



patient power

reform
scotland

patient power

Ben Thomson
Geoff Maudsley

April 2009

Reform Scotland is a charity registered in Scotland (No SCO39624) and is also a company limited by guarantee (No SC336414) with its Registered Office at The Executive Centre, 7-9 North St David Street, Edinburgh, EH2 1AW.

About Reform Scotland

Reform Scotland is an independent, non-party think tank that aims to set out a better way to deliver increased economic prosperity and more effective public services based on the traditional Scottish principles of limited government, diversity and personal responsibility.

Geoff Mawdsley is the Director of Reform Scotland.

Reform Scotland's Advisory Board

- Ben Thomson (Chairman)
- Alex Hammond-Chambers
- Martin Gilbert
- Lesley Knox
- Dan Macdonald
- Professor Sir Donald MacKay
- David Milne
- Keith Skeoch

Reform Scotland's Trustees

- Ben Thomson (Chairman)
- James Aitken
- Isobel d'Inverno
- Andrew Haldenby
- Amanda Harvie
- Gregor Stewart
- John Thomson

Contents

i	Executive summary	1
1.	Health care in Scotland	7
1.1	The current Scottish health care system	7
1.2	Statistics	9
1.3	Conclusion	13
2.	Learning lessons from overseas	16
2.1	Denmark	16
2.2	The Netherlands	18
2.3	Sweden	21
2.4	NHS in England	23
3.	How health care in Scotland should be reformed	25
4.	Conclusion	30
5.	References	31

Executive summary

Objective

'Power for the Public', Reform Scotland's earlier report, looked at the lessons that Scotland's health care system could learn from other European countries such as Denmark and Switzerland. Based on our findings, we set out three broad principles of policy which should underpin the reform of public services in Scotland.

- Public services should be more directly accountable to the people and local communities they serve
- Operational decisions should be taken as close as possible to the people they affect
- There should be a more diverse range of service providers

This report builds on that research and assesses the state of the current health care system in Scotland, identifying both its strengths and weaknesses. It examines the health care systems in a number of other European countries and then sets out how the policy principles identified in the earlier report could be applied in Scotland in order to improve the health service for the benefit of all.

Findings

- The Health and Wellbeing budget accounts for a third of the total Scottish budget and has increased by 55% in real terms over the past decade. Spending in Scotland as a percentage of GDP is on a par with other European countries. Health spending per head in Scotland is slightly below the OECD average and is higher than the UK as a whole.¹
- Although there have been increases in life expectancy, some waiting times have been reduced significantly and mortality rates for major diseases have improved, Scotland compares poorly with other European countries, including England.

¹ OECD (2007) *Health at a Glance*

- Familiar problems associated with public sector monopolies persist. The reliance on central control and management of performance within the NHS in Scotland, through an array of centrally-imposed targets, has not delivered good value for money. For example, Audit Scotland finds that although the new General Medical Services contract has delivered some improvements in primary care, it has cost more than expected and has not led to the intended reallocation of resources towards poorer and more rural areas². The top-down approach tends to stifle innovation and gives patients little control over the care they receive. There is also evidence that centralised health care delivered by a public sector monopoly does not serve the interests of the most disadvantaged in our society.
- Health services in other comparable European countries, whether taxpayer-funded as in Scotland or insurance-based systems, are designed with strong incentives to meet the needs of the patient which is a key driver of innovation and quality. Insurance-based systems provide clear accountability to patients, whilst other countries routinely offer patients a greater choice of GP or over where they are treated. This is facilitated by a clearer split between government as the funder of health care and a wider range of public, voluntary and private providers, usually at a more local level.

Policy recommendations

NHS constitution: We recommend that the health service in Scotland is made more accountable to patients through a new constitution which sets out the relationship between the health service and patients. The health service in Scotland acts as an insurer in the sense that it attempts to provide cover for all citizens in Scotland. It should act more like the insurance-based systems in other countries by defining patient entitlement so that patients know to which drugs and treatment they have access. By giving patients legal entitlements, it ensures the system is accountable to them, not government and because the entitlement is set at a national level it should help to overcome the problem of patients in some parts of the country having access to treatment while others do not.

² Audit Scotland (2008) *Review of the new General Medical Services Contract*, available at http://www.audit-scotland.gov.uk/docs/health/2008/nr_080703_general_medical_services.pdf, p. 11.

A new NHS Constitution would have the added benefit of clarifying the role of the Scottish Government in health care. Under our proposals, the Government would:

- set the legal and regulatory framework for the health service and ensure that everyone is guaranteed access to defined health care irrespective of ability to pay;
- regulate the commissioners and providers of health care to ensure that they meet approved standards as well as ensuring the supply of essential services such as A&E (this would include the national bodies such as National Services Scotland and the Special Health Boards which are already directly accountable to the Scottish Government's Health & Wellbeing Directorate);
- be the principal funder of health care in Scotland, setting the overall budget for the health service in Scotland which would come out of general taxation and be distributed to the new Health Commissioning Co-operatives on the same basis as at present – a weighted amount based on the Resource Allocation Formula; and
- establish a national tariff scheme for different NHS treatments which sets out the amount that would be paid to hospitals and other health care providers per patient they treat.

Supplementary insurance: We recommend that patients should be free to take out supplementary insurance for treatments and drugs not provided by the health service in Scotland without incurring any penalty. The Health Secretary, Nicola Sturgeon, has issued revised guidance to Health Boards on this issue. This new guidance would, under certain circumstances, enable patients to pay for new cancer drugs which the NHS did not provide without turning themselves into private patients. This is a step forward, however there are still too many grey areas. Our proposals would provide much greater clarity by forcing the Government to define exactly which treatments and drugs the NHS will cover. Patients would then know that if they wanted a specific drug that was not covered they would have to pay for it themselves. Allowing a supplementary insurance market to develop, as we propose, would enable far more people to gain access to these new drugs, which are often expensive, than is likely to occur if people have to pay out of their own pockets. The current regulations would continue to apply for those taking out private insurance that covered treatments and drugs available on the NHS.

Empowering patients: We recommend that the role of the 14 Unified NHS Boards in Scotland is changed so that they become the champions of patients, with responsibility for commissioning care on their behalf. They would be turned into 14 area-based, mutual organisations known as Health Commissioning Co-operatives, owned by their members and with direct patient representation on their boards to ensure they are run in their interests. They would be statutory bodies, regulated by the Scottish Government or its agencies and receiving their funding from the Scottish Government as at present. They would be specifically charged with ensuring the provision of essential local services such as Accident and Emergency and that patients were given a choice as to the care they received. This would require them to act as 'honest brokers', disseminating all the relevant information on health outcomes and quality of care so that patients and their GPs could make an informed choice based on the performance and quality of care offered by different providers. Money would flow through the system based on the choices of patients with the NHS tariff following the patient to the provider of his or her choice, ensuring that the system was focussed on the needs of patients.

GPs would continue to perform the role of gatekeepers to further NHS-funded health care with Health Commissioning Co-operatives contracting with GP Practices to provide primary care services. The new General Medical Services Contract allows Health Boards to negotiate with GP Practices for additional services. This should be extended with far greater discretion given to the new Health Commissioning Co-operatives to negotiate their own local contracts for primary care services within a national framework set out by the Scottish Government. Other providers should be able to tender for these contracts to provide GP services. These local contracts could be used, amongst other things, as a tool to encourage primary care services which meet local needs or to promote better health. They would be combined with an end to GP catchment areas with patients able to choose a GP practice which suits them. This choice might be based on convenience – such as a surgery providing online booking or late-night opening or simply on a patient's perception of the quality of service provided. Taken together locally-negotiated GP Contracts and patient choice of GP would reward those practices which served patient needs, fostering innovation and higher standards in the provision of primary care.

Diversity of provision: We recommend that the provision of health care is separated from its commissioning to remove any potential conflicts of interest and encourage a wider range of health care providers. This mirrors the situation in comparable European countries which provide universal health care coverage. Over time, the Scottish Government and its regulatory agencies would help existing NHS hospitals and providers of community health care to become independent, not-for-profit trusts along the same lines as in England. Their assets would have to be permanently used to provide health care and they could not be taken over by commercial organisations.

However, there would be no such restrictions on new health care providers with public bodies such as local authorities, voluntary associations and commercial entities all entitled to provide health services. As with existing providers of health care, they would be regulated by the Scottish Government and its agencies which would grant them a licence to provide health services as long as they met the required standards. They would be funded on exactly the same basis as any other provider – on the basis of the NHS tariff and the number of patients they attracted. If they could treat patients for less than the tariff amount then they would be allowed to keep what is left over to re-invest. This would provide an incentive for better service based on innovation as those providing services valued by patients and delivering better health outcomes would thrive while those not providing such a service would receive less money. As part of this move towards greater independence for the providers of health care, hospitals and other health providers should be given the freedom to restructure the services they provide and negotiate their own contracts with staff to reflect local needs and priorities.

End central targets: We recommend that all centrally-imposed targets are scrapped giving NHS managers and doctors much greater freedom to use their expertise and local knowledge to improve services for patients. This is an important part of the move away from a system of top-down performance management to one in which the health service and those who work in it are accountable to patients with the service developing in response to their needs and wishes.

Conclusion

The NHS in Scotland has many strong points. In particular, the fundamental principle that everyone in our society should be guaranteed access to health care should remain the cornerstone of our health care system. However, we should note that other countries have enshrined this vital principle without the need for a public sector monopoly over health care.

The evidence points to the fact, although there have been some improvements, our health care system is not working as well as it could. This is particularly true in comparison to systems in other comparable countries. What is clear is that the problem is not due to a lack of money as the increase in funding over recent years has been dramatic.

It is Reform Scotland's view that the necessary improvements in the performance of the service cannot be achieved simply by managing the existing system better. This is because the problems with the health service in Scotland are structural and require structural reform. Top-down performance management of a public sector monopoly is the root of the problem. We need to introduce reforms which put patients first and enable the system to develop according to their needs and wishes. The best way to achieve this is to introduce elements of patient choice and greater competition between health care providers into the system. These are the keys to increasing productivity, to providing real value for the money invested in our health service and to raising standards for all.

1. Health care in Scotland

1.1 The current Scottish health care system

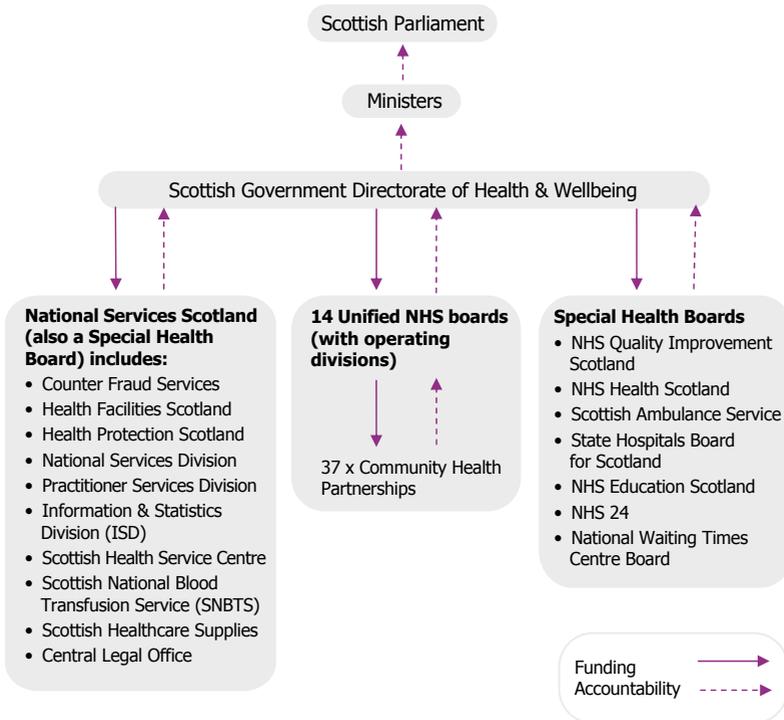
Health care in Scotland is dominated by 14 NHS Boards, which are responsible for the planning and provision of health services for their local populations based on local need. Six of the NHS Boards are coterminous with one local authority – NHS Borders, Dumfries & Galloway, Western Isles, Orkney, Shetland and Fife. The other 8 - NHS Lothian, Greater Glasgow, Forth Valley, Highland, Ayrshire & Arran, Grampian, Tayside and Lanarkshire - cover more than one council area. Most non-executive lay members of the boards are appointed by Scottish Ministers; though a councillor from each of the local authorities covered also sits as a non-executive lay member. Money flows directly from the Scottish Government to the health boards on the basis of need using the Resource Allocation Formula as of this year. Central government is also responsible for setting national objectives and holding the NHS to account for these objectives.

In addition to the geographical boards, there are a number of additional Special Health Boards, which provide services across Scotland, such as NHS 24 and the Scottish Ambulance Service. Below health boards are Community Health Partnerships (CHPs) to help provide a more seamless link between primary and secondary care. Although still relatively new, CHPs provide a number of community based services and work closely with councils, hospitals and community groups.

There are three types of health care delivery: primary care is provided through GP practices and community health services; secondary care is generally provided in hospitals, and includes both elective and emergency care; and, tertiary care covers clinical specialities.

People in Scotland can register with a GP practice provided they live within its catchment area and the surgery has vacancies for new patients. GPs tend to be independent employees contracted by an NHS board. Although the contract tends to be agreed on a national basis, NHS boards still have a degree of flexibility to retain GPs as salaried NHS employees. By registering with an NHS GP, patients can gain access to the full range of NHS health services in their area, including specialist care.

Figure 1: Current structural organisation of the Scottish NHS



Source: Robson, K, The National Health Service in Scotland, June 2007, SPICe briefing 07/32

Over the long term, people in Scotland are living longer and survival rates following major diseases are increasing. However, such improvements should be expected when considered alongside advances in medical research.

The Health and Wellbeing budget accounts for a third of the total Scottish budget and has increased by 55% in real terms over the past decade. To assess whether this increase in expenditure has generated value for money there are three types of outcome that have been considered – general public health levels, the efficiency of treatment, and the impact of treatment.

1.2 Statistics

General public health

- Male life expectancy at birth has increased from 72.4 in 1996-1998 to 74.6 in 2004-2006 while female life expectancy at birth has increased from 78.1 to 79.6.³ However, despite this increase, Scotland's life expectancy is below that of the OECD average of 81.4 years for women and 75.7 years for men⁴ and is also below the worst performing region in England.⁵
- Compared to other developed countries, in 2005 Scotland's infant mortality rate of 5.2 was better than the OECD average of 5.4, though behind the UK and a number of other European countries.⁶ However, the latest Scottish figures show an improvement with infant mortality having fallen from 5.7 deaths per 1,000 live births in 1995-1999 to 4.5 deaths in 2006.⁷
- The incidence of major illnesses has fallen in recent years.⁸
 - The standardised rate for Coronary Heart Disease (CHD) per 100,000 people has fallen from 463.5 in 1997 to 307.5 in 2006.
 - The standardised rate for strokes (cerebrovascular disease) per 100,000 people has fallen from 235.6 in 1997 to 166 in 2006.
 - Whilst the standardised rate for cancer per 100,000 people has fallen from 471.9 in 1997 to 451.5 in 2004 for men and from 392.8 to 387.9 for women.⁹

Efficiency of treatment

- The number of NHS staff has increased from 112,138.5 whole time equivalent in September 1997 to 129,423.9 in September 2005. In the same period the number of GPs increased from 3,739.9 to 4,073.8. From 2006 WTE figures, including GPs, have not been included in

3 GROS

4 OECD, *Health at a Glance*, 2007. The UK's life expectancy is 76.9 for men and 81.1 for women.

5 Department of Health, *Health Profile of England 2007*, 2007. North East was the worst performing area in England with life expectancy for men at 75.4 years and 79.8 years for women.

6 ISD, *Scottish Perinatal and Infant Mortality and Morbidity Report 2005, 2006 and OECD, Health at a Glance*, 2007

7 ISD, *Scottish Perinatal and Infant Mortality and Morbidity Report 2006*, 2007

8 ISD, October 2007

9 ISD, April 2007

official statistics. Following the introduction of 'Agenda for Change', staff figures from 2007 have been calculated slightly differently. The current headcount level of the NHS workforce in Scotland is 165,551, of which 67,965 are in nursing or midwifery, 29,755 are in administration and 4,916 are GPs.¹⁰

- Finished Consultant Episodes per staff dropped from 138 in 1996/7 to 126 in 2000/01. Although the figures also dropped in England during the period, the numbers are far higher at 221 in 1996/7 and 206 in 2000/01.¹¹
- Waiting lists for inpatient and day cases fell by 23% from 110,891 at 31st March 1998 to 84,932 at 31st March 2007.¹² In December 2008 55,634 patients were waiting for admission as an inpatient or day case (although this figure is not directly comparable to 2007 due to changes in defining and measuring waiting times introduced through 'New Ways').
- At 31st March 1998, the median wait for inpatient and day cases was 35 days with 85% of people seen within 18 weeks. By 31 December 2008 the median wait was 31 days with 99% of people seen within 18 weeks¹³ (although these figures are not directly comparable due to changes in defining and measuring waiting times introduced through 'New Ways').
- For outpatients, the median wait at 31st March 1998 was 43 days with 90.7% of people seen within 18 weeks. By 31st December 2008, the median wait was 48 days, with 99% of patients seen within 28 weeks¹⁴ (although these figures are not directly comparable due to changes in defining and measuring waiting times introduced through 'New Ways').

10 ISD, NHS Scotland Workforce statistics.

11 Irvine. B & Ginsberg. I, "England Vs Scotland: Does more money mean better health?", Civitas, June 2004

12 ISD, Inpatient / Day Case waiting list census data

13 ISD, Inpatient / Day Case waiting times data

14 ISD Outpatient waiting times data

Outcome of treatment

- Mortality rates for the major illnesses have improved:¹⁵
 - The standardised mortality rate for CHD per 100,000 people has fallen from 208.4 in 1997 to 125 in 2006
 - The standardised mortality rate for strokes per 100,000 people has fallen from 91.3 in 1997 to 62.1 in 2006
 - The mortality rate for cancer per 100,000 people has fallen from 225.6 in 1997 to 209.8 in 2005¹⁶
- Survival rates have also improved:¹⁷
 - The percentage of people surviving 30 days or more following their first emergency admission for AMI or Angina rose from 97.65% in 1997 to 98.44% in 2006
 - The percentage of people surviving 30 days or more following their first emergency admission for a stroke increased from 75.19% in 1997 to 80.77% in 2006
- Despite the improving survival and mortality rates, when compared to other countries, Scotland does not perform well:
 - Scotland's five-year survival rate for female cancer sufferers was the lowest out of 22 countries at only 48% in a study carried out by the National Cancer Institute in Milan.¹⁸
 - A recent study of cancer care across Europe found Scotland trailing behind most other countries in terms of the percentage of patients cured as well as survival rates. Only 44.8% of women in Scotland were cured and only 30.8% of men with only Poland having a worse record of the countries studied.¹⁹

¹⁵ ISD, October 2007

¹⁶ S3W-1918

¹⁷ ISD, October 2007

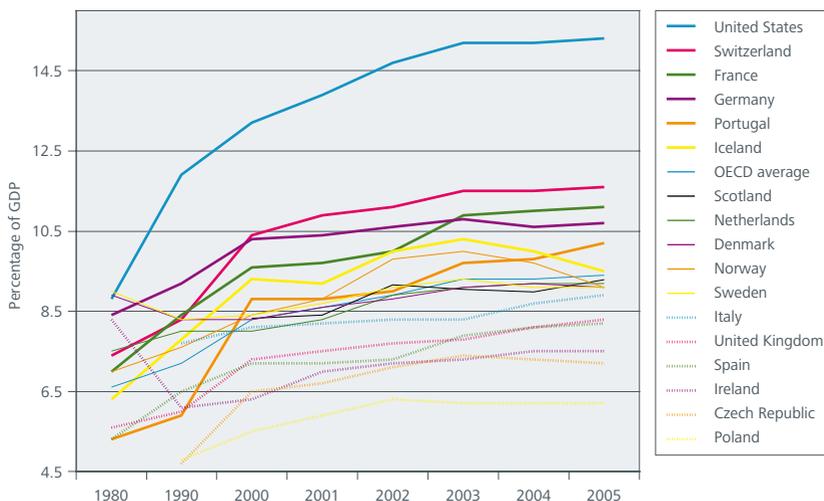
¹⁸ Daily Telegraph, "UK cancer survival rate lowest in Europe", 24th August 2007

¹⁹ European Journal of Cancer. Eurocare-4 Report. 24 March 2009

- According to the British Heart Foundation, death rates from CHD have not been falling as quickly in the UK as a number of other Western countries. Additionally, the premature death rate for CHD for men living in Scotland is almost 60% higher than in the South West of England and more than double for women.²⁰

As illustrated in Figure 2, although spending on health care as a percentage of GDP is lower than the OECD average, it is higher than the UK²¹ and a number of other European countries which perform better on a number of the key indicators discussed above.

Figure 2: Health expenditure as a percentage of GDP²²



Source: OECD Health at a Glance 2007, PESA

²⁰ British Heart Foundation, 2006 Coronary Heart Disease Statistics, 2006

²¹ PESA 2007. In 2007 spending per head on health was £1,575 for the UK as a whole and £1,788 in Scotland.

²² Figures for Scotland are estimated using the spending per head index in PESA 2004 & 2007. For example in 2001-02 health spending in Scotland was 112 to the UK's 100. OECD Health at a Glance states that UK expenditure as a percent of GDP was 7.5. $1.12 \times 7.5 = 8.4$. Therefore we can health spending in Scotland in 2001 was 8.4% GDP.

1.3 Conclusion

The figures set out in this section show that while there have been some positive developments in the performance of the health service in Scotland, there is still plenty of room for improvement. The question is why has Scotland not done as well as some other countries which seem to have adapted to the problems associated with providing health care in the modern era better than Scotland.

Much has changed since the NHS was set up in 1948. People are more affluent, they are more demanding as consumers, they can expect to live longer and so are more vulnerable to chronic illnesses.

There have also been enormous advances in medical technology over the last 60 years – in areas such as surgery, biotechnology and pharmaceuticals. All this has massively increased the scope for medical interventions and the demand on the health service has increased accordingly. This is not surprising as good health is enormously important to people because it is the key to financial and physical independence whether they are working or retired.

This has posed new challenges with which the NHS has struggled to cope as evidenced by long waiting lists and times. In the past, these problems have been put down to a lack of money going into the health care system. The massive increases in funding have made some difference in these areas, but still we lag behind.

The fundamental problem is not a lack of resources, but an inefficient use of them.

The difficulties of the NHS in Scotland are largely caused by the monopoly nature of the health service here which is why other countries have, generally, not sought to meet the challenge of providing health care through centralised, public sector monopolies.

The approach adopted in Scotland has relied upon central direction through the use of targets to ensure that providers of health care deliver a good service. To some extent, it has led to improvements. However, it has clear limits because if waiting time targets are met within existing budgets there is no pressure to increase productivity further or to improve the service for patients. At the same time, targets can distort priorities as what is not targeted is often ignored. A new approach is needed.

The major problem is that the health service in Scotland denies patients control over the health care they receive by limiting their choice and the competition between providers. Patients have limited choice over where, when and how they are treated, for example of GP Practice or where they receive specialist care. In the absence of choice, there is no means of accurately measuring and responding to demand which leads to resources being misallocated.

Further, a lack of choice means there is a lack of incentive for providers to improve as patients and funding will continue to be given to them even if they provide a poor service. This problem is made more acute because, as the health service is a monopoly provider, there is no opportunity for new providers to come in and attract patients and funding.

It is, therefore, no great surprise that monopoly health care providers tend to be less innovative as there is no incentive to find new, better ways of doing things. This was borne out by the Wanless Report, commissioned by the UK Government, which found that compared to countries such as Canada, France and Australia the NHS was the worst in terms of introducing new technologies which can make a real difference to people's lives.

Of course, many people will still defend monopoly health care provision on the grounds that it is the most equitable way of providing the service, particularly for those on lower incomes. However, there is increasing evidence that it is the better off who get most out of monopoly systems, frustrating one of the main objectives of those who created the NHS.

Julian Le Grand, a former adviser to Tony Blair when he was Prime Minister, found that:

- Unemployed, and individuals with low income and poor educational qualifications use health services less relative to need than the employed, the rich and the better educated.
- Intervention rates of Coronary Artery Bypass Grafts (CABG) or angiography following heart attack (AMI) were 30% lower in the lowest socio-economic groups than in the highest.
- Hip replacements were 20% lower among lower socio-economic groups despite roughly 30% higher need.

- Social classes IV and V had 10% fewer preventive consultations than social classes I and II after standardising for other determinants.
- A one point move down a seven point deprivation scale resulting in GPs spending 3.4% less time with the individual concerned.

The following section looks at the health care systems in a number of other countries to see what they do differently and what lessons we can learn.

2. Learning lessons from overseas

2.1 Denmark

Denmark is one of only a few countries which operates a system similar to the Scottish one, in that it is free at the point of use and doesn't rely on insurance. Denmark also has similar cultural problems to Scotland due to high levels of smoking, drinking too much alcohol, eating fatty food and taking too little exercise.²³

Key statistics

- Spending as a percentage of GDP in 2005 was 9.1% in Denmark, slightly lower than the OECD average and Scotland but higher than the UK
- Life expectancy in Denmark at birth for women was 80.2 years and 75.6 years for men in 2005. This is marginally below the OECD average, but above Scotland. Whilst infant mortality is better than the OECD average and Scotland at 4.4 deaths per 1,000 live births²⁴
- There is a high level of user satisfaction with health care services. The 1998 Eurobarometer survey showed that 91% of Danes were satisfied with their health care – the highest ranking country. In contrast, the UK polled 57%²⁵

How health care is organised

- Built on the principle of universal, free and equal access for all
- Mainly financed through local taxation
- Responsibility lies with the lowest possible administrative level
- Central Government's main functions are to regulate, coordinate and advise

The Danish health care system is funded through local taxation and freely available to all, like the Scottish system. However, responsibility for the funding, managing and operation of health care is devolved down to local

²³ Ministry of Interior & health, Health care in Denmark, 2001

²⁴ OECD, Health at a Glance, 2007.

²⁵ Blendon. R, Kim. M, Benson. J, The Public Versus The World Health Organization On Health System Performance, Health Affairs, May/June 2001

councils and municipalities. In 1999, 82.2% of total expenditure on health care was financed by a combination of state, county and municipal taxes.²⁶ Local taxes are supplemented by state subsidies and money is also transferred between areas, through central government, on the basis of need. These transfers and subsidies are agreed annually as part of the budget negotiation between central and local government. It is through these negotiations that central government is able to influence health policy by earmarked grants to assist in achieving particular targets, such as reducing waiting times, or highlighting priority areas such as cancer treatment.

Devolving the operation of health care to such a low level has meant that local areas have a strong sense of autonomy and are, therefore, often resistant to centrally-driven initiatives. There can also be differences in the health care delivered in different areas; however this often takes into account different local priorities.

In addition to state funding, there is also a growing element of private expenditure on health care. About 30% of the population has complementary voluntary health insurance (VHI)²⁷ to cover the cost of statutory co-payments applied to dental care, prescriptions, glasses and physiotherapy. Supplementary VHI is also available which allows people to jump waiting lists. While only around 5% of the population have this cover, partly because it does not offer much in terms of improved amenities, the figure is increasing due to the existence of tax incentives for employer-purchased insurance.²⁸

As in Scotland, GPs act as the gatekeepers to specialists and hospital care. However, Danes have more say over who acts as their GP, being able to choose a GP from those operating within 10km of their home and the ability to change their GP every 6 months, though in practice few do. Due to collaborations between different GPs and GP practices, GP services are available 24 hours a day. Danes also choose from two GP options. In Group 1, access to GPs is free at the point of use. In Group 2, people must pay part of the cost of a visit to a GP but are free to visit any GP or specialist without referral from a GP, whilst paying the cost of all services

²⁶ European Observatory on Health Care Systems, *HIT summary: Denmark, 2002*

²⁷ European Observatory on Health Care Systems, *HIT summary: Denmark, 2002*

²⁸ Civitas, Background Briefing, *Health Care Lessons from Denmark, 2002*

except hospital treatment. However, only 1.7% of the population have opted for the additional benefits of Group 2.²⁹

In addition to choosing a GP, since 1993 Danes have been able to choose to be treated in any public hospital in the country, as well as a small number of private hospitals. About 99%³⁰ of hospital beds are in the public sector and deliver a high standard of inpatient care. Wards generally only have two beds and everyone uses the same public hospitals.

Health lessons for Scotland

- The service is designed to meet the needs of the patient. For example, citizens can choose their GP and have far greater access to GP services outwith normal office hours than in Scotland
- Patients can choose where they receive treatment rather than being directed arbitrarily by the state
- Health care, although financed by the tax payer in Denmark, is not delivered by central government
- Delivery of health care, whether state or privately financed, is decentralised and is the responsibility of the lowest tier of government. This creates a more diverse and accountable system along with a greater sense of community ownership

2.2 The Netherlands

In contrast to Denmark and Scotland, the Netherlands operates a compulsory health insurance system and significant reforms were introduced in 2006 to correct longstanding weaknesses in the system.

²⁹ European Observatory on Health Care Systems, *HiT summary: Denmark, 2002*

³⁰ Civitas, Background Briefing. *Health Care Lessons from Denmark, 2002*

Key statistics

- Spending as a percentage of GDP on health care was 9% in the Netherlands, slightly lower than the OECD average, but higher than the UK.
- Life expectancy is 79.1 years³¹
- Major cause of death is cardiovascular disease, followed by cancer³²

How health care is organised

- A compulsory, government-defined package of health care provided by competing insurers
- Insurers cannot refuse patients treatment which, combined with a system of tax credits for those on low incomes and free insurance for those under 18, guarantees universal coverage for all residents
- Voluntary private insurance can be taken out for care not covered in the government-defined package
- Patients must register with a GP who performs the same gatekeeping role as GPs in Scotland guiding patients towards specialist care
- Over 90% of hospitals are owned and managed on a private, not-for-profit basis and specialists are self-employed

Prior to 2006, the Netherlands operated a complicated and bureaucratic system which combined Social Health Insurance (SHI) with a Private Health Insurance (PHI) scheme for high earners who could opt out of SHI. This was felt by the government to have a number of defects such as:

- A two-tier system with PHI for the wealthy and SHI for the rest which increased health inequalities
- Strong supply side controls resulted in rationing with long waiting lists
- Employers paid a large proportion of the costs which meant health insurance revenues were closely linked to the performance of the economy³³

³¹ <http://www.sciencedaily.com/releases/2009/01/01116073154.htm>

³² European Observatory on Health Care Systems, *HIT summary: Netherlands, 2005*

³³ Civitas, *Health Reform in The Netherlands*, Claire Daley and James Gubb 2007

In 2006, this changed with the ending of the division between SHI and PHI and the introduction of a new unified system of obligatory national insurance with basic care for all citizens. Under the new regulations, insurers cannot refuse coverage to any citizen, but can compete on price and quality and offer packages with additional services. Subsidies for the premiums are available for low-income citizens. The basic insurance covers all primary and secondary care; supplemental insurance is available to cover medical expenses for services not included (such as dental care and physical therapy).

To provide the government-defined package of care, patients in the Netherlands can choose from around fifty health care insurers across the country and patients can change their insurer once a year with many doing so. However, evidence suggests there is a need for more information on outcomes to ensure patients have a more informed choice and to push health care providers towards providing better care at a lower cost.

As in Scotland, GPs perform a gatekeeping role and access to specialist and tertiary care is through A&E or GP referral. GPs are often solo practices, forming co-operatives for the provision of out-of-hours services.

Almost all Dutch hospitals are private and are all non-profit. The charges that insurers pay to hospitals and doctors have been tightly regulated in the past with the government setting down fixed rates. This has meant there was a limited incentive for hospitals to increase their efficiency and to counteract this a new system of payments, Diagnose-Treatment Combinations, is being phased in to give insurers greater flexibility to negotiate prices with hospitals. In addition, insurers can refuse to contract with certain hospitals rewarding those providing a better service and driving up standards.

Health lessons for Scotland

- Universal coverage can be achieved with the government acting as regulator, but does not require the government to be the provider and main funder of health care
- The fact that patients know the package of care to which they are entitled makes the system more accountable to them and focussed on their needs
- Although it is still early days, the patient choice and managed competition

which are features of the reformed Dutch health care system are showing signs of enhancing value and efficiency

2.3 Sweden

The health status of the Swedish population is one of the best in the world. The Swedish health care system is similar in nature to that of Denmark being government-funded, heavily decentralised and providing universal access to all residents.

Key statistics

- Life expectancy in Sweden is among the highest in the Nordic countries: 82.4 years for women and 77.9 years for men in 2003. Today Sweden has one of the world's oldest populations, with more than 17% of the population being aged 65 years or older³⁴
- Diseases of the circulatory system have been significantly reduced during the last 30 years, and this is one of the major factors contributing to the rise in life expectancy in Sweden. Diseases of the circulatory system are still the leading cause of mortality, accounting for almost half of all deaths in 2001
- The cost of health and medical care amounts to approximately 9% of Sweden's GDP, a figure that has remained relatively stable since the early 1980s³⁵

How health care is organised

- Built on the principle of universal, free and equal access for all
- Financed largely through local taxation
- Responsibility for the provision of health care lies mainly with the county councils with most operating some form of purchaser-provider split
- Central government establishes the principles and guidelines for care and sets the political agenda for health and medical care

³⁴ European Observatory on Health Care Systems, *HIT summary: Sweden, 2005*

³⁵ Swedish Health Care. Swedish Institute January 2007. <http://www.sweden.se/eng/Home/Work-Live/Society--welfare/Health-care/Facts/Swedish-health-care/>

The responsibility for providing health care in Sweden is devolved to the 20 elected county councils with some related services such as care for the elderly provided by the 290 municipalities. Health is the prime responsibility of county councils and they must provide residents with high-quality health services and work towards promoting good health.

Overall responsibility for the health care sector rests at national level, with the Ministry of Health and Social Affairs. The role of central government is to establish principles and guidelines for care and to set the political agenda for health and medical care.

71% of health care is funded through local taxation with contributions from the state representing 16% of funding and patient fees only 3%. County Councils often commission services from independent health care providers. This is done through payments determined by Diagnosis-Related Group (DRG) – a system that classifies hospital cases into one of around 500 groups expected to require similar resources. This has made hospitals more independent of political bodies with some, such as St Goran's in Stockholm, becoming privately owned.

Generally patients are free to choose where they go for care. No referral is usually necessary for specialist care. This is different from many other countries, such as Scotland and the Netherlands, where 'gatekeeper functions' are more common.³⁶

Health lessons for Scotland

- The delivery of health care in Sweden is done at a local level ensuring greater accountability to local communities
- Many county councils are separating the commissioning of care from its delivery
- The use of the DRG or 'tariff' system increases the independence of health care providers and creates the opportunity to use a wider range of service providers

³⁶ Swedish Health Care. Swedish Institute January 2007. <http://www.sweden.se/eng/Home/Work-Live/Society--welfare/Health-care/Facts/Swedish-health-care/>

2.4 NHS in England

The health care system in England is part of the National Health Service (NHS) which is a UK-wide overarching body. As such, it adheres to the same fundamental principles as the NHS in Scotland being financed through general taxation and guaranteeing health care that is freely available to all.

Key statistics

- Primary Care Trusts (PCTs) account for at least 80% of the NHS budget in England^{37 38}
- There are currently 152 PCTs in England³⁹
- The NHS spent £1132 on the average person in England in 2000/2001 compared to £1347 in Scotland, yet life expectancy in Scotland is lower⁴⁰

How health care is organised

The fundamental difference between the health care systems in Scotland and England is that whereas Scotland has 14 combined Health Boards, in England there is a clearer split between the commissioning of health care and its provision. The commissioning of health care in England is largely done by Primary Care Trusts (PCTs) although they do still provide some care directly. This care is commissioned from Foundation Trusts and other providers with the decisions on providers increasingly informed by the choices which patients make themselves.

Primary Care Trusts

These are freestanding, regional bodies which manage the provision of primary care throughout England, as well as secondary care which they commission from Foundation Trusts based on the agreed NHS tariff for a range of treatments and procedures. PCTs employ their own staff, possess their own boards, and

37 *About Primary Care Trusts*. The NHS Confederation. <http://www.nhsconfed.org/Networks/PrimaryCareTrust/Pages/AboutPrimaryCareTrusts.aspx>

38 *Delivering Primary Care*. Department of Health. http://www.dh.gov.uk/en/Aboutus/HowDHworks/DH_074639

39 *About the NHS*. <http://www.nhs.uk/aboutnhs/howtheNHSworks/authoritiesandtrusts/Pages/Authoritiesandtrusts.aspx#q05>

40 *NHSScotland versus NHSEngland: Does More Money Mean Better Health?* <http://www.davidhumeinstitute.com/DH1%20Website/Events,%20transcripts%20&%20presentations/Seminars%20-%20Transcripts%20and%20Presentations/BEn%20Irvine%20Pres.pdf>

are allocated their own budget to use according to the needs of the community – although, ultimately, they are still accountable to the Secretary of State for Health.

Foundation Trusts

These are bodies designed to run secondary care – primarily hospitals. They are locally-controlled with emphasis placed on de-centralisation and greater accountability to the patient. They are commissioned by PCTs and are overseen by ‘Monitor’, which is directly accountable to government. Each Trust has a democratically elected Board of Governors and members of the public are encouraged to become members of the board or to participate in its election. The aim and purpose of these Trusts, according to the government, is to achieve “a patient-led NHS”.⁴¹

Foundation Trusts are independent legal entities, or Public Benefit Corporations, and have financial freedoms that allow them to raise capital from both public and private sectors.

Health lessons for Scotland

- The separation of the commissioning of care from its provision helps to remove potential conflicts of interest and provides greater transparency within the system
- As in the Swedish system, the introduction of an NHS tariff for a range of treatments and procedures is a spur to competition and greater efficiency
- The tariff system gives patients choice from a wider range of health care providers and can encourage innovative ways of delivering services

⁴¹ A Short Guide to NHS Foundation Trusts. NHS. http://www.dh.gov.uk/prod_consum_dh/idcplg?ldcService=SS_GET_PAGE&ssDocName=DH_4050483

3. How health care in Scotland should be reformed

There is no doubt that many patients in Scotland receive excellent care from the health service. Patient surveys tend to back this up, showing a high level of satisfaction when patients are asked about their own personal experience of treatment from the health service. This is a tribute to the many dedicated people who work in the Scottish health care system.

It is also true that there have been improvements in the performance of the health care system in Scotland. However, there are still problems that need to be addressed and these are related to the overall structure of the health service. If we aspire to match the standards of health care seen in some other European countries, then we must address these structural problems

NHS constitution

The health service in Scotland needs to be more accountable to patients and a new constitution which sets out the relationship between the health service and patients would help to bring about this fundamental shift. The health service in Scotland acts as an insurer in the sense that it attempts to provide cover for all citizens in Scotland. It should act more like the insurance-based systems in other countries by defining patient entitlement so that patients know to which drugs and treatments they have access. By giving patients legal entitlements, it ensures the system is accountable to them, not government and because the entitlement is set at a national level it should help to overcome the problem of patients in some parts of the country having access to treatment while others do not.

A new NHS Constitution would have the added benefit of clarifying the role of the Scottish Government in health care. Under our proposals, the Government would:

- set the legal and regulatory framework for the health service and ensure that everyone is guaranteed access to defined health care irrespective of ability to pay;
- regulate the commissioners and providers of health care to ensure that

they meet approved standards as well as ensuring the supply of essential public health services such as A&E (this would include the national bodies such as National Services Scotland and the Special Health Boards which are already directly accountable to the Scottish Government's Health & Wellbeing Directorate);

- be the principal funder of health care in Scotland, setting the overall budget for the health service in Scotland which would come out of general taxation and be distributed to the new Health Commissioning Co-operatives on the same basis as at present – a weighted amount based on the Resource Allocation Formula; and
- establish a national tariff scheme for different NHS treatments which sets out the amount that would be paid to hospitals and other health care providers per patient they treat.

Supplementary insurance

Once a new NHS constitution is in place, it follows that patients should be free to take out supplementary insurance for treatments and drugs not provided by the health service in Scotland without incurring any penalty. The Health Secretary, Nicola Sturgeon, has issued revised guidance to Health Boards on this issue. This new guidance would, under certain circumstances, enable patients to pay for new cancer drugs which the NHS did not provide without turning themselves into private patients. This is a step forward, however there are still too many grey areas. Our proposals would provide much greater clarity by forcing the Government to define exactly which treatments and drugs the NHS will cover. Patients would then know that if they wanted a specific drug that was not covered they would have to pay for it themselves. Allowing a supplementary insurance market to develop, as we propose, would enable far more people to gain access to these new drugs, which are often expensive, than is likely to occur if people have to pay out of their own pockets. The current regulations would continue to apply for those taking out private insurance that covered treatments and drugs available on the NHS.

Health commissioning co-operatives

To make the health care system more responsive to patients, we need bodies which serve their needs. To achieve this, the functions of the 14 Unified NHS Boards in Scotland should be split with new bodies created which would be the champions of patients, with responsibility for commissioning care on their behalf. There would be 14 area-based, mutual organisations known as Health Commissioning Co-operatives, owned by their members and with direct representation for patients and other stakeholders on their boards. They could be set up either as Industrial and Provident Societies or Community Interest Companies and could devolve responsibilities downwards to local community bodies. This would all ensure that these new bodies acted in the interests of patients in their local communities.

They would be statutory bodies, regulated by the Scottish Government or its agencies and receiving their funding from the Scottish Government as at present. They would be specifically charged with ensuring the provision of essential local services such as Accident and Emergency and that patients were given a choice as to the care they received. This would require them to act as 'honest brokers', disseminating all the relevant information on health outcomes and quality of care so that patients and their GPs could make an informed choice based on the performance and quality of care offered by different providers. In this respect, we need to ensure that we have effective measurements of the health benefits of different procedures and Dr Andrew Walker has suggested a system of QALYs (Quality Adjusted Life Years) would help in this respect. Whatever measurements are used, they should be easily available online to aid patients and their GPs.

Money would then flow through the system based on the choices of patients with the NHS tariff following the patient to the provider of his or her choice, ensuring that the system was focussed on the needs of patients.

Primary care

GPs would continue to perform the role of gatekeepers to further NHS-funded health care with Health Commissioning Co-operatives contracting with GP Practices to provide primary care services. The new General Medical Services Contract allows Health Boards to negotiate with GP Practices for additional services. This should be extended with far greater discretion given to the new Health Commissioning Co-operatives to negotiate their own local contracts for primary care services within a national framework set out by the Scottish Government. Other providers should be able to tender for these contracts to provide GP services. These local contracts could be used, amongst other things, as a tool to encourage primary care services which meet local needs or to promote better health.

They would be combined with an end to GP catchment areas with patients able to choose a GP practice which suits them. This choice might be based on convenience – such as a surgery providing online booking or late-night opening or simply on a patient's perception of the quality of service provided. Taken together locally-negotiated GP Contracts and patient choice of GP would reward those practices which served patient needs, fostering innovation and higher standards in the provision of primary care.

A wider range of health care providers

The system we propose would separate the provision of health care from its commissioning to remove any potential conflicts of interest and encourage a wider range of health care providers. This mirrors the situation in comparable European countries which provide universal health care coverage. Over time, the Scottish Government and its regulatory agencies would help existing NHS hospitals and providers of community health care to become independent, not-for-profit trusts along the same lines as in England. Their assets would have to be permanently used to provide health care and they could not be taken over by commercial organisations.

However, there would be no such restrictions on new health care providers with public bodies such as local authorities, voluntary associations and commercial entities all entitled to provide health services. As with existing providers of health care, they would be regulated by the Scottish Government

and its agencies which would grant them a licence to provide health services as long as they met the required standards. They would be funded on exactly the same basis as any other provider – on the basis of the NHS tariff and the number of patients they attracted. If they could treat patients for less than the tariff amount then they would be allowed to keep what is left over to re-invest. This would provide an incentive for better service based on innovation as those providing services valued by patients and delivering better health outcomes would thrive while those not providing such a service would receive less money. As part of this move towards greater independence for the providers of health care, hospitals and other health providers should be given the freedom to restructure the services they provide and negotiate their own contracts with staff to reflect local needs and priorities.

End central targets

Centrally-imposed targets are a management tool associated with top-down, command and control models. As such, they are a symptom of the deeper problem with the health care system in Scotland which is its fundamental structure as a centralised, public sector monopoly. As part of the necessary move away from top-down performance management, such targets should be swept away. This would give NHS managers and doctors much greater freedom to use their expertise and local knowledge to improve services for patients. This is all part of creating a health care system which is more accountable to patients with the service developing in response to their needs and wishes.

4. Conclusion

Reform Scotland believes that the reforms set out in this report offer the best way of improving the health care system in Scotland. However, as with education, there is a limit to what can be achieved by systems of health care provision. For instance, health outcomes often depend on the lifestyle choices of individuals for which they must take responsibility.

The reforms we propose aim to encourage health promotion, in particular through the GP Contract which could be used by Health Commissioning Co-operatives to encourage innovative ways of promoting individual health.

However, the key feature of the reforms set out in this paper is that they make it clear that the health service in Scotland must serve the interests of patients. As the Rt Hon Gordon Brown MP once said when he was Chancellor of the Exchequer:

*...the NHS exists for patients; public services exist not for the public servant but for the public who are served.*⁴²

That is the principle on which reform of the NHS must be based.

⁴² Brown, Gordon. Speech by the Chancellor of the Exchequer at the TGWU conference. 5 July 2001.

5. References

A Short Guide to NHS Foundation Trusts. NHS

http://www.dh.gov.uk/prod_consum_dh/idcplg?IdcService=SS_GET_PAGE&ssDocName=DH_4050483

About the NHS

<http://www.nhs.uk/aboutnhs/howtheNHSworks/authoritiesandtrusts/Pages/Authoritiesandtrusts.aspx#q05>

Audit Scotland (2008) *Review of the new General Medical Services Contract*, available at http://www.audit-scotland.gov.uk/docs/health/2008/nr_080703_general_medical_services.pdf, p.11.

Blendon R, Kim M, Benson J, 'The Public versus the World Health Organisation on Health System Performance' Health Affairs May/June 2001

British Heart Foundation, 2006 Coronary Heart Disease Statistics 2006

Brown, Gordon. 'Speech by the Chancellor of the Exchequer at the TGWU conference' 5 July 2001

Civitas, *Background Briefing. Health Care Lessons from Denmark 2002*

Civitas 'Health Reform in the Netherlands' Claire Daley and James Gubb 2007

Daily Telegraph 'UK Cancer survival rate lowest in Europe' 24th August 2007

Department of Health: 'Delivering Primary Care'

http://.dh.gov.uk/en/Aboutus/HowDHworks/DH_074639

Department of Health, *Health Profile of England 2007*

European Journal of Cancer. Eurocare-4 Report 24th March 2009

European Observatory on Health Care Systems, *HiT summary: Denmark 2002*

European Observatory on Health Care System, *HiT summary: Netherlands 2005*

European Observatory on Health Care System, *HiT summary: Sweden 2005*

General Register Office for Scotland (GROS)

<http://www.sciencedaily.com/releases/2009/01/01116073154.htm>

Irvine B & Ginsberg I 'England Vs Scotland: Does more money mean better health?', Civitas, June 2004

ISD, Inpatient/Day Case waiting list census data

ISD, Inpatient/Day Case waiting times data

ISD, NHS Scotland Workforce Statistics

ISD, Outpatient waiting times data

ISD, Scottish Perinatal and Infant Mortality and Morbidity Report 2005, 2006, 2007

Ministry of Interior & Health, Health Care in Denmark 2001

NHS Confederation: *'About Primary Care Trusts'*

<http://www.nhsconfed.org/Networks/PrimaryCareTrust/Pages/AboutPrimaryCareTrusts.aspx>

OECD (2007) *Health at a Glance*

Public Expenditure Statistical Analyses (PESA) 2007

Scottish Parliament Written Answer S3W-1918

Swedish Health Care. Swedish Institute, January 2007. <http://www.sweden.se/eng/Home/Work-Live/Society--welfare/Health-care/Facts/Swedish-health-care/>

