

Part 3

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# Conclusions



# Where are the linkages for joined-up policy?

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As the *Policy Futures for UK Health* project progressed, the danger of looking at key policy areas as discrete themes became evident. Part of the consultation process involved asking participants to identify cross-cutting themes. Five policy areas were identified as germane to all the chapters. They are:

- the determinants of health
- equity and equality
- individual and community expectations of healthcare and health
- science, technology and industrial policy
- information, evaluation and benchmarking.

This chapter outlines these themes and provides some illustrative examples.

## Determinants of health

Among the factors influencing health and disease in a population are environment, lifestyle, hereditary and intrinsic factors, as well as healthcare services (Blum, 1981; Evans and Stoddart, 1990; 1994; Labonte, 1993; Lalonde, 1974; Mausner and Kramer, 1985). These are discussed in greater detail below.

### *Environmental factors*

Environmental factors can be organised into two categories: pre-natal and post-natal. Pre-natal factors predict adult health. Maternal illness, smoking, alcoholism, high blood pressure, poor socio-economic conditions and multiple pregnancies all predict low birth weight and thus adult poor health. Relevant factors in the post-natal environment include the 'physical, chemical and biological environment', as well as the 'social, psychological and economic environment' (Monaghan *et al.*, 2003). Physical, chemical and biological risks are strongly associated with social class, largely through occupation (Barker *et al.*, 1991). Environmental risk factors include access to nutritious food, pure water and the effective disposal of sewage, environmental pollution and housing. Dampness, lack of heating and wall-to-wall carpeting have been associated with respiratory disorders (Best, 1995), while overcrowding and the broader social environment are also relevant (Last, 1998; Macintyre *et al.*, 1993; Patrick and Wickizer, 1995).

Social, psychological and economic environmental factors include the central issue of socio-economic inequality, which some consider to be the most important determinant of health inequalities (Davey-Smith *et al.*, 1997; Townsend *et al.*, 1992; Whitehead, 1995). Besides material differences by socio-economic group, relative inequality and social exclusion (Marmot *et al.*, 1995; Wilkinson, 1997; Wilkinson, 1996), worse health outcomes are related to stress, lack of social support (Berkman and Syme, 1979) and community cohesion (Halpern, 1995; Patrick and Wickizer, 1995). Lower socio-economic status is also associated with greater exposure to environmental risks, in turn associated with ill health. Those with lower socio-economic status are more likely to experience unemployment and dangerous occupations. They more often have low control over their work (Hallqvist *et al.*, 1998) and poor education. Lower socio-economic status is also associated with riskier 'lifestyle choices' (Brenner, 1995; Davey-Smith *et al.*, 1997).

### *Lifestyle factors*

Lifestyle factors are well rehearsed in contemporary policy and media. Cade *et al.* (1988) suggest that diet in adulthood may be less important than diet in childhood. Fruit and vegetables are believed to have a protective effect against bowel disease and cancer while fatty acids and salt cause heart disease and stroke (James *et al.*, 1997). A related issue is lack of exercise and obesity, which predict coronary heart disease. Smoking, alcohol and drug misuse predict health status (Bunker, 2001).

### *Hereditary and intrinsic factors*

In terms of hereditary and intrinsic factors, the most important factor is age, though gender is also relevant. The importance of genetics to many areas of health is still not clear although genes are implicated in a range of diseases. For some of these, such as breast cancer, treatment can be attempted by conventional medical methods while for others, such as Huntington's disease and cystic fibrosis, there is no currently available treatment (Lenaghan, 1998; Zimmern and Cook, 2000). Alzheimer's disease, some heart disease and diabetes are also thought to include genetic elements (Lenaghan, 1998).

### *Healthcare services*

There is debate about the contribution of healthcare services to health (McKeown, 1979). Hobbs and Jamrozik (2004) suggest that social, environmental and public health interventions are more effective ways of securing health gain than medical services. Bunker (2001) suggests that half of the increase in life expectancy can be attributed to medical care. There have been improvements within medicine – Monaghan *et al.* (2003) cite childhood leukaemia and testicular cancer as examples – but as these diseases are rare, the population effect appears small.

Since determinants are linked, policy responses need to be sufficiently sophisticated. Two challenges discussed below highlight the ever-present theme of the changing relationship of the individual and the state, but also draw on issues relevant to disease, care and the costs of health.

### *The determinants of health in joined-up policy*

The state expects individuals to 'self-care', to make healthy lifestyle choices and therefore to possess the means to act 'responsibly'. This expectation naturally implies a measure of individual agency and autonomy (Secretary of State for Health, 1999). The problem with this is that it fails to locate individuals as embedded in a socio-economic reality partly determined by state policy: individuals are not entirely autonomous and free to change behaviour and choose healthier lifestyles (Vallgarda, 2001).

Fixed circumstances often limit choice since poorer or more deprived individuals may not have the opportunity or encouragement from their environments to change their behaviours. Poorer neighbourhoods, for example, are likely to have more alcohol outlets, while healthy foods are likely to be more expensive or unavailable (Vallgarda, 2001). There are also fewer exercise facilities in poorer areas. Unhealthy lifestyle behaviours may be interpreted as a means of coping with deprivation (Brocklehurst and Costello, 2003; Vlad, 2003) because they often represent the easiest and most affordable choices. For this reason, unhealthy consumption patterns are likely to persist among the poor (Moore, 1999). Wilkinson remarks, 'Because behaviour is socially determined, individuals can only be changed by a changing society' (1996).

Reducing incidence and mortality of disease through action on health determinants within society would fundamentally impact on overall disease rates. It would have the potential to reduce levels of chronic illness and morbidity. The question that follows is whether lifestyle choices trigger forms of healthcare rationing.

Reducing health inequalities on a broader societal scale would be optimal (Klein, 2003), but it is uncertain whether the government is willing to spend (Brocklehurst and Costello, 2003) and, by implication, raise sufficient funds. There is presently concern that money is not being invested into public health research unless a crisis demands it (Frank *et al.*, 2003; Wellcome Trust, 2004), such as in the case of infectious diseases. Evaluations of public health interventions are rare (Dargie, 2000; DH, 2004; Wanless, 2004). The Medical Research Council, for example, allocates less than 4% to public health research (Millward *et al.*, 2003).

### **Equity and equality**

Health inequalities can be defined as differences in health status or in the distribution of health determinants between different population groups – differences in mobility between elderly people and younger populations, for example, or differences in mortality rates between people from different social classes (Barnes, 2004). Some health inequalities are attributable to biological variations or individual choice, others to the external environment and conditions mainly outside the control of the individuals concerned. In the UK, for instance, the South Asian population is typically less prone to cancer, but more prone to heart disease and diabetes when compared with other ethnic groups (Cappuccio *et al.*, 2002; Gill *et al.*, in press).

Health inequities, on the other hand, have a moral or ethical dimension relating to fairness and justice: 'inequity refers to differences in health which are not only unnecessary and avoidable, but in addition are considered unfair and unjust'

(Whitehead, 1992). Equity in health therefore implies that everyone should have a fair opportunity to attain their full health potential and, more pragmatically, that no one should be disadvantaged from achieving this potential if it can be avoided (Barnes, 2004). In practice, equity is usually associated with creating equal opportunities for health and with bringing health inequalities down to the lowest possible level (Barnes, 2004; Hamer *et al.*, 2003).

There is naturally a close relationship between the two concepts. If, for example, inequalities in health (namely, an uneven distribution in health outcome) are unnecessary and avoidable, then they may also be considered unjust and unfair. If the relatively high prevalence of diabetes in the South Asian UK population results from biological factors or individual choices related to diet and lifestyle, for example, this can be considered a health inequality. If, however, this unusually high rate of disease can be attributed to poorer access to healthcare or inferior disease management, this must also be considered a health inequity (Britton *et al.*, 2004). Not all health inequalities are also inequities. Older people are, on average, unavoidably less healthy than the young (a health inequality), but because this is impossible to change, we cannot consider it an inequity. A denial of services based on age, however, could be inequitable.

Nevertheless, the issue of the definition is complicated because the precise meaning and importance of equity will depend on subjective factors such as cultural beliefs and attitudes (City University London, 2004). These include:

- how inequalities are explained
- the values underpinning the healthcare system (libertarian versus egalitarian)
- whether focus is placed on horizontal (preferential treatment for those with greater health needs) or vertical equity (equal treatment for equivalent needs)
- how finance is arranged (whether a funding system is regressive, progressive or proportional)
- how equitable distribution of care is.

Concepts of equity relevant to the distribution of care include:

- utilitarianism
- equality of health outcomes
- equality of expenditure
- equality of use for equal need
- equality of access for equal need.

As a consequence, an understanding of the values and objectives of the healthcare system must be achieved prior to assessments of equity.

Implications for these debates are examined here in relation to the themes of governance and the evaluation of performance, and self-care.

### ***Equity and equality in joined-up policy***

Governments continually have to deal with competing demands for public funds, and this necessitates careful use of scarce resources. Before they take action, they must consider which means are most appropriate for reducing health inequities and how best to measure successful intervention. Should success to be measured in absolute terms, by judging the reduction in the gap between the best- and worst-off in society, or in relative terms, by judging the degree to which the worst-off have

improved relative to where they started? In view of the difficulty in leveling health status across populations, should governments accept that not only is health inequality unavoidable, but that a certain level of health inequity will always persist? Should inequity refer to access or outcome?

Whether self-care increases health inequality and inequity remains to be seen. Since self-care is based on access to information and care networks in addition to self-efficacy, it may lead to the most disadvantaged becoming more disadvantaged. For better-informed and expert patients, access to information could make the relationship between patients and medical staff more equitable. If the balance swings strongly to self-care individual, market power will become more important. People's willingness and eagerness for private care will impact on equity and access.

## Individual and community expectations of healthcare and health

Since the UK spends below the trend line for EU countries, it is to be expected that the UK public will be relatively dissatisfied with healthcare (Lister, 2005) – and they are (Mossialos, 1997). In 1982, Maxwell showed that the proportion of GDP that countries choose to spend on healthcare can be predicted from the level of GDP per capita (Maxwell, 1982). The question is whether increasing expenditure in the UK to match the levels of EU countries of similar wealth, as proposed over the next five years, will result in greater satisfaction. Research suggests that there is no direct correlation between the level of expenditure and overall healthcare performance (Appleby and Rosete, 2003; Social Services and Public Safety for NI, 2001).

Social trends data indicate that the proportion of people satisfied with hospital services remained steady between 1996 and 1998, rose in 1999 and 2000, and then fell in 2001 and 2002 – to only just over 50% of people saying they were satisfied with hospital services (ONS, 2004). Satisfaction levels were much higher for those who had recently been hospital patients and for older people (who are more likely to have been patients). Satisfaction with GP services is consistently higher than for hospitals, with higher levels of satisfaction amongst those who had recently visited their doctor.

Public expectation of healthcare is not simply for better services. Commentators suggest that patients are increasingly behaving as consumers, demanding greater levels of autonomy and choice (Coulter, 2002; Coulter and Magee, 2003; Dargie, 2000). It is not clear what relative value is placed on the availability of a local government-owned hospital – as compared to services received from a distant privately-owned or even foreign hospital. Studies show, however, that satisfaction with such treatments are comparable to those of local hospital users (Lowson *et al.*, 2002). This suggests that people care less about the provider than the service they receive.

Central forecasts of the demand for long-term care have assumed increasing unit costs but do not include provision for increasing expectations of standards and choice with rising GDP per capita (Wittenberg *et al.*, 2002). It is also apparent that a major source of dissatisfaction with current long-term care services is their fragmented and inflexible nature (Turning Point, 2004). Much emphasis has been placed on the delay or compression of the period of ill-health (Association of

Directors of Social Services, 2000) but Kirkwood suggests the scope for compression is limited (2001). This may lead to increasing dissatisfaction with the quality, nature and outcome of long-term care.

One approach to resolving this, adopted in The Netherlands, has been to give budgets to patients and let them choose their service package and care providers (Dekkers and Lister, 2002). Similar proposals are made in the current Green Paper, *Independence, Well-being and Choice: our vision for the future of social care for adults in England* (DH, 2005). The Joseph Rowntree Foundation recently published a review of long-term care funding in the UK, drawing on international experience, stating that there is a limit to funding long-term care since there are other economic pressures (Glendinning *et al.*, 2004).

Expectations for personal health may also rise with increasing wealth. They continue to divide across the inequity gap, with the poorest expecting, and getting, worse health and healthcare services. At the same time, those who are better-off demand higher levels of support for personal health maintenance, with more choice and better standards of service in healthcare (Opinion Leader Research, 2004).

Until recently, England was the only country in Europe with no real democratic involvement in health below national government. This may be one cause of a decline in social capital and trust in government (Rothstein, 2004). Local democratic involvement in health decisions can express majority values but health is also a right of those who have minority interests, both by the nature of their health needs and by reason of ethnicity or other cause. Public and patient involvement must express both majority and minority needs and expectations (CPPIH, 2004; Farrell, 2004).

While policy in a democracy cannot operate purely on the basis of public expectation, at the same time it cannot be ignored. This leads to the question of how health expectations can and should be measured. Existing measures, including patient satisfaction, are not necessarily suitable to assess the 'user perspective' (Holland *et al.*, 1998; Mossialos, 1997). A future challenge is to develop more sensitive and contextual measures.

### ***Individual and community expectations of healthcare and health in joined-up policy***

Different perceptions of health and self-assessments of health status may be related in part to different expectations for health (Salomon *et al.*, 2004). The perception of health could also be described as the gap between expectations and experience of health (Carr *et al.*, 2001). People with the same clinical condition, but with different expectations, will report a different quality of life. Some people, because of their experiences, have low expectations of health. Carr *et al.* (2001) suggest that the core objective of health promotion is to change people's expectations, but they also point out that by changing people's expectations of health, their perception of quality of life could ostensibly decrease. As patients become more informed and aware about healthcare choices, their growing awareness will lead to higher expectations. The important question is whether rising expectations or better information will lead to better health outcomes.

A combination of rising expectations and increasing reliance on self-care is likely to mean an expansion in health choices. A particular contemporary issue is the increasing array and popularity of complementary and alternative therapy available. The drive for complementary and alternative medicine (CAM) has often resulted either from a situation in which patients are not satisfied with conventional healthcare concerning the treatment and the experience of care, or because CAM is more in line with their own values and beliefs regarding health (Astin, 1998).

## Science, technology and industrial policy

The ability to prevent and treat illness requires both an understanding of disease processes and the availability of technologies, such as diagnostic tests and pharmaceutical agents. The way in which science is conducted and the factors contributing to innovation are crucial elements among the many structural mechanisms and policy considerations that determine the health of the population. Mechanisms that lie outside the health system can have significant influences upon it. These may include the processes by which research is funded, the laws that regulate technology transfer and intellectual property, the fiscal regimes imposed on the commercial sector and the principles that underpin notions of consent and confidentiality in research practice.

These matters have been the subject of discussion and debate within the scientific and medical communities, and across the biotechnology and pharmaceutical industries, for many years. The Pharmaceutical Industry Competitiveness Task Force (PICTF), which published its final report in March 2001, was perhaps the start of a more formal process for their consideration. Since then, a plethora of policy documents and statements have been issued, including:

- *Science and Innovation – working towards a ten-year investment framework* (DTI, Treasury and DfES, March 2004)
- *White Paper: our inheritance, our future – realising the potential of genetics in the NHS* (DH, June 2003)
- *Research for Patient Benefit Working Party* (DH, March 2004)
- *Bioscience 2015: improving national wealth, improving national health* (Bioscience IGT and BIA, supported by DTI, DH, November 2003)
- *Lambert Review of Business–University Collaboration* (HM Treasury, December 2003)
- *Strengthening Clinical Research* (Academy of Medical Sciences, October 2003)
- *Securing Good Health for the Whole Population* (HM Treasury and DH, February 2004)
- *Public Health Sciences: challenges and opportunities* (Wellcome Trust, March 2004).

Together these texts emphasise some common points:

- the importance of genetics and molecular science research
- the need for a vibrant research base and research capacity within the UK
- the imperative of having strong and well-developed links and collaborations between academia, the NHS and the commercial sector

- the importance of the NHS as a unique resource for clinical trials and all forms of clinical research including epidemiological studies and health service research
- the growing importance of public health and preventive medicine
- the necessity of having an appropriate and balanced regulatory regime for the conduct of research.

Biomedical sciences have the potential to impact on health over the coming decades. The legislative, regulatory and policy regimes discussed in the documents above will have an impact on how scientific advances and technology develop and how these in turn lead to interventions that benefit human health and increase the wealth of the nation. Simultaneously, they raise a series of issues that need to be addressed.

### *Science, technology and industrial policy in joined-up policy*

Policy in this area is premised on an explicit need to be joined-up. The focus should be on funding and regulation, as well as the responsibility of different agencies regarding performance measures and incentives. Once pure science enters into a phase of applied research and clinical development, it needs a greater interdisciplinary focus. The Research Assessment Exercise (RAE) of UK Higher Education Institutions, however, is structured in ways that do not necessarily support this imperative.

The allocation of research funding raises another dilemma. Is the system to encourage 'excellence or equity'? Should research monies go to places that are 'excellent' and will deliver higher returns for the money, or should they be distributed by some other 'social' and political criteria across the country? The view of the Science Technology and Industrial Policy workshop at the Policy Futures for UK Health Consultation Conference was that investment for excellence should prevail, although it should be tempered to ensure at least some degree of uniform provision.

Another aspect of research funding that requires consideration is the funding gap between early basic research (publicly-funded) and major product development (industry-funded). Between the two, as research enters a developmental phase, funding is required to establish 'proof of principle'. It is often difficult, if not impossible, to secure funding for this purpose. Policy needs to address how this gap is filled, and how the public and private sectors might work in partnership to this end.

The state is aware of the need to provide a legislative and policy framework that allows for innovation, while taking into account the values and preferences of the society in which the scientific process is embedded. This can be seen in recent legislation on the use of human tissue or of guidance and regulation in the use of stem cells. Also relevant here are issues of intellectual property rights and the extent to which the current system of patent protection provides the right balance between encouraging commercial developments and securing benefits for the public's health.

The state has a responsibility to regulate commercial interests in a manner that will reassure the public, which is currently untrusting of industry and averse to certain aspects of technological development (Stratford *et al.*, 1999; The Royal Society and Royal Academy of Engineering, 2003). The state needs to provide evidence that public money spent on development is being put to best effect, and that it is spent on social as much as economic outcomes. The tension between commercial objectives and public health values is real and needs to be explicitly

managed. It is no longer appropriate to hold the view that this relationship is one of bad versus good. Ways must be found to bring the two together.

Concerns regarding the relationship between commercial organisations and clinicians need to be addressed since government policy demands a much closer relationship between the commercial sector and both academia and the NHS. Should commercial organisations be encouraged to develop products that will then not be bought by the UK? Are there innovative ways in which government, the NHS and entrepreneurs can work together to reduce the effect of these tensions on the economy? Or ways in which products can be developed to address the actual burden of disease and allow more people to stay at home?

## Information, evaluation and benchmarking

A driving force behind all health policy is a desire to improve health status and to manage healthcare costs effectively, with demonstrable improvements in quality of care and quality of life. The bedrock of any policy development must be measurement and evaluation. In recent times, greater emphasis has been placed on integrating the collection and evaluation of data at national, regional and local level. Results thus far have been patchy and this is an area for substantial and sustained development in the future. The publications of Leatherman and Sutherland (2003, 2005) are major landmarks in documenting performance in UK health.

Following the scandals of Harold Shipman and the Bristol Royal Infirmary, in order to improve accountability and quality, the government invested significantly in boosting health information systems. It encouraged systematic evaluation of health outcomes and benchmarking of health system performance (Blalock, 1999; DH, 1997a). England launched 'the most ambitious, comprehensive and intentionally funded national initiative to improve healthcare quality in the world' (Leatherman and Sutherland, 2003). Similar trends occurred in Wales, Scotland and Northern Ireland (DH and Social Services and Public Safety for Northern Ireland, 2002; Economic Policy Unit, 2003; Health Information in Wales, 2003; Performance Assessment Network, 2004). Five years after the publication of the NHS Plan (DH, 2000), it seems reasonable to ask whether the focus on information, evaluation and benchmarking has paid off.<sup>1</sup>

In January this year, the Shipman Inquiry (Smith J, 2005) concluded that '[before 2000] local PCOs [Primary Care Organisations] did not have monitoring systems in place that might have enabled them to detect the aberrant conduct of a doctor such as Shipman'. This begs the question of whether the reforms in place today will safeguard the quality of care in the future. More broadly, is the information

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<sup>1</sup> Health information may be seen to include: all data on disease, treatment options and health risks and outcomes; public health and the functioning of the healthcare system in general. For the purposes of this chapter, 'information' is considered within the narrow confines of indicator data on processes, quality, outcomes and performance that are produced for the purposes of government-driven benchmarking efforts. Similarly, whilst recognising that not all evaluative data are used for benchmarking purposes, our discussion addresses mainly information used for national benchmarking purposes in an effort to focus discussions. For a broader discussion of these topics, see Wait (2004), Nolte *et al.* (2005) and Wait and Nolte (in press).

being collected useful for evaluation purposes? Are evaluation and benchmarking guiding policy? What can be done to strengthen this process? What are the implications for future policy recommendations? This chapter addresses each of these questions.

### *What do we know about the quality of care at present?*

One of the main reasons for recent benchmarking initiatives has been to improve the quality of care (DH, 1997b). The first Wanless report (2002) suggested that the UK had low levels of resources and poor clinical outcomes, particularly in coronary heart disease and cancer survival (Berrino *et al.*, 1995) compared to other EU countries. In 2003, focusing on quality measures, Leatherman and Sutherland conducted what has been heralded as 'the most thorough review of data on quality [in the NHS] yet' (2003). They found a mixed picture of 'improvement, stasis and deterioration' (Leatherman and Sutherland, 2003). The number of patients waiting 12 months or longer for admission to hospital fell from 50 000 in 1999 to only 73 in late 2002, for example, but 20% of patients still wait more than six months and the number of operations cancelled at the last minute has risen. There are improvements to targets set in the National Service Frameworks (NSFs) but no data on conditions not covered by NSFs. The conclusion on the state of quality in the NHS, therefore, is one of cautious optimism. Further data and a longer period of time are needed before a more definite verdict can be advanced (Smith, 2003; Leatherman and Sutherland, 2003). A further report by Leatherman and Sutherland (2005) has been published coincidentally with this book.

### *Is the information we are collecting useful for evaluation?*

Most health information systems were originally designed for financial management rather than evaluation purposes. Lack of available data may force healthcare systems to focus measurement on what is available, rather than what is most meaningful (Smith, 1995; Walshe, 2003). In the above example, NHS targets focused on the number of patients waiting more than 12 months for admission, without taking into account the growing number of patients whose surgeries are cancelled at the last minute (Smith, 2003). In this type of scenario, indicators may not necessarily reflect areas that need improvement, require prioritisation and match system goals (Smith, 1995; 2002; Walshe, 2003; Walshe and Freeman, 2002).

The culture of benchmarking has inadvertently led to a near-exclusive emphasis on the results of healthcare systems, with little attention to understanding why and how results have been obtained (Blalock, 1999). Lack of reliable data remains a significant impediment to any thorough evaluation of quality or performance within the NHS (Leatherman and Sutherland, 2003).

### *Is benchmarking guiding policy?*

Although Marshall *et al.* (2003) suggest that the most important goal of benchmarking is to guide policy, several scholars have expressed fears that indicator measurement has become an end in itself. They have argued for the evaluation of benchmarking indicator systems and progression towards a true culture of

performance (Blalock, 1999; Goddard *et al.*, 2000; Smith, 2002; Walshe, 2003). A House of Commons Public Administration Select Committee found that lack of articulation between policy objectives, targets and indicators undermined the credibility of benchmarking initiatives. It states:

*Targets should never be accepted as a substitute for a clearly expressed strategy and set of priorities ... The target setting process has subverted this relationship with targets becoming almost an end in themselves, rather than providing an accurate measure of progress towards the organisation's goals and objectives. Targets can be good servants, but are poor masters. (2003)*

The fault does not lie with measurement efforts, but with the inadequate use and application of information produced. In political climates dominated by short-term imperatives and high media attention, there is inevitably a high risk of misinterpreting or misusing benchmarking data (Goddard *et al.*, 2000; McKee, 2002; Walshe *et al.*, 2001). Even when reliable evaluations do exist, findings are not necessarily translated into policy. Too few policies are evidence-based (Black, 2001; McIntyre *et al.*, 2001). These predictable weaknesses do not, however, make for a case against the benefits of benchmarking.

### ***Improving benchmarking – the role of coherence, capacity and clinical engagement***

Coherence, capacity and clinical engagement need to be emphasised to make current benchmarking more effective in driving healthcare system performance and quality (Smith, 2002).

'Coherence' implies that benchmarking initiatives fit in with other external review systems in place and that their roles are complementary and not duplicative or undermining. An example would be the efforts made to consolidate different 'arm's-length' bodies responsible for regulation and evaluation within the NHS. Consolidation is being evidenced in Scotland with the joining of different organisations under the umbrella of NHS Quality Improvement Scotland.

'Capacity' suggests that the healthcare system has the structures and skills in place to accommodate a performing benchmarking system and to ensure that it meets its objectives. It has implications for resources and cultural changes needed within healthcare systems at managerial and clinical levels.

Possibly the most critical success factor in benchmarking and evaluation efforts is 'clinical engagement'. A routine review and application of benchmarking data by clinical professionals is needed to improve data validity. This, in turn, will inform and improve clinical practice (Leatherman and Sutherland, 2003).

An audit of nine NHS hospital trusts found evidence of manipulation of waiting list data in order to meet government waiting list targets, often resulting in delayed treatment for other patients (Goddard *et al.*, 2000; NAO, 2001). 'Target fatigue' is a phrase coined to describe the lethargy brought on to hospitals, practitioners and local managers when faced with increasing checklists of targets and indicators but little rationale for how data will be used. In an evaluation of the impact of the Clinical Outcomes Indicators in Scotland, surveyed hospitals dismissed the information provided because of lack of credibility of the indicator framework, poor timeliness, little training and facilitation to interpret the data, no incentives to meet

targets and no external accountability for the data (Goddard *et al.*, 2000). Clinical management needs to be matched with the engagement of executive management at all levels within the healthcare system.

To ensure useful, relevant benchmarking frameworks, the following aspects should be emphasised:

- *transparency* about the methods used to derive indicators and clear caveats about data limitations may help prevent inappropriate interpretation of results
- *a clear classification of target achievement*, such as the Scottish Executive's advocacy that targets be reported as 'achieved', 'ongoing', 'on track', 'delayed' or 'may not be achieved'
- *judicious selection of indicators and targets*
- *specification of the timeframe needed* to allow for meaningful interpretation
- *timeliness of data* to allow feedback to clinical practice
- *presentation of clusters of performance indicators* to avoid gaming and facilitate interpretation (Audit Commission, 2003).

### ***Information, evaluation and benchmarking in joined-up policy***

Greater emphasis on information, evaluation and benchmarking has implications for the other policy areas which will affect health and the healthcare system in years to come. Technology is fundamental to data collection and analysis. Other implications discussed here are in governance and care.

Although one of the stated objectives of benchmarking is to improve accountability across the healthcare system (Nutley and Smith, 1998), there is often a tension between centrally-driven performance management systems and decentralisation of service delivery and resource allocation. For this reason, policy-makers have been advocating 'a new localism' in benchmarking (House of Commons Public Administration Select Committee, 2003) that combines clusters of national performance indicators with locally-set targets to foster improvement (Audit Commission, 2003; Scottish Executive, 2003). Further direct involvement of the public in setting policy goals and targets has been proposed but the willingness of the public to be involved in health policy making is questionable.

Similarly, although one of the stated aims of benchmarking is to allow individuals to make better choices about their care options (Nutley and Smith, 1998), there is evidence that the public do not use this information to guide treatment decisions (Marshall *et al.*, 2003). This may be due to lack of understanding of the data (Vaiana and McGlynn, 2002), limited trust in their provenance (Bentley and Nash, 1998) and no sense of ownership for the data produced. The question of who has responsibility within the system for conveying or translating this information to patients and their families needs to be considered.

However, still too little is known about whether the focus on data collection and benchmarking is actually contributing towards improving the health of our population (Sheldon, 1998). Most indicators reflect processes, not outcomes, of care (Goddard *et al.*, 2000). The 2004 Wanless report lamented the lack of evaluation data available to help guide future public health policies. The lack of a comprehensive evaluative framework for benchmarking makes it difficult to establish a causal relationship between specific processes of care and health outcomes. This precludes the possibility of making practical recommendations for meaningful

service improvements (Nolte *et al.*, 2005) although early evidence of the use of indicators and targets in England would support their utility for improvement (Audit Commission, 2003).

## Conclusions

These cross-cutting themes emerged from the process of undertaking the *Policy Futures for UK Health* project and the recognition of the difficulties associated with addressing health policy as a series of separate themes. Given the breadth and complexity associated with health policy, some sort of thematic focus is inevitable. The discussion of cross-cutting themes – a set of issues running through all the policy areas – demonstrates the strong need for policymakers to make connections across fields and to locate ‘bits’ of policy within a larger picture. On the one hand, this need to broaden thinking and joined-up policy is obvious. On the other, it has not yet been properly addressed. The preceding discussion of cross-cutting themes aims to point to where some important linkages may be, and thus to support more effective policymaking for the future.

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