommendations (for example on the use of vitamins to reduce cardiovascular risk). In the same spirit, NICE has also produced 'cost saving guidance' (NICE website, 2011a; 2012b). This includes guidance on the treatment of respiratory tract infection in primary care, which indicates that the use of a 'no prescribing' or 'delayed prescribing' policy is expected to lead to a reduction in antibiotic prescribing of £3.7 million nationally in addition to reduced antibiotic resistance and adverse events associated with antibiotic use.

As reforms to the NHS take shape, it is likely that the principles used by NICE will remain unchanged, but it is as yet unclear as to what its precise role will be in future, or what impact this might have on the NHS benefits package.

### Commissioning

Since 2003, most commissioning of NHS services has been undertaken by local PCTs. PCTs have held around 80 per cent of the NHS budget and been responsible for commissioning primary, secondary and community health care services for their local populations. Within their allocated budget, PCTs have had a duty to commission services to meet the needs of their local populations, at the same time as implementing NICE decisions and guidance and meeting national targets. In reconciling these different priorities, PCTs have become important shapers of the benefits package available locally.

It is nevertheless important to note that PCTs have not been the sole organisations in the NHS with responsibilities for commissioning. A variety of other commissioning organisations exists within the NHS:

- national or regional bodies commissioning highly specialised services and services for rare conditions
- joint commissioning arrangements where NHS bodies hold joint budgets with local authorities and commission services in a collective manner (for example for mental health)

- various forms of practice-based commissioning, under which some PCT commissioning is devolved to general practices
- primary care provider organisations that also play a commissioning role, such as general practice-based Personal Medical Services schemes
- person-level commissioning via personal budgets.

Each of these levels has some influence on the package available and services that are funded for local people (Smith and others, 2004). However, the PCT has, over the past decade, been the dominant commissioning body.

Following the publication of the 2010 White Paper *Equity and Excellence: Liberating the NHS* (DH, 2010b) and the subsequent Health and Social Care Bill 2011, the commissioning environment is undergoing extensive reform. PCTs and practice-based commissioning will be abolished in April 2013, with an as yet undetermined number of clinical commissioning groups assuming their purchasing role. Local health and wellbeing boards will lead joint commissioning with local government, and the NHS Commissioning Board will carry out national/regional commissioning of specialised and primary care services.

At the time of writing (February 2012), there is still some uncertainty about the exact form that the new arrangements will take, in terms of the size of commissioning groups, their powers, sanctions for budgetary breaches, accountability arrangements and the extent to which the NHS Commissioning Board (and Secretary of State for Health) will in future constrain local freedoms. However, regardless of the precise form of the changes brought about by the reforms, it is likely that the core challenges associated with commissioning will remain: that is, how to ensure that the NHS optimises the use it makes of a fixed national budget and how to ensure that the funding decisions made at a local level are sensitive to local needs, respect national objectives and are transparent to the public.

### Clinical decisions

Clinicians, in discussion with their patients, play a crucial role in establishing which services are actually provided and which are not. Clinicians recommend to patients whether a given service or treatment is 'clinically appropriate'. In aggregate, the countless individual decisions made in respect of millions of patients have an immense impact on the distribution of NHS spending between categories of service. Clinicians at all points in the system (but especially general practitioners) have a fundamental role in influencing access to NHS resources, and therefore shaping the benefits package.

Clinicians in turn will be subject to numerous influences in their treatment recommendations. As well as any requirements from commissioners, these might include:

- guidance from national professional bodies such as the royal colleges
- regulatory requirements of bodies such as the General Medical Council
- local treatment policies set by their employing organisation or partnership.

Although some of these influences are intended to reduce inappropriate variation, there remain considerable differences in treatment patterns in the NHS that cannot in their

entirety be explained by clinical need, illustrated for example in the *NHS Atlas of Variation 2011* (DH, 2011c). Appleby and others (2011) document the large variations between PCTs in admission rates for certain high-volume procedures, procedures incurring high levels of expenditure and procedures with high levels of uncertainty concerning efficacy. Such variations in utilisation might be justified if they reflect local differences in patient preferences, patient clinical needs or the local opportunity costs of different treatments. Local clinical discretion (and variation) may in such cases be beneficial if it enables local decision-makers to pursue cost-effective treatment of individual patients. However, if the clinical variation merely reflects a lack of information on optimal patient pathways, inefficient practices or unwarranted patient access to NHS care, it may compromise the efficient and equitable use of NHS resources (Smith and Dixon, 2012).

## An assessment of the current system

### Cost containment and allocative efficiency

The main methods of containing costs in the NHS have traditionally been to set a fixed global budget at the local level, and for the Department of Health to manage performance robustly against that budget. Local decision-makers are given a high degree of autonomy as to how the budget is spent, notwithstanding the national guidance and targets noted above. Commissioners (with a few exceptions) have usually been able to ensure that the package available in their local area is comprehensive, and can be provided within the budgets allocated, albeit sometimes with long waiting times.

But there is inertia in the system. For example, rather than seeking to make substantial changes to their local benefits package, PCTs have tended to follow historical patterns of service when setting priorities (Robinson and others, 2011). As Donaldson and others (2010, p. 802) put it, commissioners will often approach decisions with a view to giving providers 'what you had last year plus a bit more'. In this sense, few decision-makers ask 'about how this money is used never mind whether to maximum effect' (2010, p. 802).

There are, of course, notable exceptions. For example, Croydon Primary Care Trust developed a list of 34 low-priority procedures of 'limited clinical value', for which strict access criteria were introduced, with the intention that only patients likely to benefit from the procedures could secure access (London Health Observatory, 2007). The procedures were divided into four groups:

- relatively ineffective interventions
- potentially cosmetic interventions
- effective interventions with a poor benefit/risk balance in mild cases
- effective interventions where more cost-effective alternatives should be tried first.

More generally, the Audit Commission (2011) notes that PCTs have used a range of sources for decommissioning low-value treatments, and that annual savings of up to £441 million may be feasible if best practice were followed everywhere. In addition, under the umbrella of Department of Health initiatives such as World Class Commissioning and Quality, Innovation, Productivity and Prevention (QIPP), some PCTs have developed priority-setting approaches and have started to move funding away from low-value procedures and services.

Nevertheless, recent work by Robinson and others (2011) has shown that the priority setting of most PCTs – even those employing advanced methods of setting priorities – has remained focused on incremental decisions about new funding and new developments, rather than reassessing their core set of health services. Moreover, although the devolution of decision-making allows local commissioners to adjust the local package in line with local budgets, it also means that many of the same priority-setting processes relating to the same set of services may be replicated up and down the country. Given that the characteristics of many services and patients do not vary materially across the country, it seems difficult to defend much of this replication of effort.

NICE is internationally recognised as a leading authority on health technology assessment. Through its rigorous assessments and clear focus on cost-effectiveness, and the ability to mandate some treatments, it has had a strong impact on shaping some elements of the NHS benefits package. For example, it has helped to reduce some unexplained variation across local areas, in particular in cancer care (Chalkidou, 2009). However, NICE's impact has some limitations.

First, it has tended to focus more on assessing whether *new* expensive drugs and technologies should be included within the NHS benefits package, rather than assessing the cost-effectiveness of treatments already funded.

Second, despite the legal force of some of NICE's recommendations, there is some evidence to show that they are not always followed by commissioners, providers and clinicians on the ground. For example, a study by Cullum and others (2004) showed that while in some instances clinical practice was consistently highly compliant with NICE guidance (for example guidance on the removal of wisdom teeth and the use of taxanes for breast cancer), in others it was consistently non-compliant (for example, guidance on the use of Orlistat, a drug designed to treat obesity). Moreover, some organisations appeared to exhibit more consistent compliance than others across a range of guidance.

Cullum and others identified a number of possible barriers to implementation of NICE recommendations. An enduring issue is an unwillingness among commissioners to sacrifice existing services for newly recommended interventions. For example, recent NICE guidelines state that any patient with a body mass index of 40 or above should be referred for bariatric weight loss surgery, as well as those with a body mass index of between 35 and 40 who have other conditions such as Type 2 diabetes. However, some PCTs have failed to implement this guidance, claiming that it is too costly, instead restricting surgery to those with a body mass index of 50 to 60 (Royal College of Surgeons, 2010). Such arguments may indicate that the cost-effectiveness 'threshold' adopted by NICE may be too liberal given the budgetary circumstances prevailing in some PCTs. However, given the lack of evidence on the cost-effectiveness of many established programmes of care, it is difficult to validate this claim (Appleby and others, 2009b).

It is unclear what effect the recently proposed changes to commissioning will have on the cost-effectiveness of NHS care. The new commissioning bodies are likely to be relatively inexperienced at setting commissioning priorities, financial management and budgetary control – they will require support and vigilant monitoring. The general practitioners forming clinical commissioning groups will also face the challenge of being simultaneously providers and commissioners. They will have to justify to their patients local commissioning decisions for which they have been responsible and that may at times lead to restrictions in the care available.

### Local autonomy and equity of access

A significant benefit of the present system is that it enables a range of actors to shape the NHS benefits package in line with local needs and preferences. Clinicians are given the freedom and power to respond to the idiosyncrasies of individual cases, rather than forcing the patient through a 'one-size-fits-all' approach. For example, one can easily imagine a situation where a general practitioner will decide that, although a patient does not meet the usual clinical threshold for a particular procedure, the psychological distress being experienced by the patient is an adequate reason for referral.

However, this local autonomy has given rise to substantial variability in intervention rates, and therefore a potential inequity in the availability of benefits funded in different geographical locations. The concern is not necessarily with variation in the package *per se* – for the package will naturally vary as it responds to the different needs of different populations – but rather *unjustified* variation in the package, that is, variation that cannot be explained by a variation in need.

Analysis of programme budgeting data for 2006/07 by The King's Fund showed that there were apparently large variations between PCTs, not only in the amount they spent per head of population but also in the proportion of each PCT budget devoted to each disease area (Appleby and Gregory, 2008). Care must be taken with the quality of the programme budgeting data. However, in an extreme example, Islington Primary Care Trust was found to spend 2.9 times more per head (£332) on mental health care than East Riding of Yorkshire Primary Care Trust (£114), even after taking into account legitimate reasons for variation (for example, the age and need profile of the population, the cost of local services and so on) (Appleby and Gregory, 2008).

Variations in appropriateness criteria are also evident. For example, there has been substantial variation in criteria for eligibility for in vitro fertilisation (IVF) treatment, such as a woman's body mass index and her partner's smoking status. The Department of Health was so concerned by this variation that it had to remind PCTs of current NICE guidelines (DH, 2011d).

A central feature of the proposed reforms to the NHS is to devolve more decision-making power to local bodies, and to focus on clinical outcomes as the prime yardstick for performance assessment (DH, 2010b). Application of this principle is likely to lead to greater variation in utilisation of health services than at present. A key question is therefore whether this increased variation in services provided will nevertheless lead to improved health outcomes (and reduced health inequalities). Furthermore, even if the reforms succeed in bringing about a greater degree of local autonomy in decision-making, the public may not tolerate the 'postcode lottery' that would probably become apparent, even if it were eventually shown to give rise to better health overall.

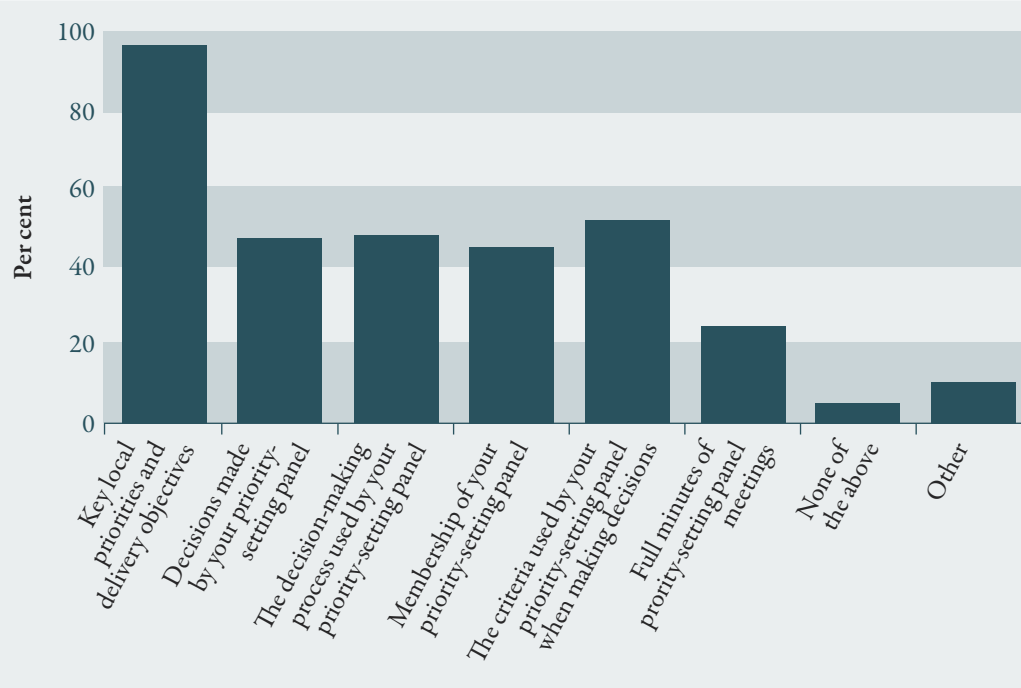
### Accountability and transparency

The present system has a mixed record with regard to accountability and transparency. For example, NICE makes strenuous efforts not only to involve the public in its decisions through citizen councils (NICE website, 2011b) but also to make its processes as transparent as possible (NICE website, 2011c).

However, PCTs' achievements in this area have been mixed. Some PCTs have made public which services they considered low priority and which they did not routinely fund. For example, Wirral Primary Care Trust's policy on low-priority procedures specifically stated that the PCT did not in general support referral for homeopathy.

Access to homeopathy funded by the PCT required prior approval through an appeals process, with key criteria for approval including evidence of effectiveness, failure of conventional treatment and assurance concerning the training and qualifications of the proposed provider (Wirral PCT, 2011). A national survey of PCTs by Robinson and others (2011) in 2009/10 showed that of the PCTs that responded, only 45 per cent stated that the criteria used by priority-setting panels when making decisions were made explicit to the public, and only 44 per cent stated that the decisions of priority-setting panels were made available to the public (see Figure 2.2).

**Figure 2.2: Aspects of the priority-setting process that PCTs currently make explicit to the public**



Source: Robinson and others (2011)

Commentators have noted that the process by which the NHS sets its benefits package remains both obscure and lacking in accountability to local populations. As Klein and others (1995, p. 772) put it: ‘The issue of rationing [in the UK] offers a case study in blame diffusion. Ministers have accepted that rationing is inevitable ... [they will] on occasion define what should be provided (for which they can claim credit) but will almost never explicitly decide what should not be provided (which might attract blame).’

It can be argued that national politicians are ultimately accountable to the population (at election time) for the performance of the NHS, including decisions in funding priorities locally and nationally. However, there is a parallel argument that such national accountability should be augmented by strong local accountability, particularly when increased local autonomy is being introduced, and the local population has no choice of commissioner (as is the case at present). Increased local accountability might be secured by greater transparency over funding decisions and greater involvement by the public on setting priorities. The current reform proposals appear to acknowledge some of these

arguments. For example, the creation of local health and wellbeing boards and (following the recommendations of the NHS Future Forum, 2011; DH, 2011e) the proposal for clinical commissioning groups to hold meetings in public is intended to improve the accountability of clinical commissioning groups to the local population.

Not all commentators agree that obscurity and lack of accountability when setting a benefits package should necessarily be considered a problem. For example, Mechanic (1997) argues that it allows decision-makers at all levels the time and freedom to make sensitive judgements. This explains why policy-makers may be attracted to a system in which difficult and contentious decisions can usually be made piecemeal and locally. It can also be argued that more transparent processes are costly to implement and an over-rigid package would be insensitive to individual circumstances, as well as vulnerable to 'capture' by powerful interest groups.

Ham and Coulter (2001, p. 164) nevertheless argue that priority-setting choices 'need to be informed by an understanding of community preferences if they are to gain acceptance among those affected'. Moreover, a lack of proper community engagement can be detrimental to the decision-making process as a whole. In a blame-free environment, decision-makers have less pressure on them to act reasonably. In contrast, if decision makers were encouraged to make their decision-making processes and decisions public, it would help to guard against inconsistency, unjust preferences and groundless exceptions.

## Summary

The current package of benefits funded by the NHS is arrived at implicitly through the decisions of actors at all levels of the health care system, including politicians, regulators, commissioners, clinicians and patients. The principal advantages of this are a more responsive approach to meeting local needs, strong budgetary control and a diffusion of responsibility for highly complex choices. However, the current system also has several failings:

- it does not retain a strong focus on allocative efficiency
- it leads to variation in the benefits package available in different localities
- it often offers little accountability to local populations.

The extent to which the proposed reforms of the NHS will address these issues remains an open question. In the following chapter, we examine how other countries have constructed a national benefits package and how far it has helped them to address the challenges of priority setting.



## 3. Nationally set benefits packages

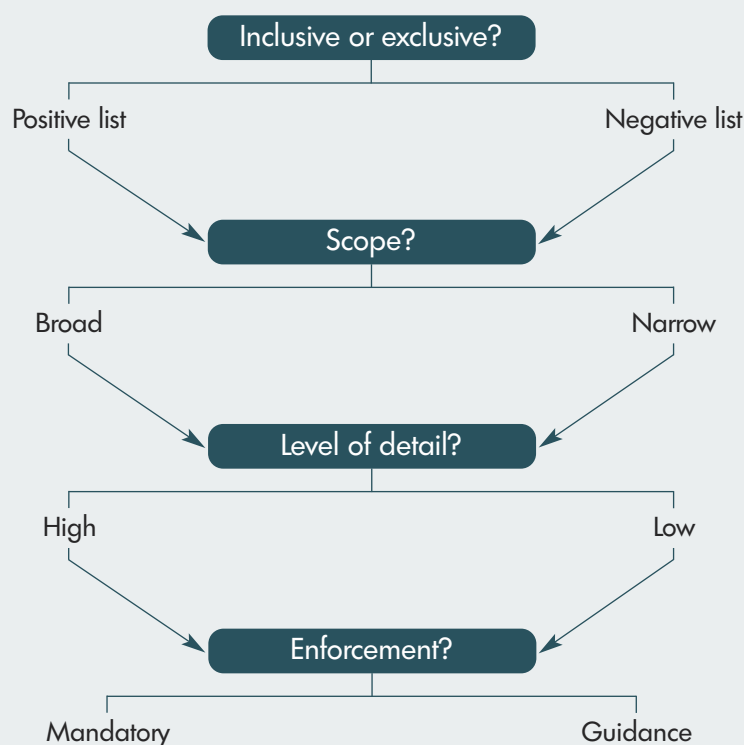
This chapter examines the various forms that a formal national benefits package might take, drawing on international experience. There are four principal dimensions along which benefit packages tend to differ (see Figure 3.1):

- whether they are defined in an inclusive or exclusive fashion
- their scope (the extent to which all health services are considered or not)
- their level of detail (how and when the treatment should be applied)
- the extent to which they are enforced.

### Inclusive and exclusive packages

There are two basic forms that a list of national benefits could take: either a positive list of services included in the package, or a negative list of all those services that are excluded. For example, the health care systems in Armenia, the Czech Republic, Estonia, the Russian Federation, Slovakia and Switzerland each have a benefits package that is described using a positive list or catalogue, detailing all the services guaranteed for

Figure 3.1: The four dimensions of a nationally set and explicitly defined benefits package



citizens or insured persons (Hunter and others, 2005, p. 173). In contrast, in countries such as Finland, Latvia and Lithuania, the benefits package is primarily described in terms of exclusion rather than inclusion (Hunter, and others, 2005, p. 173). Of course, many countries have both positive and negative lists. For example, Italy's catalogue of benefits (*livelli essenziali di assistenza*/levels of essential health care) describes both the services that the national health service (*Servizio Sanitario Nazionale*) is required to provide uniformly in all regions and those services excluded on the basis of various criteria, including proven clinical ineffectiveness (Lo Scalzo and others, 2009).

Exclusions may be in terms of whole services, or certain services for certain people (using appropriateness criteria). For example, although certain aspects of the arrangements have subsequently changed, Bilde and others (2005) report that in Denmark legislation ensured that unmarried women and women over 45 years of age could not have IVF treatment; that sterilisation could not be provided to people under 25 years of age; and induced abortions after week 12 of pregnancy were only allowed after permission from the Minister of Justice, and with specific medical or social indications.

A well-known example of seeking to create a 'positive' list is the Oregon Health Plan developed in the early 1990s for the state's Medicaid recipients (Medicaid being public health insurance cover for low-income populations in the United States). The original aim was to introduce limits to care available under Medicaid by setting a prioritised list of treatments, and in doing so expand the coverage of Medicaid benefits to a greater number of low-income people without any health insurance. The starting point for the list was a broad set of treatment categories arranged in priority order (Dixon and Welch, 1991). Within each category, pairs of medical conditions and treatments were ranked based on effectiveness and cost.

The theory of how the list would function to control costs and extend coverage was simple: a line would be drawn at a point on the list based on the amount of money the Oregon legislature set aside for its Health Plan every two years. Everything above the line would be covered but nothing below it. Over time, the line could be moved depending on technological advance and the budget available. When the first list was created, it contained 696 condition-treatment pairs and the cut-off point was drawn at 565. The ranking was informed by cost-effectiveness, but also by public priorities (from extensive public consultation) and 'commonsense' judgements by members of the Oregon Health Commission. A revised list went into effect in April 2010, which includes 678 lines and covers treatments up to line 502 (Oregon Health Services Commission website, 2010).

The difference between a positive and negative list lies in how 'explicit' the package is about which benefits are included. In the case of a positive list, the contents of the package are necessarily explicit. With a negative list, a service provider or user must infer what the package contains. In principle, developing a positive list involves subjecting all of the existing benefits to review. It is technically complex, and likely to involve considerably more effort than specifying a negative list. The task becomes even more complex if limitations are placed on who may receive a treatment included in the list (see the section 'Level of detail' below).

## Scope

National benefit packages can differ in their scope, that is, the extent to which the list refers to the whole spectrum of health care, or just to subsets such as services for particular conditions, or to particular types of service.

For example, one could say that the benefits package of the German Statutory Health Insurance scheme has a 'wide' scope. As explained in the account of the Statutory Health Insurance benefits package in Book V of the *German Social Code (Sozialgesetzbuch)*, it covers a wide range of services, relating to:

- prevention of disease
- screening for disease
- diagnostic procedures
- treatment of disease (including ambulatory medical care, dental care, drugs, non-physician care, medical devices, inpatient/hospital care, nursing care at home and certain areas of rehabilitation)
- transportation (German Federal Ministry of Justice website, 2012; Busse, 1999).

Other health systems have more limited scope. For example, the Canadian public package excludes reimbursement for pharmaceuticals outside of a hospital setting. Packages in some lower-income countries refer only to hospital care, leaving citizens to make their own arrangements for primary care and pharmaceuticals. The Chilean benefits package (see the next section) refers only to a limited number of conditions. The implicit English NHS package excludes consideration of long-term social care, and it is noteworthy that the somewhat unclear boundary with health care has given rise to a need for more detailed guidance than in other parts of the NHS benefits package.

## Level of detail

Another variable is the amount of detail in a nationally set benefits package about which services are funded, in what circumstances and with what financial costs. For example, some benefits packages go into great detail about the appropriateness criteria applied to included services, as well as any financial limitations. However, others only set out approved services in general terms. The level of detail included in the package shapes the degree to which local decision-makers are given the autonomy to interpret the remit of the package in relation to specific cases. Chile and Germany illustrate the two ends of the continuum – see Boxes 3.1 and 3.2 on page 26.

Successive governments in New Zealand have developed highly detailed 'Clinical Priority Assessment Criteria' and 'booking systems' to select and prioritise patients for access to publicly funded elective surgery (Hadorn and Holmes, 1997; Derrett and others, 2003). These national-level measures were intended to prevent variation in health services utilisation and the inequitable access to health care resources, effectively by formalising clinical judgement.

### Box 3.1: Chile's 'Regime of Explicit Guarantees in Health Law' or Plan AUGE

Plan AUGE came into effect following the passing of Law 19,966 in 2005. The Plan guaranteed government funding for health care services, initially relating to a list of 40 diseases and health conditions, which was later expanded to 65 high-priority health conditions (The Rockefeller Foundation, 2010). Within this system, funding is guaranteed by the government regardless of a citizen's affiliation to the public FONASA insurance system or the private ISAPRES system.

Although Chile's Plan AUGE is directed towards a relatively small range of services in comparison to Germany's Statutory Health Insurance scheme, it includes significant detail about services within its scope. The plan sets out a maximum waiting period for receiving services at each stage of a patient's interaction (the sub-guarantee of 'opportunity') as well as the set of activities, procedures and technologies necessary for treating each medical condition (sub-guarantee of 'quality') and the maximum that a family can spend per year on health (sub-guarantee of 'financial protection') (World Bank, 2008, p. 4). It also defines the medical response for each disease and condition; and emphasises prevention, early examination of symptoms, and primary care (World Bank, 2008, p. 4). Hence, while the benefits package set out in Plan AUGE is relatively small, it has a significant level of detail.

### Box 3.2: The Social Health Insurance scheme in Germany

Although the benefits package of Germany's Social Health Insurance scheme is wide in scope, some of the benefits covered in the package are not set out precisely. For example, along with the overall framework provided by Book V of the *Social Code*, there are several benefit catalogues that explain the details of the Social Health Insurance benefits package: Diagnosis Related Groups, Uniform Value Scale, Uniform Value Scale for Dentists and Uniform Value Scale for Dental Technicians. However, the level of detail in these catalogues is highly variable. Thus, while benefits offered in the outpatient sector are defined explicitly on a positive list (the so-called Uniform Value Scale), the benefits covered under 'inpatient care' are left largely implicit (Bäumler and others, 2008, p. 9). In principle, all inpatient health care services that are not explicitly excluded by a directive of the Federal Joint Committee could be provided at the expense of Social Health Insurance (Bäumler and others, 2008, p. 9).

In practice, the provision of certain procedures is neither limited to a certain disease, nor are they excluded from being used for another disease (Busse and others, 2005, p. 84). For example, in France, as in Germany, little attempt is made to describe the appropriateness criteria attached to the services included in the Social Health Insurance scheme. Rather, in most cases, services will be funded by Social Security (*Sécurité Sociale*) provided a doctor considers them medically necessary and, in some cases, applies for prior authorisation (*entente préalable*) (Bellanger and others, 2005, s25).

## Degree of enforcement

Finally, benefits packages differ in the extent to which they are enforced. At one end of the spectrum, one might imagine a package that has a degree of legislative force behind it, effectively prohibiting purchasers from buying any services outside the boundaries of the prescribed package (or legally requiring them to purchase services included within it). For example, Pharmac, the Pharmaceutical Management Agency of New Zealand, has such an approach for the prescribing and purchasing of pharmaceuticals (Cumming and others, 2010). At the other end of the spectrum, a benefits package might merely offer purchasers a guide to preferred services. In this latter case, adherence to the package may not even be monitored, suggesting that its influence on the delivered health care may be limited.

Between these two poles, there is a range of further options, some of which are hard to characterise neatly, as seen in the Spanish example in Box 3.3.

### Box 3.3: Spain – a national benefits package and autonomous regions

Spain has a tax-funded, national health care system in which most services are publicly provided, with some contracting arrangements with private and local public bodies. What is particularly interesting about the Spanish system is the interplay between national bodies and largely independent regions, the so-called 'autonomous communities'. At present, national legislation sets out what regions are obliged to provide and, since 2006, a national body (the Interterritorial Council of the Spanish National Health Service/*Consejo Interterritorial del Servicio Nacional de Salud*) has been responsible for reviewing the contents of the common basic package (García-Armesto and others, 2010). However, within Spain's highly devolved system, autonomous communities are able to re-evaluate their benefits package depending on their respective financial and political situation, and to offer additional or new benefits (Planas-Miret and others, 2005). Thus, despite a strong, national, legislated benefits package, variation in the package of care in different autonomous communities remains, with some regions broadening and developing the range of services they provide and others offering a more restricted range (García-Sánchez and Carrillo Tirado, 2008, p. 18).

Italy has similar enforcement arrangements for its national benefits package. In theory, the benefits package of Italy's health service is first set at a national level, with further decisions about supplementary services left to its regions, or private insurance companies. However, within this system, the 'force' of the national benefits package and its hold over purchasers is difficult to assess. In principle, the national government has exclusive power to set the levels of essential health care (*livelli essenziali di assistenza*) and is responsible for ensuring the general objectives and fundamental principles of the national health care system (Lo Scalzo and others, 2009). Regions are then given exclusive responsibility for the organisation and administration of publicly financed health care (Lo Scalzo and others, 2009). However, as Hunter and others (2005, p. 174) point out, because national standards are rarely explicitly defined, 'enforcement' is often a matter of negotiation and interpretation between central government and the regions rather than a matter of hard-and-fast rules. Hence, one could say that Italy's benefits package sits awkwardly between the idea of a legally enforced contract with local purchasers and a starting point for negotiation and further discussion on what services can eventually be purchased.

## Summary

It is not possible in this brief chapter to summarise all the nuances of different international experience in setting national benefit packages. For further details, see for example the results of the European Commission ‘HealthBASKET’ project comparing nine European countries (Schreyögg and others, 2005; see Appendix for a summary) and the country profiles prepared by the European Observatory on Health Systems and Policies.<sup>1</sup>

In summary, a national benefits package might take a wide range of different forms, determined by their design along four key dimensions. However, those drawing up various different kinds of benefits packages have faced common problems. In the next chapter we examine some of these problems and assess how helpful or otherwise it would be to set a national benefits package for the English NHS.

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1. [www.euro.who.int/en/who-we-are/partners/observatory](http://www.euro.who.int/en/who-we-are/partners/observatory)

## 4. Setting a national benefits package for the NHS

This chapter examines the merits of instituting a national benefits package for the NHS in England. The assessment is made in relation to three areas: containing costs and improving efficiency; equity; and accountability and transparency.

### Implications for containing costs and improving efficiency

The most immediate argument for setting the NHS benefits package at a national level is that it might help contain costs and improve the efficiency of the NHS as a whole. A national organisation such as the NHS Commissioning Board could use the mechanism of a national benefits package to increase the commissioning of cost-effective treatments and the decommissioning of treatments that are not cost-effective.

For example, one could in principle envisage assessing all potential treatments in the manner currently pursued by NICE, rank them according to cost-effectiveness (or whatever other evaluation criterion was selected), and thereby specify the package that maximised benefits (however defined) subject to the fixed NHS budget. This was essentially the approach taken in Oregon, which was outlined in Chapter 3. With sufficient performance management – often lacking in respect of the implementation of NICE guidance at a local level – this kind of national-level mechanism could have the potential to influence strongly what is commissioned at a local level.

Furthermore, the sort of information provided by NICE is a public good. Therefore, as long as such a body is given very clear criteria for ranking treatments, there is a strong argument for using a single decision-making organisation to assess the relevant evidence and undertake the necessary analysis. Unless there is significant legitimate freedom for local areas to vary the criteria for assessment (which in England seems unlikely), it is inefficient and unnecessary for a large number of local organisations to duplicate the task.

However, international experience shows that there is good reason to be cautious about the effectiveness of a national benefits package in improving efficiency. First, to be effective, it is likely that the established benefits package would have to be specified in considerable detail, with indications of appropriateness as well as choice of interventions. The experience of Chile has shown that one can draw up a detailed account of the benefits package when the package itself is relatively small, but it is almost impossible to enter into that level of detail with respect to a large benefits package. Explicitly defined benefits packages are therefore usually wide in scope, low in detail and lightly enforced. If this were the outcome in England, specification of a national package might merely serve to create a culture of entitlement, expanding rather than appropriately constraining the overall demand for health care, and hence failing to control expenditure.

Second, it would be extremely challenging and costly to assess each treatment and service on the basis of stated objectives (such as cost-effectiveness), and to update these assessments as new technologies or new evidence emerged. As Stolk and Poley (2005, p. 5) point out in relation to a similar idea voiced in the Netherlands, it would be difficult ‘to screen the whole benefit package in terms of necessity and cost-effectiveness ... there are about 11,000 different medicines on the market in the Netherlands’.

Third, in some areas, assessing cost-effectiveness (or performance against other national objectives) may prove impossible, due to a lack of information and the challenges of modelling costs and health benefits of treatment. At present, pharmaceutical companies have a strong incentive to produce information and evidence in advance of a NICE decision because of their incentive to receive approval. But this incentive does not apply to the majority of drugs, diagnostics and technologies in common usage in the NHS. For the majority of such treatments, there are numerous technical and analytical difficulties in performing a cost-effectiveness analysis, particularly when ethical constraints preclude randomisation.

Fourth, if one were to rank all services and treatments according to specified criteria, the setting of the benefits package requires the detailing of a threshold beyond which treatments are rejected. NICE is generally assumed to apply a maximum threshold of about £30,000 per quality-adjusted life year for accepting new treatments (Appleby and others, 2009). However, it also takes other criteria such as equity and proximity to death into account, and there is therefore some variation around that level. For example, NICE has noted that, when evaluating the effectiveness of different palliative care treatments, it may be necessary to adopt a different approach that takes into account extending life, relieving suffering, improving functioning or extending care and compassion (Russell and others, 1996).

This experience highlights the complexity that would be involved in setting a 'cut-off' point for inclusion in the package if multiple criteria (beyond cost-effectiveness) are applied to the selection of treatments. It is therefore unsurprising that nearly all international examples of comprehensive 'positive list' benefit packages have broadly defined the scope of the package but leave most decisions about when and to whom to provide the treatment to local clinical decision-making. Reimbursement is based on clinically assessed medical necessity, possibly with some types of care requiring pre-authorisation.

The weaknesses of the prioritised list as a cost containment strategy can be illustrated by the Oregon experience. First, the list in the Oregon Health Plan did not control expenditure on treatments that were above the line, and few of the most expensive treatments fell below it. All diagnostic services were covered, even for conditions for which the treatment itself was not covered. The initial thinking was that costs would be held back by introducing the list alongside managed care. But even with 85 per cent of people in managed care, costs grew rapidly. Second, to make any substantial savings, Oregon had to drop hundreds of condition-treatment pairs from the plan, including treatable cancers and other serious conditions. Such decisions were medically and morally difficult to take in full public view (Dixon and Welch, 1991). Furthermore, what remained covered by the plan after dropping so many conditions would not have made sense from a health care perspective. According to Jonathan Oberlander, a political scientist from the University of North Carolina at Chapel Hill who has followed the Oregon experiment closely, the intentions behind the plan were good and noble but the notion that health care costs could be controlled line by line was foolish (Oberlander, 2007; Alakeson, 2008).

Furthermore, unless the criteria for ranking treatments were chosen with great care, perverse choices might result. As the experience with NICE and in Oregon has indicated, reliance on cost-effectiveness as a sole criterion for choosing the benefits package is unlikely to be adequate. But this begs the question of what additional criteria, such as uncertainty, equity, other notions of fairness or wider social benefits, should be included, and how they should be integrated into evaluative methodology. In practice, therefore, creating a national benefits package to improve allocative efficiency and control costs, while remaining consistent and fair, presents a formidable series of challenges.



## Would a benefits package improve equity of service provision in the NHS?

Promotion of equitable access to care for the population is a fundamental rationale for national intervention in locally delivered public services. The NHS is funded by national taxation, so citizens reasonably expect some uniformity in the health services made available. Another strong argument for setting the NHS benefits package at a national level would therefore be to combat unexplained or unjustified variation in what the NHS provides. In other words, one could use a national benefits package to reduce the postcode lottery.

The ability to reduce variation in the benefits package commissioned locally would depend on two things: first, being able to draw up a sufficiently detailed package to restrict local room for manoeuvre (say, including extensive appropriateness criteria); and second, being able to enforce such appropriateness criteria from the national level. This would mean setting the package in much the same way as Chile established its Plan AUGE, rather than leaving local decision-makers to interpret a general plan, as in Germany, or giving regions some flexibility to alter the package, as in Italy and Spain. In this sense, a national benefits package could be a powerful mechanism for improving equity of access to care within a devolved commissioning environment.

There are, however, other challenges to be overcome. First, drawing up sufficient appropriateness criteria to restrict local variation would be very challenging, even if the example set by NICE shows that it can be done in some areas. When it comes to tightly enforced appropriateness criteria, Chile represents the exception rather than the rule, and has the advantage of having to consider a very limited range of services. In many of the countries that have set a national benefits package, it is standard practice to leave judgements about a service's appropriateness to the local doctor (see the section 'Level of detail' in Chapter 3). In practical terms, it is likely that the most that can be hoped for is specification of appropriateness criteria for a limited number of treatments for which evidence about effectiveness for different patient groups is reasonably secure. Likewise, the costs of monitoring compliance and enforcing the package may be substantial.

Second, with detailed specification of patient entitlements, there may be little scope for the discretion needed to adhere to local budgets. Local commissioning may become little more than passive reimbursement of national entitlements, and the incentive for commissioners to seek out innovative ways of working within fixed budgets may be lost (McMahon and others, 2006, p. 346). In short, expenditure control may be compromised, even if equity of access is safeguarded.

## Implications for accountability and transparency

A third argument for setting a national benefits package is that it would promote transparency and accountability. The idea is that it would set out explicitly both the services to which citizens were entitled, and the process by which the associated decisions were reached, taking the principles underlying the NHS Constitution to their logical conclusion. A nationally defined benefits package would make rationing – that is, the failure to offer care, or the denial of care, from which patients could benefit (Maynard, 1999) – explicit, rather than leaving it to occur implicitly.

Making explicit the extent of the NHS benefits package could have a number of advantages. First, members of the public would be able to hold decision-makers to account at all levels of the system for the services they provide. It can be argued that such explicitness would create a steady improvement in decision-making processes (Maynard, 1998). Second, by creating a single benefits package at the national level, it would be clear where accountability for the limits of the package lay. Front-line providers would be given clear guidance on what services could or could not be provided, and absolved from blame for any denial of treatment. In particular, general practitioners would not be put in the potentially difficult position of being both a rationer of care and a patient's advocate. Third, transparency would give greater certainty to citizens on the limits of the NHS basket of services. It could thereby facilitate a market in complementary private health insurance to cover the gaps by allowing patients to see where they needed to 'top up' their care and where the NHS would provide for them, as is common in countries such as France and Ireland to cover gaps in financial coverage.

However, national and international experience shows that explicitness comes with certain disadvantages, over and above the costs of making the package explicit in the first place. First, there is some evidence that the creation of a national benefits package does not necessarily increase the public knowledge of entitlements, even if it is widely advertised. For example, even though Chile's Plan AUGE is entirely explicit about the rights that citizens have to certain health care services, this entitlement does not appear to be as widely known to the public as was intended (World Bank, 2008). One of the most heavily discussed aspects of Plan AUGE was the ability of health care users to claim their rights and take action if health care providers fail to comply with the guarantees. However, evidence collected by the regulatory body, the Health Superintendency (*Superintendencia de Salud*), shows that a significant percentage of the population is still not aware of the guarantees included in the AUGE. Only 48 per cent of respondents were aware of at least one of the explicit guarantees, and 29 per cent knew of the existence of all four guarantees (World Bank, 2008, p. 8).

Equally, there is some doubt about how transparent one can be about a health service package. For example, even in the case of New Zealand's explicit priority scoring system, commentators have been quick to point out that much of the system remains based on implicit decisions. As Dew and others (2005) explain, given the continued role of clinical judgement in priority assessment, implicit rather than explicit rationing is still a strong factor in accessing elective surgery in New Zealand, and likely to remain so for many specialties.

Second, greater transparency could lead to an unjust distortion of the benefits package. By making the boundaries of the NHS' benefits package plain for all to see, politicians may come under pressure from powerful interest groups to depart from systematic rules for setting the package and make unwarranted changes to the present package or to restore services that have been dropped. In England, the existence of NICE has helped to reduce that pressure, or at least act as a buffer between politicians and interest groups. By way of illustration, politicians in Israel have been subject to immense pressure to adjust the scope of the benefits package, as set out in Box 4.1 opposite.

#### Box 4.1: The experience of allowing statutory health insurers in Israel to determine their own package of care

Chinitz and others (1998) describe the experience in Israel in 1998 when the government put forward a proposal to allow statutory health insurers to determine flexibly their own service basket, subject to regulation by the Minister of Health. Almost as soon as this Bill was published, it became the focus of intense public debate and activity on the part of consumer groups, specific disease groups, and human rights organisations. Delegations of patients seeking coverage of drugs not included in the basic basket were received by President Ezer Weizman and, in a nationally televised event, Tal Levi, a young girl with cancer, pleaded to receive drugs not currently covered. Furthermore, when a drug for the treatment of Alzheimer's disease, which had been sought by families of patients with the disease, was not included, the protests of the families were well covered in the news.

Third, the solidarity principle underlying the NHS relies on the willingness of higher-earning, young and healthy people to cross-subsidise low-earning, older and sicker people, through their tax contributions. Creation of an explicit benefits package might start to make the magnitude of such transfers explicit and contentious. Whether that would compromise solidarity in relation to the NHS is an open question. However, such uncertainty suggests a need for significant caution in pressing for greater levels of transparency concerning the NHS package.

Finally, one consequence of transparency is that it might encourage the development of a market in private health insurance that covered some treatments or user charges not covered by the package. The longer-term impact that the widespread use of private health insurance in England would have on the traditional NHS solidarity principle needs to be carefully considered. To what extent would it be considered acceptable for those who were able to pay for private insurance to secure access to a broader benefits package than the rest of the population, and would it compromise the widespread support for the NHS necessary to secure its continued funding from national taxation?

#### Summary

The arguments for creating an explicit NHS benefits package are that it could:

- improve allocative efficiency
- help constrain expenditure
- increase equity
- strengthen transparency and accountability of services funded by the NHS.

However, there are many reasons for believing that advantages of explicitly setting a package may not be realised, and that it may also give rise to a number of adverse consequences. In particular, a national benefits package might:

- prove technically challenging to develop and enforce
- limit necessary local autonomy of commissioners in adhering to budgets
- limit necessary local autonomy of providers in adapting to variations in patients' needs

- be vulnerable to arbitrary departures from consistent decision-making, in the face of lobbying and other political pressures
- compromise the solidarity principle on which the NHS relies.

Table 4.1, opposite, presents a summary of the arguments for and against a nationally determined benefits package against each of the three main criteria of efficiency, equity and transparency. It can be seen that in relation to these core issues, the idea of instituting a national benefits package may in practice lead to inefficiencies and implementation difficulties. Therefore, in the next chapter we discuss whether there are alternative mechanisms that might help to achieve the objectives of a national benefits package while mitigating some of the adverse consequences.

**Table 4.1: Arguments for and against a nationally determined benefits package**

	Arguments for	Arguments against
<b>Implications for containing costs and improving efficiency</b>	<ul style="list-style-type: none"> <li>• Would improve commissioning of cost-effective treatments and decommissioning of treatments that are not cost-effective</li> <li>• Would reduce duplication by vesting decision-making powers in a single, national body (for example NHS Commissioning Board)</li> </ul>	<ul style="list-style-type: none"> <li>• Difficulties in drawing up an explicit account of the benefits package when the package itself is fairly large</li> <li>• Challenges and costs in assessing each treatment and service on the basis of cost-effectiveness, and to updating as new technologies of evidence emerge</li> <li>• Assessing cost-effectiveness in some areas may prove impossible</li> <li>• Complexity involved in setting a ‘cut-off’ point for inclusion in the package if multiple criteria (beyond cost-effectiveness) are applied</li> <li>• Question of which criteria, beyond cost-effectiveness, need to be included and how they should be balanced against one another</li> </ul>
<b>Implications for equity in service provision</b>	<ul style="list-style-type: none"> <li>• Would set the NHS benefits package at a national level in order to combat unexplained or unjustified variation</li> </ul>	<ul style="list-style-type: none"> <li>• Drawing up sufficient appropriateness criteria to restrict local variation would be very challenging</li> <li>• Would restrict the scope of local bodies to adhere to local budgets – expenditure control may be compromised</li> </ul>
<b>Implications for accountability and transparency</b>	<ul style="list-style-type: none"> <li>• Would enable the public to hold decision-makers to account for the services they provide</li> <li>• Would give greater certainty to the public as to the limits of the NHS benefits package</li> <li>• Would help to facilitate the private, complementary health insurance market to cover gaps in care</li> </ul>	<ul style="list-style-type: none"> <li>• Evidence that explicitly stating what a health service’s benefits package contains does not substantially improve public knowledge of entitlements</li> <li>• Doubts around how transparent one could be about entitlements – especially around appropriateness criteria</li> <li>• Possibility of transparency leading to an unjust distortion of treatments and services available</li> <li>• Threat to solidarity by making transfer of resources from higher-earning, younger healthy people to low-earning, older, sicker people explicit; and by facilitating a private, complementary insurance market</li> </ul>

## 5. Alternative policy options

Given the difficulties set out in the preceding chapters, we conclude that the creation of an explicit national benefits package is not a policy that can be recommended. However, the motivation for examining this policy option remains pressing: the need to extract maximum benefit from a limited NHS budget while preserving equity and accountability, particularly in the current austere financial climate.

In this chapter we examine alternative options for improving the way the benefits package provided by the NHS is arrived at in England in the context of the reform programme proposed by the Coalition Government. We have split these options into the level at which they might be applied: nationally, locally and at the level of citizens, patients and carers.

In carrying out this analysis, it is assumed that policy-makers wish systematically to pursue their objectives for health services subject to a national budget constraint. As noted in Chapter 1, it is impossible to develop policies or clinical guidance without a clear statement of what those objectives might be. The work of NICE is based on the principle of maximising cost-effectiveness, subject to additional considerations such as equity and uncertainty, and we assume that similar objectives would inform the potential initiatives described below. In each section, policies are identified that might help to promote such objectives, while maintaining local flexibility to manage uncertainty, respond to local circumstances and adhere to local budgets.

### National-level reforms

As currently envisaged, the NHS Commissioning Board will play a central role in shaping the behaviour of local commissioners and, in turn, providers. It will be essential that the Board has a clear framework setting out the strategic principles and objectives for commissioning. There are a number of functions related to priority setting, resource allocation and commissioning that are best undertaken at a national level, either by the Board or an 'arm's-length' agency, to promote consistency of policy and avoid unnecessary duplication of effort at the local level.

#### Establishing national principles and rationalising existing legislation

Although developing and implementing a comprehensive 'positive list' of benefits may not be feasible or desirable, there is a strong case for defining more explicitly how public money will be spent in the NHS. To this end, one option is to establish a set of national principles that would provide local decision-makers with the broad parameters within which commissioning decisions should be made. To improve transparency and accountability, these principles could be published openly, perhaps in the NHS Constitution.

While a set of principles would not constrain local commissioning to the same extent as a nationally defined benefits package, it would give local decision-makers clear direction as to how they should use their local flexibilities, and inform local priority setting. It would, for example, signal to local commissioners and the public a clear commitment to greater effectiveness, equity and efficiency, as well as transparency and accountability. It would also empower regulators, local authorities and citizens in challenging purchasing decisions made at a local level, for example by clinical commissioning groups that appear to invest in treatments of low value or lacking a strong evidence base.

For this to be feasible, the Secretary of State for Health would in turn have to give the NHS Commissioning Board very clear strategic terms of reference, perhaps in the 'NHS mandate' proposed in the Health and Social Care Bill 2011. As explained in Chapter 2, the NHS benefits package is currently shaped by laws, regulations, guidelines and government directives. These are, however, diffuse in nature and generally opaque to the public. It may be possible to take advantage of the proposed NHS reforms and use mechanisms such as the NHS Commissioning Board's terms of reference to guide the gradual rationalisation of existing legislation and regulations into a more coherent package of principles to inform priority-setting and funding decisions. In the future, the NHS Constitution could be used to explain the force and relevance of the legal framework to the wider population, improving public awareness of their entitlements and setting out limits of what the NHS can offer.

#### The information role of the NHS Commissioning Board, NICE and the Care Quality Commission

The NHS Commissioning Board has commissioned NICE to develop quality standards (with associated indicators), some of which will inform a new national Commissioning Outcomes Framework for the NHS. This is intended to form the national framework for commissioning, against which the performance of clinical commissioning groups will be assessed, and accountability to patients and the public demonstrated (NICE website, 2012). The Board will have a crucial role in coordinating the work of NICE, NHS Evidence, the Care Quality Commission, Monitor and other regulators in bringing together the necessary evidence and standards into a framework for commissioning that can assure delivery of the proposed new NHS Commissioning Outcomes Framework.

NICE should continue to develop integrated guidance on cost-effective practice in the management of conditions, including the specification of 'do not do' procedures or procedures of low value, encouraging decommissioning of low-value services and developing appropriateness criteria for treatments. A key issue would be how binding to make the guidance from NICE. Determining the degree of local clinical flexibility within an overall commissioning framework will be complex and challenging, and there are likely to be 'test cases' along the way, where the balance of national consistency and local flexibility will be defined and refined.

The NHS Commissioning Board could also have a central role in determining where new evidence is required to improve efficiency in the NHS (Smith and Dixon, 2012). For example, the Board might ask NICE to identify evidence gaps relating to established services and processes of care. Addressing these gaps would require NICE to work closely with the National Institute for Health Research and universities to develop a research agenda that addresses national information priorities for commissioning. Over time, new evidence could be used by the NHS Commissioning Board and NICE to issue guidance to local clinical commissioners about how to channel public investment towards more efficient care.

There is some evidence to show that reporting of performance can be powerful in driving improvement in health care systems. For example, Lindenauer and others (2007) show that reporting to the public can be as effective an incentive as financial rewards in convincing providers to improve their clinical performance. In order to align local commissioning decisions more closely with evidence-based and best-practice care and to reduce unexplained variation across the country, it will be important for commissioners

to have access to accurate information about their (and their providers') performance relative to others. The NHS Commissioning Board should provide commissioners and the public with comparable information about the use of procedures or drugs, where necessary adjusted for relevant population characteristics. The Care Quality Commission should align its performance monitoring and reporting with NICE guidance.

Information of particular relevance to the shaping of the benefits package would be:

- performance metrics such as the rate of referrals for certain treatments in different areas of the country
- the exceptional purchase by commissioners of low-value treatments
- adherence by commissioners and providers to best-practice guidelines
- the use of appropriate low-price drugs
- health gain secured
- relevant indicators of health inequalities.

This information would allow commissioners and local service users to see how the local benefits package compared to the range of services delivered in other localities and nationally, and would also assist patient choice of provider.

#### Provider payment mechanisms

The structure and level of payment tariffs have a profound influence on commissioner and provider behaviour, and by implication play a role in shaping the benefits package. The tariff for health care should, as far as possible, encourage the provision of a cost-effective benefits package that is affordable within the available budget. Where evidence of best practice is available, the level of the tariff (set by Monitor) and rules about how the tariff works, including when non-payment applies (set by the NHS Commissioning Board), could influence which treatments are provided and in what circumstances. For example, if a provider continued to undertake procedures from the 'do not do' list specified by NICE and included in the Commissioning Outcomes Framework, payment could be withheld by commissioners. Similarly, failure to take account of appropriateness criteria that led to a treatment being provided to an individual for whom it was not indicated could also result in payment being reduced or withheld, or payment could be made conditional on an exception reporting process.

Best-practice tariffs could also be used to encourage the provision of cost-effective treatments. At present, the health service is expanding best-practice tariffs into areas such as adult renal dialysis, interventional radiology, and primary total hip and knee replacements (DH, 2011f). However, such tariffs could be expanded yet further, making receipt of a full tariff conditional on adherence to clear quality standards across a care pathway. Another possibility would be to use Patient Reported Outcome Measures to require a certain average health gain secured by providers – this could be built into the Commissioning Outcomes Framework. This would introduce an element of 'pay for performance' that could improve quality of care and (if properly designed) reduce treatment of patients with low capacity to benefit. The NHS Commissioning Board might also examine developments in Germany where a lower tariff is paid for care in providers providing low volumes of care and where lower volume is associated with worse clinical outcomes (Busse and others, 2011, Chapter 14).



The impact of the tariffs on commissioners, who are liable for their payment, should also be considered. For example, if lower tariffs were paid for low-quality care, commissioners (especially where they are general practitioners) may have a perverse incentive to refer patients to low-quality providers. This illustrates the need for a very clear performance-reporting infrastructure for commissioners, so that they can be held to account for such behaviour. To neutralise the financial benefits of commissioning low-quality care, there may be a case for imposing financial penalties on commissioners, for example by not allowing them to retain the savings generated by paying less than the full tariff.

### Local-level reforms

The current proposed NHS reforms imply considerable delegation of responsibility to local organisations, in particular general practitioner commissioners (in clinical commissioning groups) and the expanded number of NHS foundation trusts. It will be essential that local decision-making is transparent, and that local accountability arrangements, particularly for new clinical commissioners, are structured so that the priority-setting and spending decisions of local organisations can be properly scrutinised. This might entail formal local consultation processes for significant departures from national guidelines or restrictions to access.

#### The role of commissioners

The decisions of local commissioners – clinical commissioning groups – will in future play a critical role in shaping the NHS benefits package, much as PCT decisions currently do. They need to develop the capacity to understand evidence, to interpret national guidance appropriately and to exercise local discretion when appropriate. Priority setting will become a central preoccupation of clinical commissioning groups, and they will need rapidly to assemble skills to fulfil that role. It is likely that there will be many priority-setting issues that are common to many clinical commissioning groups, and which can therefore be most effectively addressed through collective arrangements to assemble, analyse and disseminate relevant evidence.

#### The role of providers

Even in the absence of an explicit benefits package, it will be important to encourage local clinicians to provide evidence-based and best-practice care through a variety of alternative mechanisms. In general, the ‘rigidity’ of clinical guidance should depend on the degree of certainty in the evidence. At one extreme, quality guidelines might be mandatory if unequivocal evidence links good outcomes for most patients to certain clinical actions. At the other extreme, where evidence is lacking, or there is great heterogeneity among patients, guidelines might be merely advisory. Several intermediate approaches can be envisaged for some treatments, such as the requirement to report an ‘exception’ for departure from the default treatment, or the requirement to secure prior consent from the commissioner to provide some treatments.

As an example of ‘nudging’ clinicians towards preferred treatments, clinical prompts and other kinds of decision supports can be highly effective at translating evidence about best practice into day-to-day clinical decisions (Bates and others, 2001; Thursky and others, 2006; Menachemi and others, 2007; Zaidi and others, 2008). Huge strides have been made in the NHS in the quality of prescribing using these tools. According to a study by Kawamoto and others (2005), the effectiveness of these prompts can be further enhanced if they are well designed and automated. They claim that, ‘as a general principle, our findings suggest that an effective clinical decision support system must minimise the

effort required by clinicians to receive and act on system recommendations' (p. 7). This is another area where NICE quality standards will be invaluable to the shaping of the Commissioning Outcomes Framework and the wider application of the Framework in the reformed NHS. The ability to turn quality standards into effective prompts may be critical to shaping provider behaviour.

Public reporting of provider performance is increasingly prevalent, and when well designed can promote desired improvements in provider and practitioner behaviour (Hibbard and others, 2005). Increasing demands for transparency and accountability are driving more widespread use of such schemes, and they are likely to become important in areas such as adherence to guidelines. However, they will have to be designed thoughtfully in order to avoid some of the unintended consequences that can arise from any performance-reporting scheme.

Financial incentives are also likely to play a role in encouraging preferred behaviour among organisations and individual practitioners. Although the evidence is disputed, many commentators have argued that the implementation of the Quality and Outcomes Framework in use in general practice offers an indication of what can be achieved even in a complex primary care setting (Roland, 2007; Gillam and Siriwardena, 2010; Peckham and Wallace, 2010; Doran and others, 2011). This suggests that there is scope for careful experimentation with pay-for-performance schemes in many other NHS settings to encourage adherence to the preferred treatment pathways. However, the design of such schemes is complex, and the effectiveness of pay-for-performance continues to be studied, so evaluations of such experiments will provide important insights.

### Citizens, patients and carers

'Supply-side' decisions (those made by NHS bodies) have historically been more influential in shaping the NHS benefits package than 'demand-side' decisions (those made by patients and carers) (Thomson and others, 2010). However, there are ways in which the NHS could involve patients and carers in helping to align the benefits package more closely with effective practice. It is important to note though that, as NHS patients, citizens are likely to be interested in effectiveness more than cost-effectiveness, as they do not bear directly the costs of the treatment they receive. It is mainly their role as taxpayers that prompts an interest in cost-effectiveness.

There is scope for greater clarity about what patients and the public can expect from the NHS benefits package. NICE already develops versions of its guidance for patients and the public, outlining the treatment and care they should expect to receive for a particular condition. This guidance is available via the NICE<sup>2</sup> and NHS Choices<sup>3</sup> websites. For example, the guide relating to the treatment of depression in adults specifies that adults with moderate or severe depression should be offered both an antidepressant and a psychological treatment, either cognitive behavioural therapy or interpersonal therapy. The availability of clear information for patients on best-practice treatment can be a tool with which to hold providers to account – more active marketing of this kind of information to individuals could create demand-side pressure for more evidence-based care.

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2. [www.nice.org.uk/](http://www.nice.org.uk/)

3. [www.nhs.uk/Pages/HomePage.aspx](http://www.nhs.uk/Pages/HomePage.aspx)

Financial incentives in the form of modest co-payments are used by the health systems of many countries, both to provide additional income to the health system and to try to influence patients' patterns of behaviour. Because of the strong underpinning principle of access to NHS care on the basis of need, not of the ability to pay, the NHS has made little use of co-payments, and even where it does – for example for prescription charges in England – about 90 per cent of those in receipt of prescriptions enjoy exemption. Experience in countries such as France, Germany and Sweden shows that imposition of user fees is feasible and can have some impact, but mainly as a way of managing demand for care rather than as a significant source of health system finance.

A reduction in co-payments (or positive financial incentives) can be used to reward desirable behaviour or encourage the use of particular kinds of care. For example, there are exemptions in France for certain charges relating to chronic disease care in order to encourage patients to seek early intervention and effective management (Thomson and others, 2010). In New Zealand, there has been a policy focus on reducing co-payments for general practice, as part of a wider drive to reduce health inequalities and avoid those with high levels of need missing out on vital preventative and treatment services within primary care (Cumming and Mays, 2011).

Notwithstanding the practice adopted in many countries, in the form of co-payments for services such as general practice visits, hospital hotel services or urgent care centres, the practicality of extending user charges in the NHS beyond the current levels is highly questionable, given their political sensitivity. It is unlikely that any government would be eager to promote such a policy, although it may be the case that some future government will find it necessary to consider modest user charges as a mechanism for guiding patients towards preferred use of the health service. This might take the form of retaining free access for mandated, cost-effective care, but imposing a user charge if a patient prefers a more costly treatment or drug. Such incremental 'top-up' charges are widely used in countries with systems of reference prices for pharmaceuticals (Kanavos and Reinhardt, 2003).

Alternative approaches to the demand side may involve 'nudges' towards preferred use of NHS services. These might arise from the provision of clear information about the relative merits of alternative treatments, and designing services to make it easy for patients to follow particular care pathways, particularly for complex or long-term care. Preferred combinations of services could then be packaged together. While patients might remain free to request alternative care pathways, the default choice would be the one that performs best according to criteria such as cost-effectiveness.

Finally, the move towards 'personalised' medicine suggests that, in the future, patients with some conditions may demand bespoke treatment, designed in the light of their circumstances and preferences. This does not necessarily compromise the principle of seeking to constrain NHS provision to cost-effective treatments. However, it does multiply the complexity of the task, and reinforces the need to offer patients clear guidance on the range of treatments that the NHS is able to make available.

The ultimate devolution of commissioning care takes the form of 'personal budgets' given to patients with certain long-term care needs. The budget can be used to purchase care in line with the patient's own preferences, with the intended consequence of substantial variations in care packages. In this case, the 'benefits package' does not pre-judge the care received, but instead offers the patient an entitlement in the form of the personalised budget rather than any specific treatment.

## Summary

The explicit specification of a national benefits package cannot be recommended. However, as resources are limited, there remains a pressing need to encourage provision of health care in line with agreed national criteria, if those resources are to be used to best effect. We have suggested mechanisms for securing better use of NHS resources, at a national, local, and an individual level. The recommendations flowing from this analysis are given in the concluding section.

## 6. Conclusion

The idea of setting out explicitly the entitlements of patients, in the form of a nationally specified NHS benefits package, may seem initially to be attractive. This report has examined the merits of such a move according to its likely impact in three key areas: containing costs and improving efficiency; equity; and accountability and transparency. We have argued that for a number of reasons the development of a detailed national benefits package for the NHS is likely to be infeasible, and implementing it may lead to adverse outcomes.



This report recommends against the introduction of an explicit national benefits package. However, such a conclusion does not change the motivation for this study: the need to extract maximum benefit from a limited NHS budget while preserving equity and accountability, particularly in an austere financial climate. The report therefore makes a number of recommendations for changes that could be made to improve the way the NHS benefits package is shaped, without going as far as specifying a national set of NHS-funded services. The recommendations are as follows:



1. **A set of principles should be established that can shape how public money is spent in the NHS** and, conversely, inform decisions about what will no longer be paid for. These principles could be enshrined in the NHS Constitution and restated in the annual Secretary of State for Health's mandate to the NHS Commissioning Board (and in turn to the new clinical commissioning groups), reminding NHS commissioners of what should underpin their decision-making about resources and services. The principles are likely to be based on existing NHS criteria such as clinical effectiveness, cost-effectiveness and equity.
2. Acting on the mandate set by the Secretary of State, **the NHS Commissioning Board should perform a crucial role in setting the scope of funding and service provision in the reformed NHS, and working with the National Institute for Health and Clinical Excellence (NICE) to determine a Commissioning Outcomes Framework** that will guide the activities of local commissioners, against which they will be held to account. The NHS Commissioning Board should commission core standards for NHS care from NICE – these must incorporate information about cost-effectiveness, best evidence-based clinical practice, and advice on efficient service provision.
3. **The NHS Commissioning Board should use NICE guidance for producing, as a starting point, a national list of the treatments that public money should not be spent on in the NHS**, unless there are exceptional circumstances. Local clinical commissioning groups should be required to report publicly on their progress in following this 'do not do' advice, explaining any exceptions where such procedures are funded. More generally, clinical commissioning groups should be expected to report on departures from national guidance.

4. **The standards developed by NICE and set out in the Commissioning Outcomes Framework should be aligned with the structure and level of the NHS tariff.** Hospitals and other providers would therefore be paid by commissioners in a way that upholds an NHS benefits package that is affordable, clinically effective and cost-effective.
5. **Wherever possible, providers and clinicians should be ‘nudged’ towards clinical and cost-effective care** through: public exception reporting of services that are funded outside of Commissioning Outcomes Framework standards; the use of information technology-based clinical prompts for general practitioners and specialists at the point of diagnosis and treatment; and other information technology solutions such as monitoring adherence to guidelines.
6. **The NHS Commissioning Board should provide the public with information about the relative performance of local commissioners against selected outcome indicators** from those set out in the NHS Constitution and the Commissioning Outcomes Framework. In this way, the NHS Commissioning Board will help to inform the public about what is in the *de facto* NHS benefits package and what they should expect from their local NHS, and encourage stronger local challenge and accountability in respect of funding decisions and how these decisions are made.
7. **Decision-making in clinical commissioning groups should be made transparent, so that departures from certain national guidelines, and from NHS commissioning principles, are subject to proper scrutiny before they are finalised.** Relevant information should be made available to local authorities, the media and citizens, and mechanisms put in place to permit representations to be heard.
8. **Patients should be ‘nudged’ towards preferred use of NHS services**, through the provision of clear information and making it easy for patients to make the ‘right’ choices. We consider it unlikely that policy-makers will seek to apply additional user charges in the NHS in the foreseeable future.



# Appendix: Level of regulation of the benefits package


Adapted from *HealthBASKET: Synthesis report* (Busse and others, 2006)

	Document(s) and purpose	General	Specified inclusions
<b>Denmark</b> 	<b>Hospital Act</b> Regulation of hospitals	Hospital care	
	<b>Public Health Insurance Act</b> Entitlement to services of Primary care	Primary care and prevention	
	<b>Medicines Act</b> Regulation of access to pharmaceuticals	Pharmaceuticals	
	<b>Social Services Act</b> Regulation of rehabilitation and other services	Rehabilitation and other services	
<b>France</b> 	<b>SSC. Art. L.321-1</b> Definition of entitlements	Hospital care	Health care at private and public institutions Rehabilitation at private and public institutions Physiotherapy at private and public institutions
		Outpatient care	General practitioners Specialists Dentists Midwives
		Diagnostic services and care prescribed by physicians	Laboratories Speech therapy Nursing Physiotherapy
		Drugs, medical appliances and durables	Included in positive list
		Health care and related transport	

	Document(s) and purpose	General	Specified inclusions
<b>Germany</b> 	<b>SGB V</b> Definition of entitlements for insurees in the statutory health insurance	Prevention of disease and its worsening	Primary prevention Dental prevention Mother-child/Father-child Spa Disability prevention Contraception Abortion <ul style="list-style-type: none"> <li>• Anaesthetics</li> <li>• Surgical or medical intervention</li> <li>• Vaginal intervention, incl. drug injection</li> <li>• Delivery of labour inducing drugs</li> </ul>
		Screening	Health check-up <ul style="list-style-type: none"> <li>• Hypertension screening</li> <li>• Hypercholesterolemia screening</li> <li>• Diabetes screening</li> <li>• Cancer screening</li> </ul> Children screening <ul style="list-style-type: none"> <li>• Health and development assessment</li> </ul>
		Treatment of disease	Treatment <ul style="list-style-type: none"> <li>• In- and outpatient, incl. drugs, devices and medical products</li> <li>• Rehabilitation</li> </ul> In vitro fertilisation Medical and dental treatment Maxillofacial treatment Drugs and medical products Medical aids 'Soziotherapie' Rehabilitation
<b>Hungary</b> 	<b>Act LXXXIII 1997</b> <b>Services of Compulsory Health Insurance</b> Definition of entitlements	Services for prevention and early detection	
		Curative services	Family doctor services Dental care Outpatient specialist service Inpatient care
		Other services	Deliveries Infertility treatment Medical rehabilitation Patient transportation Emergency ambulance services



	Document(s) and purpose	General	Specified inclusions
<b>Italy</b> 	<b>DCPM 29 2001</b> Definition of national standards of care (Levels of Essential Care, LEAs)	Public and occupational health care services	Hygiene and public health <ul style="list-style-type: none"> <li>• 25 services divided in 3 groups</li> </ul> Food control and hygiene surveillance <ul style="list-style-type: none"> <li>• 8 services</li> </ul> Occupational security and prevention <ul style="list-style-type: none"> <li>• 14 services</li> </ul> Public health and veterinary services <ul style="list-style-type: none"> <li>• 31 services in 3 groups</li> </ul> Individual prevention care <ul style="list-style-type: none"> <li>• 3 services</li> </ul>
		Community care services	Primary care services Territory emergency services Pharmaceutical services Integrative care Specialist outpatient services Prosthesis care Ambulatory home care Residential and semi-residential care Thermal (spa) care
		Hospital care services	<ul style="list-style-type: none"> <li>• 7 groups</li> </ul>
<b>Netherlands</b> 	<b>ZFW</b> Entitlements to health insurance	General practitioner care	
		Paramedical care	
		Obstetric care	
		Maternity care	
		Pharmaceutical care	
		Medical devices	
		Dental care	
		Specialist medical care	Hospital inpatient Hospital outpatient Other
		Audiological assistance	
Outpatient haemodialysis			

	Document(s) and purpose	General	Specified inclusions
Netherlands Continued		Rehabilitative care	Genetic testing Thrombosis prevention Chronic intermittent ventilation
		Transportation	
	AWBZ Entitlements to health insurance in exceptional circumstances	Prevention services	Antenatal care Tests in connection with congenital metabolic dysfunction
		Long-term medical treatment, nursing or personal home care	
Poland 	Constitution of the Republic of Poland Definition of citizens' rights	Health protection	
		Health care services	Special services for pregnant women, children, disabled and elderly people
		Prevention of epidemic diseases and environment degradation	
	Health Insurance Law Definition of services funded from public money	Diagnostic tests	Laboratory tests
		Protection of health, prevention of disease and injury screening	Vaccinations
		Primary health care	
		Specialist outpatient	
		Medical rehabilitation	
		Dentistry services	
		Hospital treatment	
		Highly specialised services	
		Psychology	Examination and treatment
		Logopedy	Examination and treatment
		Nursing care	Hospices and palliative care
Antenatal care and newborn care	Newborn health and development assessment		
Care during breastfeeding period			

	Document(s) and purpose	General	Specified inclusions
<b>Poland</b> Continued		Healthy child care	Health and development assessment
		Spa	
		Medical products and aids	
		Medical transport	
		Emergency care	
<b>Spain</b> 	<b>RD 63/1995/ Law 16/2003</b> Organisation of the health services provided by NHS  Definition of minimum benefits to be provided by all autonomous communities	Public health services	Epidemiological information and surveillance Health protection Health promotion Diseases and disability prevention Surveillance and control of risks from imported goods Environment health promotion and protection Occupational health promotion and protection Food security promotion On demand outpatient services (elective and urgent), office-based and home-based
		Primary care services	Indication, prescription and delivery of diagnostic and therapeutic interventions Prevention, health promotion, family health and community health interventions Information and surveillance Outpatient rehabilitation Specific services for women, children, adolescent, elderly, special risk groups and chronically ill Palliative care for the terminally ill Mental health care Dental health care Outpatient specialised health care
		Specialised care	Specialised ambulatory care in day-hospitals Specialised inpatient care <ul style="list-style-type: none"> <li>• Medical, surgical, obstetric and paediatric</li> </ul>

	Document(s) and purpose	General	Specified inclusions
Spain Continued			<ul style="list-style-type: none"> <li>Coordination with outpatient care and home hospital</li> <li>Indication, prescription and delivery of diagnostic and therapeutic interventions</li> <li>Organ, tissue and cell transplantation</li> <li>Palliative care for the terminally ill</li> <li>Mental health care</li> <li>Rehabilitation</li> <li>Long-term health care</li> </ul>
		Socio-sanitary care	<ul style="list-style-type: none"> <li>Convalescence care</li> <li>Rehabilitation</li> </ul>
		Pharmaceuticals	<ul style="list-style-type: none"> <li>Convalescence care</li> <li>Rehabilitation</li> </ul>
		Health care information and documentation	
UK 	NHS Acts 1946 and 1977 Definition of the general duties of the NHS ('comprehensive health services')	Hospital accommodation	<ul style="list-style-type: none"> <li>Medical services</li> <li>Nursing services</li> <li>Specialist services</li> <li>Other services</li> <li>High-security psychiatric services</li> </ul>
		Family planning services	
		Dental inspections of school pupils	
		Primary care	<ul style="list-style-type: none"> <li>General medical services</li> <li>General dental services</li> <li>Pharmaceutical services</li> <li>Ophthalmic services</li> <li>Other specialist outpatient services</li> <li>Mother and children care</li> <li>Home nursing</li> <li>Vaccinations and immunisations</li> <li>Ambulance services</li> </ul>
		Aftercare of persons who have suffered from illness	

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## Peter C. Smith

Peter is Professor of Health Policy, and is co-Director of the Centre for Health Policy in the Institute of Global Health Innovation, at Imperial College London. He has worked and published in a number of disciplinary settings, including statistics, operational research and accountancy. His main work has been in the economics of health and the broader public services, most recently as the Director of the Centre for Health Economics at the University of York.

Peter has acted in numerous governmental advisory capacities, has been a board member of the Audit Commission, and is currently a member of the NHS Co-operation and Competition Panel. He has also advised many overseas governments and international agencies, including the World Health Organization, the International Monetary Fund, the World Bank, the European Commission, and the Organisation for Economic Cooperation and Development. He has published over 100 peer-reviewed journal papers and ten books.

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ISBN: 978-1-905030-53-8