

# Accountability in the UK Healthcare System: An Overview

## Obligation de rendre compte dans le système de santé du Royaume-Uni : un aperçu



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### Abstract

Recent changes in the English National Health Service (NHS) have introduced new complexities into the accountability arrangements for healthcare services. This commentary describes how the new organizational structures have challenged the traditional centralized accountability structures by creating a more dispersed system of governance for local healthcare commissioners. It sets the context of discussions about accountability in the UK NHS and then describes the key changes in England following the implementation of the NHS reforms in April 2013. The commentary concludes that while there is increased complexity of accountability within a more decentralized and fragmented healthcare system, the government's goal of achieving increased local autonomy and greater control by general practitioners (GPs) will probably not be realized. In particular, the system will continue to have strongly centralized aspects, with increased regulation and central political responsibility.

### Résumé

De récents changements dans le système de santé NHS, au Royaume-Uni, ont ajouté un niveau de complexité dans les arrangements de l'obligation de rendre compte pour les services de santé. Ce commentaire décrit comment les nouvelles structures organisationnelles mettent au défi les structures centralisées traditionnelles de l'obligation de rendre compte, et ce, en

créant un système de gouvernance plus dispersé pour les commissaires locaux des services de santé. Il présente le contexte des discussions sur l'obligation de rendre compte dans le NHS et décrit les principaux changements en Angleterre, qui ont suivi la mise en œuvre des réformes du NHS, en avril 2013. En guise de conclusion, le commentaire indique que bien qu'il y ait une hausse du niveau de complexité pour l'obligation de rendre compte, au sein d'un système de santé plus fragmenté et décentralisé, l'objectif du gouvernement visant à atteindre une plus grande autonomie au niveau local et un plus grand contrôle des médecins ne se réalisera probablement jamais. En particulier, il continuera d'y avoir de forts aspects centralisateurs ainsi qu'un accroissement de la réglementation et des responsabilités politiques centrales.

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**T**HE NATIONAL HEALTH SERVICE (NHS) OF THE UK IS GENERALLY DESCRIBED as a “command and control” system that provides the context for accountability within the NHS. Budgets and strategic policy are set centrally by the government and Department of Health (DoH) and administered locally by NHS organizations with delegated powers, but with direct lines of accountability to the DoH, albeit mediated through central and regional administrative structures. The situation is more complex, however, than the “command and control” model would suggest. Since 1948 the balance between central and local control and autonomy has fluctuated with successive governments, and now also includes diversity between devolved governments in Northern Ireland, Scotland and Wales (Exworthy et al. 1999; Peckham et al. 2008). The NHS also embodies both diversity between devolved political systems and uniformity across the United Kingdom. At the time of writing, the NHS in Wales, Scotland and Northern Ireland is under the control of the devolved authorities overseen by the territorial parliaments of Wales and Scotland and the Northern Ireland Assembly. However, the national (UK) character of the health service is reinforced by centralized funding and an emphasis on shared values such as equitable access, universality, free access and comprehensiveness, as well as by professional conformity and common standards or conditions of service. An additional complexity is that the NHS is formed of a series of local health services (Powell 1998) responding to local needs and conditions and working in partnership with other local organizations (Exworthy and Peckham 1998). There is, therefore, a tension between the requirement for central accountability for the NHS and the need for local accountability to reflect local contextual issues. There has also been a shift in the way accountability within the NHS is developing, from a centralized bureaucratic governance structure to one where there is greater decentralization of control over inputs and processes but an increasing centralization of outcome measures through performance targets and regulation (Peckham et al. 2005, 2008).

Some aspects of healthcare demonstrate both centralist and decentralist approaches – such as utilizing national frameworks to develop local innovative solutions and supporting changes in the workforce. While the UK retains significant elements of a centrally coordinated

system, political devolution and changes in the organization of health services, in England in particular, have resulted in an increasingly complex framework for the accountability of UK health services. These are described in more detail in this commentary.

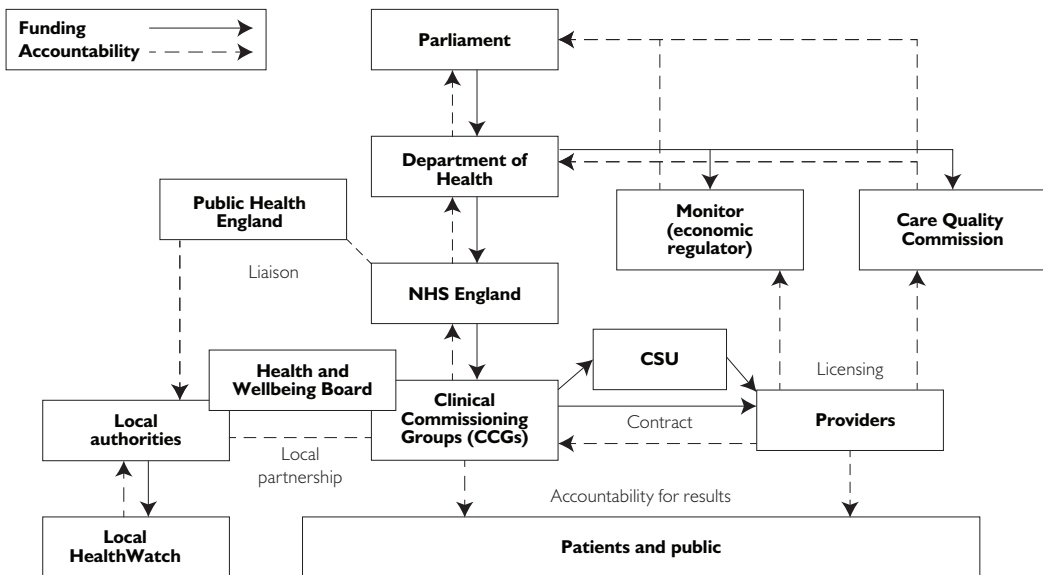
### Changing Contexts of Accountability in the NHS: The New English System

On coming to power in 2010, the coalition government of Conservatives and Liberal Democrats embarked on a major reorganization of the English NHS system, despite having initially promised “no more top-down reorganisations of the NHS” (Government of England 2010):

The Government’s reforms will liberate professionals and providers from top-down control. This is the only way to secure the quality, innovation and productivity needed to improve outcomes. We will give responsibility for commissioning and budgets to groups of GP [general practitioner] practices; and providers will be freed from government control to shape their services around the needs and choices of patients. Greater autonomy will be matched by increased accountability to patients and democratic legitimacy, with a transparent regime of economic regulation and quality inspection to hold providers to account for the results they deliver. (Department of Health 2010: para. 4.1)

The new English system shown in Figure 1 represents a substantial and radical overhaul of the NHS in England that affected almost every level of the service and was decidedly “top down.”

FIGURE 1. The NHS in England from April 2013



Prior to April 2013, primary care trusts (PCTs) held delegated responsibility for 85% of the NHS budget; they commissioned and contracted the majority of primary and secondary care for a defined geographical population and had responsibility for public health. PCTs had boards constituted of executive and non-executive directors and were held to account by a regional authority. Since April, no single organization holds budgets for all healthcare sectors and public health. The principle of geographic populations has been retained, but clinical commissioning groups (CCGs) do not contract general medical services (GMS contracts are now commissioned by NHS England) or some specialist services and do not commission public health services (where responsibility lies with Public Health England and local government). CCGs are held to account by NHS England but also have to respond to their co-located local authority. The new structure has created a complex web of relationships.

The changes in the English NHS, introduced in 2010 and enacted in 2012/13, had three main goals:

- to stimulate a self-sustaining set of incentives that foster continuous organizational reform driven by clinicians;
- to allow greater autonomy, but on a selective basis and dependent on central assessment of performance against centrally set criteria;
- to create a pluralist model of local provision. (Department of Health 2010)

The changes themselves were extensive in scope, involving the removal of overall responsibility for running the NHS from the DoH and handing it to a new arm's-length body, NHS England (NHSE), which is also responsible for commissioning 40% of English health services (e.g., general practice, dental services, specialist services and some public health programs). Central accountability of the NHS to the government flows from the NHS mandate – a contract between the DoH and NHSE that sets out the government's requirements (see Box 1).

The mandate sets out the contractual obligation of NHSE to deliver healthcare and the areas that it will be accountable for to the DoH. It incorporates a mixture of specific government policy objectives and a framework within which national and local NHSs are expected to operate. The secretary of state for health has specific duties set out in the *Health and Social Care Act, 2012*, including the promotion of a comprehensive health service, reducing inequalities and having regard for the NHS Constitution. The secretary is accountable to Parliament. Responsibility (and accountability) for operational aspects of the English NHS have been delegated from the DoH to NHSE, which then holds local NHS organizations to account through the outcomes framework or through direct contractual mechanisms (e.g., for general practice or locally delivered specialist services). The NHS Constitution sets out a principle for the government to ensure that “there is always a clear and up-to-date statement of NHS accountability” and a transparent process of accountability that is clear to the public, patients and staff (Department of Health 2013).

BOX 1. The NHS mandate

**The Mandate – at a glance**

The mandate is structured around five key areas, which align with the NHS Outcomes Framework, as well as including additional direction on topics such as finance. (This is only a summary – see the Mandate for details.)

**1. Preventing people from dying prematurely**

We want England to become among the best in Europe at preventing ill-health, and providing better early diagnosis and treatment of conditions, such as cancer and heart disease, so that more of us can enjoy the prospect of a long and healthy old age. Objectives include:

- Supporting the earlier diagnosis of illness;
- Ensuring people have access to the right treatment when they need it;
- Reducing unjustified variation between hospitals in avoidable deaths;
- Using every contact with NHS staff as an opportunity to help people stay in good health.

**2. Enhancing quality of life for people with long-term conditions**

We want the NHS to be among the best in Europe in supporting people to manage ongoing physical and mental health conditions, such as diabetes and depression, so that people can experience a better quality of life, and so that care feels much more joined up. Objectives include:

- Involving people in their own care and treatment;
- The use of technology (e.g., ordering repeat prescriptions online);
- Better integration of care across different services;
- Better diagnosis and care of those with dementia.

**3. Helping people to recover from episodes of ill health or following injury**

The Board is being asked to highlight the differences in quality and results between services across the country in order to share best (practice) and improve services.

- Ensuring greater equality between access to mental and physical health services;
- Improving transparency through publication of data and involving local people in decision-making about services.

**4. Ensuring that people have a positive experience of care**

The Board is being asked to make sure we experience better care, not just better treatment, particularly for older people and at the end of people's lives. Objectives include:

- Measuring and understanding how people feel about their care ("the friends and family test");
- Ensuring vulnerable people receive safe, appropriate, high quality care;
- Improving the standards of care and experience for women during pregnancy;
- Supporting children and young people with specific health and care needs;
- Providing good quality care seven days of the week;
- Improve access and waiting times for all mental health services, including IAPT.

**5. Treating and caring for people in a safe environment and protecting them from avoidable harm**

The Board is being asked to continue to reduce the number of incidents of avoidable harm and make progress towards embedding a culture of patient safety through improved reporting of incidents.

**6. Freeing the NHS to innovate**

We want to get the best health outcomes for patients through objectives that include:

- Strengthening autonomy at the local level;
- Promoting research and innovation;
- Controlling incentives, such as introducing the quality premium for CCGs;
- Leading the continued drive for efficiency savings, while maintaining quality, through QUIPP.

**7. The broader role of the NHS in society**

We want the Board to promote and support participation by NHS organizations and NHS patients in research, to improve patient outcomes and to contribute to economic growth. The Board must also seek to make partnership working a success.

**8. Finance**

The Board's revenue budget for 2013-14 is £95.6 billion. Its objective is to ensure good financial management and improvements in value for money across the NHS.

The statement emphasizes the importance of accountability to patients and the public more generally, as well as outlining arrangements for organizational responsibility and accountability within the English health system. The actual degree of autonomy from the DoH that NHSE will enjoy is debatable. There is both formal oversight and a blurred distinction as to whether NHSE is answerable only to its board or whether it also responds to political pressure from the public or from the DoH and Parliament.

Alongside the creation of NHS England there has been some concentration of regulatory structures at a national level, with wider powers for the Care Quality Commission and Monitor as key regulators of NHS and healthcare providers in England. The National Institute for Health Care Excellence has also seen its guidance role significantly developed.

It is responsible for the development of outcomes measures for the Quality and Outcomes Framework and also the Commissioning Outcomes Framework (Department of Health 2012). The new NHS system has substantially increased the level of centralization, shifting powers and functions previously held by PCTs and regional strategic health authorities to enhanced national agencies.

Responsibility for commissioning the majority of services for a defined geographical population lies with the CCGs, which involve primary care physicians (GPs) working together with other local clinicians, managers and lay representatives. However, while emphasizing CCGs' local freedom and accountability, the government has created a highly centralized accountability structure within which CCGs operate. CCGs had to go through a formal authorization process managed by NHS England to assess their fitness to be autonomous statutory organizations and sanction formal appointment processes for key board members. Standard constitutions have been developed by NHSE and the DoH, and CCGs are monitored by NHSE through a new outcomes framework. Regulation is also provided by Monitor, an arm's-length government body that was set up to regulate NHS Foundation Trusts and now has an expanded role as economic regulator of the new NHS system. Monitor's responsibilities include preventing anticompetitive behaviour, promoting integration, setting prices within the system and ensuring service continuity. This framework constitutes a fairly strong national accountability.

Similarly, the actual degree of autonomy of CCGs is also open to question. While policy highlights the "liberation" of professionals to make commissioning decisions, it is clear that "CCGs (unlike all previous manifestations of clinically led commissioning) will be statutory bodies with associated accountability and governance responsibilities. This will act to limit GPs' ability to act quickly and autonomously" (Checkland et al. 2012: 120). CCGs are subject to a complex web of accountability relationships. The strongest form of accountability is likely to be their accountability to NHSE, as this is backed by sanctions and subject to annual assessment. Furthermore, the currency of this accountability is clearly established, encompassing fiscal accountability and program accountability for the CCG outcomes indicator set. The accountability to other external bodies is, by contrast, much weaker and less clearly defined, with CCGs simply required to "give an account" of how they have responded to the locally developed joint strategic plan but where there are no associated sanctions. Accountability to Monitor, as the national financial regulator, may be more formal because Monitor is apparently being empowered to enforce competition law, but how this principle will be applied remains unclear. More interestingly, other non-health regulators are now intervening within the healthcare sector, including the Office for Fair Trading and the Competition Commission – both of which have ruled on recent health service organizational changes. Accountability to the public is focused upon the relatively weak notion of "transparency," with no associated sanctions. In addition, there are further layers of professional accountability to the local medical committee (the local manifestation of the UK General Medical Committee, which regulates professional medical practice).

Internal accountability relationships are similarly complex. Locally, CCGs are accountable to their board, which consists of elected GP members, certain centrally authorized posts (including the chair and an accountable officer) and other appointed members, including two lay members. The CCG governing body is elected by and answerable to GP members. This status as a “membership” organization is highlighted as a key new and desirable feature of CCGs. However, it remains to be seen whether, for example, in the future, GP practices might try to act together to dismiss a governing body that was not performing as they would like. Furthermore, should the wishes of the CCG membership clash with the requirements of NHS England (as is entirely possible), it will be interesting to see how a governing body might resolve the ensuing conflict.

However, there is also oversight through new local authority subcommittees known as health and wellbeing boards (HWBs). Government policy places key importance on the role of the HWB as part of its aim to increase democratic legitimacy and accountability. HWBs are part of the local council’s statutory arrangements and provide strategic direction and promote health and social care integration (Department of Health 2010: para. 4.17). However, their accountability role is also seen as important:

The joint local leadership of CCGs and local authorities through the health and wellbeing board will be at the heart of this new health and social care system. ... They will enable greater local democratic legitimacy of commissioning decisions, and provide an opportunity for challenge, discussion and the involvement of local representatives. (Department of Health 2011: 15)

CCGs have a representative on the HWB and are expected to set their own priorities in response to the strategic direction set by their local HWB. It is not clear how this relationship will evolve or what influence local authorities will have over local health services planning despite this statutory strategic role, as this is a new area of responsibility. CCGs are also required to be responsive to local populations, with responsibilities for consulting with patients and the public. Despite the rhetoric of increased localness and decentralized decision-making, accountability is, as suggested earlier, dispersed between central and local accountability and between formal and less formal accountabilities (Checkland et al. 2013).

### **Tensions between Central and Local Accountability in the New English NHS**

Despite government policy promoting a more decentralized NHS structure and commissioning, it is hard to see how a system funded from central taxation can successfully be entirely removed from the overview of the central political system. While it is possible to argue the theoretical distinctions between developing policy (a political responsibility) and delivering healthcare (a management responsibility), distinctions between policy formation and policy implementation are, in reality, hard to make (Hill and Hupe 2002). There has also been a

shift towards a decentralization of responsibility for processes and service delivery, but within very clear, centrally defined goals and outcomes to be achieved (Osborne and Gaebler 1992; Peckham et al. 2008). In addition, any local change of NHS services can potentially raise national political concerns because of the nature of the UK parliamentary system and the fact that funding comes from general taxation, an issue firmly in the jurisdiction of Parliament. Current debates about the national payment-by-results (PBR) tariffs are an example of how the concerns and decisions at a local level are constrained by nationally set tariffs (Jones 2012). Questions are also being asked about the role of resource allocation models used within the NHS (Buck and Dixon 2013).

Responsibility for quality of care is another contentious area within this more fragmented governance system. Recent national concerns about accident and emergency (A&E) attendances, poor performance in hospitals and even individual patient care issues can easily become national political concerns (Francis 2013). These national issues highlight the varying responsibilities of, and relationships among, national policy makers, regulators and local CCGs and providers.

The introduction of NHSE and CCGs was aimed at increasing the autonomy of the NHS and GPs' leverage over the system. Instead, it has created a more fragmented and complex commissioning and service delivery system – introducing complexities to accountability structures and new forms of organizational accountability that operate alongside existing funding and professional accountability structures. While aspects of the NHS have been decentralized, there are continuing central accountability structures that, in a more diversified and fragmented system, create a context that ultimately favours stronger centralized accountability. Alongside these tensions are increasing tensions between a move towards more competition and market approaches to service provision and policies that stress greater integration and a desire in many local areas to develop and manage services. Traditionally within the NHS, central accountability has remained predominant; as yet, there is little to suggest that this situation will change in the future.

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