

A Critical Appraisal of Accountability Structures in Integrated Health Care Systems.

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TERMS OF REFERENCE.

This paper has been prepared as a contribution to the Scottish Executive's Review of Management and Decision Making in NHSScotland. Its terms of reference are:

'To undertake a critical appraisal of accountability structures of integrated health care systems in different countries (including the UK) based on a review of current academic research.

Work should include a brief description and comparison of:

- 'internal' accountability structures of health care systems; and
- 'external' accountability of health care systems to central and / or local government; to patients and users of services; and to local populations.

The appraisal should focus in particular on health care systems that are generally perceived to have achieved significant recent improvements in one or more of the following areas:

- health outcomes for local populations;
- the patient experience;
- responsiveness to patients and users of services;
- shifting the balance towards treatment in primary care settings.

It would also be useful to have an assessment of the impact of any recent re-organisations on the quality and depth of accountability and responsiveness'.

Summary

This paper explores how the concept of accountability has developed and changed in the context of health care. A distinction is made between *political* and *administrative* accountability as a framework for a comparative analysis of how the countries of the UK and other advanced health care systems have addressed the concept. The nature of political accountability is considered and the arrangements in different countries discussed. Evidence on the performance of organizational models that have been used to structure administrative accountability is reviewed, principally international experience of managed competition and internal markets, and post-market models that seek to integrate health care delivery. The growing use of information as an accountability instrument is reviewed in the context of rapidly growing interest in the measurement of health care performance.

1. Introduction

The paper begins by giving some consideration to the definition of accountability and identifies a framework for the evaluation of recent trends in the development of accountability structures and processes. Some aspect of accountability is a concern in all developed health care systems enabling on the one hand, a wide range of experience to inform the paper, and on the other a diversity that is potentially overwhelming and unhelpful. Narrowing the study to 'integrated health care systems' poses its own problems of definition; for instance, the United States is commonly perceived to be a country without an integrated health care system, but has *within* it numerous, highly integrated health care systems who compete for subscribers either on a profit making or not for profit basis (e.g. Kaiser Permanente) or serve defined population groups (e.g. the Veteran's Health Care Administration [1]). Accordingly the paper has taken a pragmatic approach to the inclusion of comparators, using the evidence and experience of many 'systems' if it appears to be relevant to the analysis. In so doing it draws primarily, though not exclusively, on the experience of OECD countries where the majority of health care funding is raised from public sources, either through taxation (e.g. Italy, Spain, New Zealand) or compulsory social insurance (e.g. France, Germany). A comprehensive listing of references and sources is included.

2. Defining Accountability.

Accountability is commonly understood to mean the giving of an explanation for the discharge of responsibilities entrusted to individuals or organizations, in short a reckoning, a justification of their conduct. Its etymological roots are in the keeping of financial accounts, and whilst financial management is still an important component of the present day use of the term, it is only one part, others having emerged to complement the original meaning. Similarly, over time the nature, character and application of the many aspects of accountability has also evolved. In short, we are wrestling with a word which is used in diverse and changing contexts, and which conveys particular meanings to actors in those contexts at particular times and places. If 'democracy has become the most promiscuous word in the world of public affairs,' [2] accountability cannot be far behind. The two words are, of course, related. In a democracy the governed periodically require a reckoning from their political leaders and have the option to dispense with their services if found wanting.

Accountability is thus a fundamental component of governance, requiring a process for judging the performance of the 'governors' by the 'governed', with the implication that some form of performance measurement, however basic, informs the exercise of that judgement. Implied also is the need for the actions of those being held to account to be open to scrutiny, that those making the judgements are in a position to cross examine the accountable by having access to information on their actions. It is unsurprising therefore, to observe a growing sophistication in the measurement of performance, and calls for greater openness in the decision making processes of publicly owned organizations. Similarly, the more dynamic sounding concept of 'performance management' has overtaken the passive sounding activity of 'performance monitoring' in accountability processes. Accountability is thus an incentive to improved performance, publicly available information and the day of reckoning being its drivers. NHSScotland's Performance Assessment and Accountability Review Arrangements [3] makes these points explicitly, the first of its three objectives being to 'encourage sustained improvement' in the performance of the NHS; its second the 'management of NHS performance by NHS Boards'; and its third the role of accounting for NHS performance to 'the Scottish Executive and the people of Scotland'. To quote New [4], 'accountability is in vogue'.

Day and Klein [5] studied accountability in five public services in the UK (including the health service) and described accountability as a "fashionably 'good' word", a "slippery and ambiguous term ...Its various meanings [tending] to be conflated ...often with confusing results'. In the context of Australian public services, Sinclair [6] likened accountability to a chameleon, observing that like the reptile, accountability is much, 'sought after but elusive', and capable of adaptation in response to environmental change. In her study of leaders of public sector organizations in the Australian State of Victoria, she attempted to identify how they defined the term. Two contrasting ways or 'discourses' were used by the interviewees, the structural discourse with its emphasis on formal roles and relationships; and the personal discourse, which revealed an 'emotional' dimension to accountability as felt by those involved in its processes. People interviewed in this study moved readily between these discourses, reminding us that accountability is a subjective construct, informed by experience of it, and one that changes with context, as much as it is a formalized process of reckoning. Emmanuel and Emmanuel [7] warn of the dangers of trying to apply a single model of accountability to health care, offering a theoretical framework that distinguishes between what they term three accountability domains, the professional, economic and political. Mulgan [8] has referred to the ever-expanding nature of the concept beyond the 'core' idea of being called to account. Thus accountability is sometimes equated with the broader notion of responsiveness to public concerns even though there is no formal calling to account, and with the public dialogue that is inherent to democratic government.

Sinclair's small-scale study is valuable also for what it revealed empirically of the forms or types of accountability described by public service leaders. Five categories were identified: political; managerial; public; professional; and personal – the last, 'a self imposed allegiance to basic values such as respect for human dignity'. New [4] looking specifically at the accountability of organizations within the NHS from a theoretical

perspective distinguished between political accountability – the relationship between the governed and those who govern – and administrative accountability – the means whereby the agents of those who govern are held to account. These two categories are very similar to Sinclair’s ‘political’ and ‘managerial’ forms, and conceive of accountability as control [8]. Public accountability in Sinclair’s typology is concerned with direct accountability of agencies to the public and communities they serve, which Mulgan argues is as an extension of the concept to embrace ‘responsiveness’. Professional accountabilities are associated with the codes, values, standards of behaviour and practice that are integral to the membership of particular professional groups. None of the categories that have been distinguished should be regarded as watertight compartments as there are connections and overlap between them. Indeed one of the characteristics of public management is the need to work with multiple accountabilities [9] and accountability policy initiatives are frequently intended to strengthen more than one of its dimensions. The categories do, though provide a means of structuring a discussion of this subtle and complex concept, and this paper focuses on two of them: political accountability and administrative (managerial accountability). In both the commonly understood features of accountability are present: there is an *external* dimension in the sense that those who are holding others to account are outside the accountable body; and there is a process of *social interaction and exchange* with rights of *authority* over those being held to account [8]. The second of these characteristics is absent when accountability is conceived as responsiveness or dialogue. Given the terms of reference, which focus on accountability *structures*, as instruments of exchange and authority, the paper does not address these extensions of the concept. They are, however, of great, and growing importance in health care systems, the engagement of patients and the public in the activities of health care organizations being pursued to sensitize them to local needs and preferences and to secure greater legitimacy when making contentious decisions. The substantial literature on these matters is therefore beyond the scope of this paper. Similarly, as the terms of reference are focused on accountability *structures* in care *systems* the issue of professional accountability is not discussed in any detail.

An important point must be made, however, about the relative weight or influence of these different dimensions of accountability on health care systems and the actors and agencies within them. Alford’s [10] analysis of the distribution of power between structural interest groups in health care has a relevance to this discussion since accountability is about the control of power and those who exercise it. In his analysis, Alford identified a dominant interest (power) group of ‘professional monopolizers’, primarily the medical profession; a challenging group of ‘corporate rationalizers’, in the form of hospital administrators and government officials; and ‘repressed interests’ typified by consumers and communities without influence in health care systems. Observing attempts by the corporate rationalizers to challenge the power of the professional monopolizers, Alford had identified one of the major dynamics of health care change in the 1980s and 1990s, represented in the NHS, for instance, by the rise of the general management function. In contrast, Rowe and Shepherd [11] argue that there has been least movement in the direction of community interests. Applying these ideas to Sinclair, New, and Mulgan’s typologies of accountabilities may suggest that we can expect to discern a relative weakening of traditionally dominant professional

accountabilities, in the face of challenges by ascendant political and management accountabilities, whilst community (public) accountabilities remain comparatively weak. Reform of professional regulation, the emphasis on corporate and clinical governance, national service plans, and performance assessment frameworks including numerous quantitative indicators, can be conceived as part of a recent NHS policy repertoire that has shifted the balance in favour of political and administrative accountabilities. In comparison, a recent analysis [12] of structural interests in Primary Care Groups in England, 'highlights the continuing weakness of the community as an interest group despite the emphasis on involving patients and the public'. It is difficult to measure these dynamics with any precision, but Alford's analysis offers an insight to this slippery concept that adapts, like the chameleon, to changes in its environment.

Political Accountability

This form of accountability is comparatively well understood. It is a fundamental feature of democratic government. It is so familiar it is unnecessary to rehearse its essential features in any detail. Typically, political responsibility for health and health services rests with elected politicians who are held to account for their stewardship of their responsibilities by the public at periodic elections. Different countries take different views on the nature of those responsibilities and their distribution between levels of government; in other words, they take a different view of what a government minister of health or chair of a local council committee should be politically accountable for. There are no hard and fast rules here; arrangements vary according to the political, social, and constitutional history of individual countries.

The UK.

In comparison with most countries the extent to which political accountability for health care is centralized in the UK is unusual. Between 1948 and 1999 the NHS, unlike any other public service, and unlike health care elsewhere, was funded and run by central (Westminster) government and its agents [2]. Political devolution in 1999 has changed the constitutional landscape of the UK so that political accountability for the NHS is now focused at the national level in each country rather than at Westminster. However, there is still only a limited role for locally elected governments (unlike education); and the European Union has limited competence in this arena (unlike agriculture). There are, in consequence, no other elected representatives to take the credit or share the blame for the NHS [13] a reflection of the deliberate choice to centralize political accountability when the NHS was created [14]. Even though the NHS conducts most of its business through organizations that are individual statutory bodies, central government ministers have always had a legal power of direction over their agent's activities. Ministers have also continued Aneurin Bevan's preference for appointed rather than elected membership of them, contributing to what Stewart [15] termed the 'new magistracy' that runs the 'Quango state'.

The consequences of these arrangements are many, but two stand out. First, an elaborate apparatus has developed to enable central government ministers to be held to account [2]

and to hold their agent's to account. These have been modified, indeed intensified, by the creation of devolved political institutions, but their essential character remains intact. Legislatures and their committees scrutinize legislative proposals, and through the parliamentary questions and debates enquire into every nook and cranny of the NHS. They are aided in their work by statutory, independent audit bodies, whose reports can make uncomfortable reading for ministers. The legality of ministerial actions and those of their agents are challenged in the courts, and by tribunals concerned with particular issues (e.g. mental health). In a less formal sense, but arguably in the modern world of at least equal importance, the media contributes to the political accountability of ministerial stewardship of the NHS.

The complexity of the arrangements that have evolved in the health service is such that they are not always well understood. In theory, ministers are politically accountable to legislatures for everything that takes place in the NHS. The Royal Commission on the NHS in 1979 came to the view that this was a 'constitutional fiction' [16]. For ministers to be able to fulfil their political accountabilities it has been necessary to develop systems of 'administrative accountability' within the health service (see the next section). In practice political and administrative accountabilities can be difficult to distinguish. The confusion is well illustrated by the case of the Inquiry into the Personality Disorder Unit at Ashworth Hospital in England (The Fallon inquiry)[17]. Fallon attempted to unravel the accountabilities and responsibilities of individuals and organizations that had been involved in the management of the hospital and was especially perplexed by the role of the NHS Chief Executive in England, concluding that he was,

'not "in charge" of the NHS in the accepted sense of that expression. The NHS Executive is part of the Department of Health and the Chief Executive and his staff are civil servants. They have no direct line of accountability for the actions and conduct of NHS field authorities, ...[but monitoring of them] is carried out by the NHS Executive and ... [they] are answerable for their performance to... the Chief Executive and ultimately to the Secretary of State. Their accountability, however, is said to be direct to the Secretary of State' (Fallon Inquiry, Section 5.1.2).

Outside the NHS attempts have been made to address the 'fiction' by formalizing the distinction between political and administrative accountabilities. The creation of Executive Agencies in the 1980s and 1990s sought to put distance between ministerial policy making responsibilities (political accountabilities) and policy implementation and operational management undertaken in agencies (administrative accountabilities). Agency chief executives are accountable to the legislature for the administration of their agencies, and ministers are (theoretically) removed from having to explain every action taken by them [18,19].

In the health service a similar idea has surfaced from time to time, most recently in a paper by the King's Fund [20], which suggested the creation of an 'NHS Corporation' working at arms length from government and separately accountable to Parliament. It is an idea that has not found favour in the past and there is no evidence of enthusiasm for it amongst present day ministers. The principal reason is because it is difficult to maintain

'distance' when 'operational problems' in high profile public services escalate, as they tend to do, into major political furores. Even if ministers were prepared to 'let go' of the day-to-day problems of the NHS, it is not obviously the case that legislatures would be willing to allow them. The example of the English Prison Service in the 1990s revealed the tensions that can arise over the between an agency's chief executive and its political master [21]. In Scotland, the problems of the Scottish Qualifications Agency in 2001 inevitably became the problems of the education minister in the Scottish Executive. In both case parliamentarians took a very close interest in the relationship between the minister and the agency for obvious political reasons.

The second consequence of centralized political accountabilities is that it often leads to accusations of a 'democratic deficit', particularly when ministerial agents make unpopular proposals for change, the case of hospital closure being the example par excellence. Formally, the decision to close or keep open a hospital remains a ministerial decision, but it is commonly thought of as the final rubber stamp on the actions of ministers' agents, not least perhaps because the closure proposal may well originate as a consequence of ministerial policy. Centralized political accountability is perceived to be remote and ineffective, and can lead to confusion about what is meant by the term NHS [22]. The political cost can be high, evidenced by the victory of an independent candidate in the Wyre Forest constituency in the UK election of 2001. Dr Richard Taylor a retired doctor, found himself elected after standing in defence of services at his local hospital in Kidderminster. On the other hand, when ministers seek to control their agents through the various means at their disposal, principally the distribution of money and the issue of 'guidance', they may find themselves accused of insensitivity to local circumstances.

This dilemma has given rise to calls for democratically elected local bodies to replace or supplement central political accountabilities. Hunter [23] made such a case in the context of the NHS internal market, arguing that health care purchasing by health authorities lacked democratic legitimacy. In his view, an appointed agency accountable to distant ministers could not satisfactorily meet the requirement for public scrutiny. Others, including the BMA [24] and the National Association of Health Authorities [25] have taken a different view a view, fearful of what might happen if local councilors were entrusted with the responsibility for the NHS. Amongst their concerns were worries for the 'national character' of the health service and the disruption of organizational change. Klein and New [2] suggest there is another consideration, the potential for increased conflict between local and central accountability, as the respective politicians wrestle over the relative weight of their mandates. That is the experience of many other countries (see below).

At various times governments have attempted to square this awkward circle by appointing directly elected members of local authorities to be members of health bodies. For many years local authorities nominated councilors to serve on health authorities and they typically made up to a third of the overall membership. These arrangements came to an end with Working for Patients [26] and the introduction of a 'corporate model' of ministerially appointed executive and non-executive members, the latter group sometimes including local councilors, not of right, but on the basis of their personal qualities. Only

in 2001 did this situation change in Scotland [27] when local authorities were invited once more to make nominations to ministers to consider when appointing the new NHS Boards. These nominations are subject to the general requirements of Public Appointments Commissioner, which are designed to reduce the risk of political cronyism in the appointments process. The number of local authority members appointed varies according to the local political geography. Important though these changes have been they are unlikely to satisfy those who would prefer an extension of local political accountability.

Other Countries

Few other countries have centralized political accountability for their health care system to the extent of the UK. The nearest equivalents are Portugal, New Zealand, Spain, and Italy all of which have health services with strong similarities to the UK. ***Portugal*** has centralized political accountability in its Minister of Health who is ultimately responsible for the actions of a decentralized administrative structure similar to that which existed in England prior to the abolition of Regional Health Authorities in 1994. ***Spain*** and ***Italy*** have national health services but have devolved political control of health care to regional governments. Recent changes in the organization of ***New Zealand's*** health care system have strong parallels with current policy in Scotland. A new (Labour/Alliance) coalition government elected in 2000 set up 21 District Health Boards (on 1st January 2001) accountable to the Minister for Health. In designing this model the problem of balancing local interests with centralized political accountability was addressed by directly electing 7 of the 11 members of the DHB to represent the local community. The Minister for Health appoints the balance of the Board and its Chair. The Boards have twin functions of purchasing health care and providing it and are held to account for both by the Minister.

Spain and ***Italy***, like New Zealand, have national health services, but political responsibility is shared between the national government and 'Autonomous Communities' (of which there are 17 in Spain, e.g. Catalonia) and 'Regions' (of which there are 21 in Italy, e.g. Lombardy). The sharing of political accountability in this way is a fundamental feature of federal states, such as ***Canada, Australia, and Germany***. The precise division of responsibilities varies between countries and *within* some of them (asymmetric devolution is a particularly striking in Spain), but a common feature is conflict over the constitutional competence of each level of government.

In federations the central government typically defines a framework of health care principles and benefits that apply throughout the country, but states, provinces, regions, autonomous communities are responsible for organizing the delivery of health care. The resultant tensions require elaborate inter-government machinery (akin to the UK's Joint Ministerial Committee) to coordinate health care administration. Conflict usually arises over the funding of health care (Italy, Canada and Australia are prime examples) and concerns that the actions of the individual administrations may undermine the social solidarity of 'national health services' (e.g. Italy) or encourage what is known in the UK as the 'postcode lottery of care'. Growing diversity in a country's health care system may

be interpreted as inequality even if the divergence is democratically legitimated. The result is that the actions of individual administrations are closely observed to assess the impact of their policies [28]. Banting and Corbett (2002) suggest that in federal countries there is a special sensitivity associated with health care that ultimately constrains political ambitions to diverge from a 'national' pattern of service; health care acts as a unifying force that helps sustain a sense of national identity.

This also appears to be case in *Sweden*, a unitary state, where in common with other Scandinavian countries, national government shares political accountability for health care with local government. Elected local County Councils are responsible for organising the delivery of health care within a framework of nationally agreed principles, and most of the costs of the public health care system are met from locally raised income taxes. Recent actions by the largest of the County Councils, Stockholm, which privatised the operation of a general hospital, have brought local and national administrations (under different political control) into conflict, the national government enacting a controversial law that attempts to prevent further privatisation of emergency hospitals [30]. These tensions are not evident in other Scandinavian countries. In *Finland* political accountability for health care is shared between the 448 municipalities, which have primary responsibility, and the national government. The average population size of the municipalities is 11,000 people, which group together into 20 hospital districts to manage secondary care services. Health care funding comes from a blend of national and municipal taxes and social insurance. National regulation of the health care system is limited, and has lessened since 1993, with the consequence that there is considerable diversity in the pattern of health care, which is accepted as it rests on the decisions taken by locally elected politicians [31]. The same preference for local political control over national uniformity is evident in *Denmark* and *Norway*.

Within federal and decentralized nations the individual states, regions, provinces etc also share political responsibilities with other locally elected bodies. In *Canada* the administration of health care *within* the provinces has been the subject of increasing decentralization, the extent of direct election varying amongst them. The policy is regarded by some as experimental in the absence of evidence of its contribution to health service effectiveness and health outcomes [32]. Lomas et al's [33] study of board members of devolved health care authorities in 3 Canadian provinces revealed the tensions arising between them and provincial governments.

In *Spain* the direction of travel since the late 1980s has been in the opposite direction. Although 'municipalities' have retained some powers most have been transferred 'upwards' to the Autonomous Communities, though not without political difficulties, notably in Barcelona. [34]. Attempts to remove hospital management from the line of political accountability by the creation of 'Fundaciones' – independent hospital providers have been successfully resisted [35]. The process of 'upward' transfer of municipal political responsibilities is evident also in *Italy* and a similar trend is emerging in the *Republic of Ireland*. In the latter, political responsibility for health care is essentially shared between the central government and the elected members of Ireland's 10 Regional Health Boards, who as in New Zealand, are supplemented by ministerial appointees. The

recently published Irish Health Strategy [36] observed that one of the consequences of these arrangements for hospital services was that, ‘local considerations rather than national evidence-based considerations hold sway,’ and have led to the planned creation on a statutory basis of a National Hospitals Agency under the control of the Minister of Health.

In addition to the question of the *level* at which political accountability resides is the question of its *extent*. The amount of health care funding that comes from taxation, the degree to which health care facilities are in public ownership, and the extent of public sector employment of health care workers are key considerations. Political accountability in the UK is intense primarily because the state is dominant on all of these counts. In many countries this is not the case. In *Canada* and *Australia* for instance there is a greater role for private and independent providers (including GPs), and for private funding. In *France, Germany* [37] and the *Netherlands* [38] the state has established compulsory social insurance systems but day-to-day administration of health care funding is the hands of myriad sickness funds (accountable to their members), which raise revenue from contributions levied on employees and employers. Some health care provision is made by the state but much of it is delivered by independent for profit, and not for profit organisations accountable in accordance with laws governing such organisations in the country concerned. In *Germany* the ‘corporatist’ sector is a key partner of the Federal and Lander governments and has several important aspects:

‘Firstly, it hands over certain rights of the state as defined by law to corporatist self-governed institutions. Secondly, the corporatist institutions have mandatory membership and the right to raise their own financial resources under the auspices of, and regulation by the state. Thirdly, the corporatist institutions have the right and obligation to negotiate and sign contracts with other corporatist institutions and to finance or deliver services to their members’, [39].

The nature of political accountability in this situation is changed to a focus on the effectiveness of the *regulation* of multiple actors in the health care system. Reflecting on the *Dutch* health care system Scheerder and Schrijvers [40] make the point that this requires the state to develop a relationship with numerous interest groups - civic society - ‘a countervailing force to political power’, and make a choice between seeing it ‘as an enemy to be conquered’ or an opportunity to create alliances.

How then does the experience of the UK and Scotland compare? On the whole political accountability is more centralized than in many countries. This has advantages: complex, politically charged negotiations between levels of government are avoided; it enables central governments to control public spending on health care; it should enable national priorities to be addressed; and reduce the danger of a ‘postcode lottery’ of care. On the other hand it runs the risk of bringing every health care problem, and every pressure group, to the door of central government, provoking a need for sophisticated systems of ‘administrative accountability’ to protect ministers. It has led to allegations of a democratic deficit when local communities and their representatives, aggrieved by the actions of ministerial agents, claim to be ignored and their concerns dismissed. Finally, it

may foster a dependence on central government and retard the contribution of ‘civic society’.

Administrative Accountability

In New’s [4] typology administrative accountability is concerned with the agencies and individuals responsible for implementing the decisions of law making bodies. As we have seen in the NHS these are difficult to separate from political accountabilities not least because the ministers’ principal civil service advisers (the NHS Chief Executive and Head of the Health Department) fulfil the role of ‘accountable officer’ and have responsibilities to legislatures for the activities of NHS bodies. This often places the accountable officer in the uncomfortable position of having to explain events of which they may only have retrospective knowledge. They may be accused of not knowing of something others believe they should have known about or failing to have in place effective controls to prevent some situation occurring in the first place. The 1979 Royal Commission on the NHS described this as a ‘gap between the formal, detailed accountability that a minister and his chief official carry....and the realities of the situation’ (p298). A subsequent series of critical reports by the House of Commons Public Accounts Committee (PAC) on the actions of the Wessex and West Midlands Regional Health Authorities in the early 1990s [41] illustrated the perils of falling into the gap.

Closing the accountability gap dominated debate about governance in the NHS in the 1990s. Critical PAC reports led to a series of changes in the governance of the NHS throughout the UK, including the adoption of Codes of Conduct for members of health bodies, and the appointment of NHS Board and NHS Trust Chief Executives as ‘accountable officers’, answerable to legislatures as well as their departmental official and political masters. The Chief Executive of NHSScotland set out the current arrangements in Scotland to the Parliament’s Audit Committee in 2001. Commenting that, ‘Ultimately, the minister is responsible for the overall direction of the NHS’, he explained that:

‘Before the Scottish Parliament was set up, chief executives in the NHS were accounting officers and sub-accounting officers to the chief executive of the management executive in Scotland. As a result, the chief executive of the management executive was the principal accounting officer, with the NHS chief executives acting as sub-accounting officers for the spend within their area. With the Scottish Parliament, that relationship has changed. All chief executives in the NHS in Scotland are accountable officers reporting directly to the Parliament.

NHS organisations are obviously accountable to the Minister for Health and Community Care for the performance of their business and for the strategic direction that has been set for the NHS in their area. They are monitored on their performance by the health department, which is responsible for issuing guidance to the organisations to allow them to conduct their business.’ [42].

The second paragraph of this quotation is helpful in setting the context for administrative accountability in the NHS; as well as supporting ministerial political accountability, it is central to the process of ensuring NHS organisations do what ministers want them to do, in ways that conform to proper conduct of public business. New [4] identified 3 dimensions to this, which he termed fiscal accountability, a concern with the proper administration of resource inputs; process accountability, the efficient conversion of those inputs to outputs e.g. treated patients; and programme accountability, the effective conversion of inputs into outcomes e.g. improved health status, sometimes called ‘social result’ [43]. The explanation of changes in the accountability given to the Scottish Parliament by the Chief Executive of NHSScotland typifies the policy response to concerns about fiscal accountability in the NHS.

Concerns with these forms of administrative accountability in health care are part of a larger response to the problems of managing public services that have been described as the New Public Management (NPM). Hood [44] characterises NPM as the merger of public and private sector management practices; an emphasis on results; and the substitution of a high level of trust in the power of markets and private business methods for established trust in public servants and professionals. He identifies seven dimensions of NPM. In summary they are:

1. the *disaggregation* of public sector organisations into separate and distinctive management units, enjoying increased delegation and management autonomy;
2. *competition* between public sector organisations and between them and the private sector;
3. the adoption of *private sector-style management practices* e.g. in relation to remuneration;
4. *discipline and parsimony* in the resource use;
5. *hands on management styles* by high profile management leaders;
6. the adoption of explicit and *measurable standards of performance*;
7. the control of public organisations through *output measures*.

These dimensions provide a useful way of reflecting on the changes in organisational and administrative accountabilities that have occurred in health care in different countries since the 1990s. In adopting them, we should acknowledge Hood’s conclusion that the extent to which they were adopted in different countries depended on the presence of both *motive* and *opportunity*, which in his view, were present in countries where ‘outsized government’ demanded resource savings in the face of fiscal stress, and where there were ‘points of leverage’ over whole public services. In health care terms this suggests that apart from the UK, the Scandinavian countries, Spain, Portugal, Italy, Australia, Canada,

and New Zealand would be the places where we would expect the most complete adoption of NPM.

Whilst the response to NPM has varied amongst countries it is possible to identify policy trends in the management of health care that have been favoured throughout the 1990s. They can be summarised as a progression from experimentation with internal markets and managed competition, to a growing interest in system integration, supported by increasing sophistication in processes of performance management, the measurement and public disclosure of organisational performance, and the use of information as an instrument of accountability. Each is considered in turn in the sections that follow, but it is important to note that not every country has followed the route of whole system reform. Exceptions are *Finland*, *Norway* [45] and *Denmark* [46] where there has been an absence of the market reform initiatives attempted in many other countries. Instead there has been a preference for dealing with the pressures of change by making adjustments within a long established pattern of political and administrative accountabilities.

Managed Competition and Internal Markets

The background to the adoption of managed competition and the impact of the new public management in the *UK's* national health services at the end of the 1980s has been well documented [47]. Similar reforms occurred, to varying degrees, at about the same time in *Sweden* [48] *New Zealand* [49] *Italy*, [50] the *Netherlands* [51] and some of *Spain's* Autonomous Communities (notably Catalonia) [34]. Drawing on Enthoven's [52] ideas managed competition and internal markets were intended to address the problems of *process* accountability, that is the conversion of inputs into outputs, particularly the cost and quality of those outputs. Subsequently, and secondarily, internal markets were also seen as way of addressing *programme* accountabilities, reflected in the UK context by the emergence of the health care 'commissioning' function undertaken by health authorities as an activity distinct from health care 'purchasing' undertaken by general practice fundholders. This restructuring of organisational relationships equates to a move away from sole reliance on *vertical* accountability (command and control) by creating *horizontal* contractual accountability between purchasers and competing providers. Typically, the vertical relationship between purchasers and their political and administrative superiors remained relatively strong, but the equivalent links with providers were, theoretically, deliberately weakened to give them greater autonomy in responding to the requirements of purchasers. The new contractual accountabilities in the NHS were not legally enforceable, and ironically, contractual disputes were resolved through an arbitration process administered by bodies to which the contracting parties were vertically accountable.

By the end of the 1990s support for internal markets in some countries (notably New Zealand and Scotland) has waned, and in others their operation has been modified in the light of experience, notably England. Explanations for the retreat from internal markets include changes in the political control and ideologies of governments, public and

professional reaction to markets, and some empirical evidence on their effects. It is this last category that is of interest in this paper.

In the *Netherlands* Lieverdink [51] has documented the rise and fall of ‘regulated competition’ when an initial consensus on its desirability gave way to political stalemate over the complexities of its implementation. Although the original intentions may have been unrealised the policy has achieved ‘latent success’ in the form of a growing commercialisation of health care by ‘attending to the wishes of clients’ amidst concerns that the solidarity (equity of access) of Dutch health care may be jeopardised. This is the issue at the heart of much empirical analysis of internal markets. Andersen et al [53] discuss these tensions in their review of health care reform in *Sweden*. Observing that ‘there is still only limited empirical evidence available on the results in terms of efficiency and equity’ of Stockholm’s internal market, they conclude that solidarity may have been adversely affected, but other government actions (budget control and service cuts) have been more important instruments of cost control. This has not diminished the enthusiasm of Stockholm’s current political leaders for competition in health care, extending it to include private providers, some of whom are former publicly owned hospitals [30].

Fougere’s [49] account of experience with an internal market in *New Zealand* illustrates how the original intentions of its proponents were continually modified by experience making it difficult to establish a formal research based evaluation of their impact. Instead he attempts to draw out the nature of and reaction to a ‘spectacular pattern of changing organisational form’. Four purchasers (Regional Health Authorities) became the focus of criticism from 23 providers (Crown Health Enterprises) claiming additional resources, from communities on whose behalf they supposedly acted, and from government when their actions challenged its policy and funding intentions. Located at the point where ‘contradictory accountabilities intersect’ they became ‘dynamic flashpoints’ in the health care system. As a focus for controversy and disliked by the other actors in the system they were eventually amalgamated into a single, national purchaser in 1997. One of the unexpected consequences of the creation of a market and the purchasing function was the emergence of Independent Practitioner Associations (IPA), groupings of hitherto independent general practitioners, traditionally paid on a fee for service basis. They have taken a variety of different legal and organisational entities to initially manage contractual relationships with purchasers over capped budgets. From these beginnings IPAs have developed to become an important component of New Zealand’s health care system, a local focus for coordinated action in primary care [54].

In so far as quantitative evidence is concerned Fougere indicates that cost containment failed and waiting times increased. A more recent analysis by Cummings and Mays [55] assessed the performance of the model in relation to criteria of: efficiency, responsiveness, quality; choice; equity of access; accountability; and financial management and cost containment. Their overall conclusion was that, ‘the limited evidence available does not suggest that the New Zealand quasi-market in health led to obvious improvements’, attributing this outcome to the weakness of incentives and the strength of constraints associated with public funding and public ownership of hospitals.

There are strong parallels between the New Zealand experience and that of the *UK*. Mays et al (2000) [56] have attempted to summarize the (English) published and, where available, unpublished research evidence on the performance of the internal market in the UK. Using criteria of efficiency, equity, quality, choice and responsiveness, and accountability, they assessed separately the impact of GP fundholding, health authority purchasing and NHS Trust status. Little measurable change could be attributed unequivocally to the market, and again the principal reasons offered in explanation are the weakness of incentives and the strength of public funding and government constraints on the actors. A study of fundholding [57] found that it had achieved some benefits for patients and had helped accelerate the development of primary care but brought with it large transaction costs and concerns about equity of access. Its derivative, the Total Purchasing Pilots, which extended the scope of the initial fundholding scheme to embrace (potentially) all health care purchasing, was evaluated by Mays et al [58] who concluded that their achievements tended to be ‘small scale, local and incremental’, but did ‘shift the balance of influence in the NHS from the hospital’, (p277). Although the accountability arrangements in the two schemes differed, in both cases those involved were given great discretion over their activities, and subjected to minimal monitoring and formal processes of administrative accountability.

Light [59,60,61] argues that the lessons learned by countries that experimented with managed competition and internal markets were unsurprising given experience in the United States. He offers three main reasons why internal markets have not delivered the improvements their protagonists claimed for them; firstly, the rhetorical themes of managed competition are adopted as ideologies but markets are never fully established; secondly the purchaser–provider split is unsustainable because purchasers need to be involved with the finer points of provision; and thirdly the political risks of competitively driven disruption are too great. However, in common with others he draws attention to the unanticipated consequences of internal markets that have subsequently informed subsequent reform, causing the state and its agents to ‘think and act’ like commissioners of ‘evidence based quality and health gain’, in other words to shift their thinking from *process* to *programme* accountabilities.

Saltman [62] considers that experimentation with internal markets has generated a new regulatory role for the state. As governments increased the autonomy of actors in health systems they also found themselves having to respond to the consequences of their agents’ activities. Instead of a decreased role for the state, there has been a paradoxical strengthening of the link between administrative and political accountabilities through the ‘ratcheting up of state regulatory oversight and supervision’ (p1681). In discharging its new regulatory role the state faces a dilemma over the balance between the ‘sticks’ of command and control bureaucracies and the ‘carrots’ that incentivise behaviours in markets, a challenge he concludes that ‘may be among the most difficult for the State in the next phase of health care reform’.

Integration

One of the observations commonly made of internal markets is that they led to a fragmentation of health care delivery, in Light's words a depletion of 'the rich stock of social capital on which good clinical medicine depends' [61]. Re-ordering administrative accountabilities to restore this stock through models of health care integration is an avowed aim of much recent health care policy. Again, the form taken in different countries varies, not least in the UK's health services [13]. Interest in health care integration is not limited to countries retreating from internal market experiments, [63] rather it appears to be the new Holy Grail of health care policy makers everywhere, spawning, for instance, new academic journals devoted to it (www.ijic.org) and a WHO Centre for Integrated Care in Barcelona (www.euro.who.int/integratedcare). Research evidence on the performance of these policies is scarce, simply because many of them have been introduced only recently. There is, however, a growing literature that describes some of them and makes tentative assessments of their effects. Those countries at the forefront of internal market experimentation are also the countries at the leading edge of system re-integration, the exceptions being some parts of Sweden (Stockholm especially)[64] Italy, (Lombardy) [50] and Catalonia in Spain. In particular there are some similarities in the reforms underway in the individual countries of the UK and New Zealand. Restructuring administrative accountabilities is not the only strategy that is being employed in pursuit of integration, others including investments in information systems, the development and implementation of clinical guidelines and the creation of Managed Clinical Networks [65] Although consideration of these is beyond the immediate focus of this paper the potential of them as strategies to accompany structural change must be acknowledged.

Typical objectives of the current reforms can be summarized as:

a focus on population health improvement (programme accountabilities) as well as health care improvement (process accountabilities);

a delegation of power to local organizational forms serving recognisable communities;
an extended role for primary care practitioners in the overall health care system;

a renegotiated relationship between the 'centre' and the 'periphery' of health systems;
more effective links between health care and related public services, especially social care (horizontal integration);

and, between primary and secondary care (vertical integration).

In *New Zealand* the Labour/Alliance government elected in 1999 (subsequently replaced by a new Labour dominated coalition of three parties in July 2002) set about completing the job of abolishing the internal market of the 1990s begun by their immediate predecessors [66,67] judging it to have failed to deliver sufficient cost and quality improvements. 21 District Health Boards were set up (on 1st January 2001) accountable to the Minister for Health for both purchasing and providing health care, so although the

market may have disappeared the new arrangements recognize and maintain these as distinct roles within a single organization. The Ministry determines the global budget of the individual health boards and is developing a geographical resource allocation formula akin to Scotland's Arbutnott Formula. Tightly defined accountability agreements, defined in legislation, individually addressing 'purchasing' performance and 'provider' performance structure the formal relationship between the Boards and the Ministry of Health ([68]. The District Health Boards are also required to produce District Strategic Plans for approval by the Minister.

Cummings and Mays [55] have made an initial assessment of the strengths and weaknesses of the new structures, employing the same criteria used in reviews of internal markets (see above). In respect to accountability they point up the tension between central decision making, which is undoubtedly strengthened in this model, and local accountabilities given the inclusion of elected members on health boards (described earlier in this paper). They also identify concerns about the administration costs associated with 21 Boards, and the distribution of scarce purchasing skills among them, and raise doubts about the ability of these new organizations to avoid a conflict of interest between their twin responsibilities having been encouraged to secure hospital services from beyond their in-house providers. They speculate that the purchasing function may shift to newly established Primary Care Organizations, not for profit groupings of general practitioners and the successors to Independent Practitioner Associations (IPAs) encouraged since 1993. 80% of GPs belonged to IPAs by 1999, attracted by the financial incentives on offer that enabled savings generated by them from capitation funding to be reinvested in local services. In the current model these PCOs operate under contract to the DHBs and are only concerned with primary care. Cummings and Mays suggest that the New Zealand model, as it is currently constructed, is likely to perpetuate the domination of secondary care, in contrast with England's Primary Care Trusts whose control of hospital budgets puts them in the 'driving seat' and well placed to pursue vertical integration.

To the extent that the New Zealand model has a parallel in Britain, it is with Scotland's unified NHS Boards and Local Health Care Co-operatives (LHCCs) rather than with Primary Care Trusts in England and Wales. Neither PCOs nor LHCCs have any accountability (administrative or political) relationship with the communities they serve, though attempts are being made to strengthen public involvement in them, an example of Mulgan's [8] notion of accountability as responsiveness. A similar situation is evident in *Australia*, where 'Divisions of General Practice' have been established. These are 'local networks of GPs engaged in cooperative networks and activities working within defined geographical areas' [69]. Introduced in 1993 there are now 123 divisions including all Australian GPs. They are of varying size and internal governance, having been given discretion in these matters by the Federal Government that funds them and to whom they are administratively accountable. They are not health delivery organizations, but are intended to strengthen local health care integration. An initial focus on health services has broadened to an interest in population health, encouraged by 'outcome-based funding' that is intended (with limited success) to cause the divisions to focus on six national health priorities.

Before considering some of the national *differences* in NHS governance that have emerged recently in the **UK**, it is necessary to take stock of the evidence, in so far as it exists, on the effects of New Labour's restructuring of administrative accountabilities since 1997. In the style of Giddens's [70], Third Way Ham [71] presented Labour's health service reforms as a series of apparently contradictory dualities: central direction *and* local autonomy; incentives *and* sanctions; competition *and* planning, and he pondered on the sustainability of this approach and its effects. Le Grand [72] has subsequently published an assessment of the early changes in England, pointing out that (as in New Zealand) the purchaser-provider separation has been reconfigured rather than entirely abolished, collaboration between the actors being encouraged instead of competition, and the entire health care system subjected to stronger central management direction to the extent that he concludes 'control triumphed over both competition and collaboration' [72 p121]. As far as process accountability – the conversion of financial inputs into activity outputs - is concerned the early results of these changes, according to Le Grand, have been unimpressive, the efficiency of England's health service declining in both 1998 and 1999. Capacity constraints that have hindered the expansion of activity are part of the explanation, but in Le Grand's view the bigger problem is the nature of incentives in the reformed NHS, in Saltman's [62] terms there being too many sticks and not enough carrots. The lessons, Le Grand concludes, are to avoid 'heavy-handed central control'; to encourage competitive pressures through the purchasing role given to PCTs which need not result in the rejection of co-operation; and the removal of perverse incentives (e.g. the co-existence of public and private practice by NHS consultants) and the creation of new (though unspecified) ones.

Political devolution within the UK has created the possibility of each country's NHS addressing governance issues in different ways, creating something of a natural laboratory in which ideas can be tested. So far only initial assessments of the impact of devolution have been made rather than formal evaluations, but divergence in the governance of the NHS is increasingly apparent, even though all of these systems adopt 'partnership' and 'collaboration' as the key concepts in their organizational designs. Points of divergence include the degree to which a purchaser-provider separation has been abolished; the mechanisms for primary care doctors to influence secondary care; the approach to 'localisation' of the health care system; and the flow of funds within the NHS. Scotland and England stand at different ends of a spectrum on some of these [73]. Arrangements in Wales attempt to shift the focus of the NHS to local communities, but implementation of the new arrangements will not be completed until 2003. In common with most other issues in Northern Ireland reform of the health care system is secondary to the peace process, but organisational possibilities rather than proposals have been published recently.

For the purpose of this paper the situation in Scotland is taken as read. In **England** the major restructuring of the NHS as described in 'Shifting the Balance' [74] is well advanced. As its title suggests its objective is the devolution of decision-making power down the NHS structure, in an attempt to lessen 'heavy handed control' from the Department of Health. 303 Primary Care Trusts have been established throughout the

NHS, providing primary care and related services, and commissioning other services from providers in the NHS (Trusts) and beyond with budgets determined by formula allocated direct to them by the Department of Health. PCTs have a flexible governance model that distinguishes between the responsibilities of its appointed Board (maximum membership of 14) and an Executive Committee made up of local primary care professionals (maximum number 18). A revised national health care pricing system is being introduced to avoid the need for complex service contracts on the one hand, but also to reward providers for the volume and case complexity of the care provided. The 'best' performing NHS providers are being encouraged to consider applying for 'Foundation' status, which will bring additional management autonomy. 28 Strategic Health Authorities have been established from the beginning of April of this year to performance manage the 'health economy' of PCTs and other NHS Trusts within their geographical patch. They have been described by ministers as the new 'headquarters' of the NHS in England, but have been given clear instructions to operate according to the subsidiarity principle. Inspection and audit of all of these bodies is, subject to legislation, to be consolidated in a new national body, the Commission for Health Care Audit and Inspection (CHAI), which will report to Parliament on its findings, though the administrative accountability of NHS bodies to the Secretary of State for Health and his political accountabilities are undisturbed.

In *Wales* [75] the post internal market health service has been the subject of a series of hotly debated proposals that were finally settled in November 2001. 22 Local Health Boards are being established and come into effect on 1st April 2003. The distinctive feature of these proposals is the deliberate attempt to effect closer working between health and local authorities, as their boundaries are coterminous. The design of these proposals is heavily influenced by concerns about the health status of people in Wales and a belief that it can be improved by co-ordination of the activities of health and local authorities working with, and sensitive to the needs of relatively small communities. LHBs will combine delivery functions for primary care services and commissioning responsibilities for other services from NHS Trusts, which are retained. LHBs are expected to work together in local 'Partnerships' of which it is expected there will be 10 or 12 to make best use of skills and resources. In a typical Partnership it is anticipated that there will be 2 LHBs, 2 local authorities, and one NHS Trust. At a national level the Assembly's NHS Directorate is establishing 3 regional bases that will, 'enable the Directorate to maintain a visible local presence.....and hold lead organizations to account on a day to day basis' [75].

In *Northern Ireland* the process of reform is least advanced. Fundholding continued long after its abolition elsewhere in the UK, since when there has been only modest change in the administrative structure of health care. Northern Ireland's Health and Social Services Boards, as their name suggests have always combined responsibilities for both services, and the most important move so far has been to create Local Health and Social Care Groups with the aim of bringing a community focus to their work. Health care structures are currently under review following the publication for consultation of 'Developing Better Services: Modernising Hospitals and Reforming Structures in June 2002 [76]. No preferred model is offered in the paper, though clear recommendations for

the future configuration of acute hospital services have emerged after a protracted process of review and consultation. As a wider review of public administration in Northern Ireland is underway it is unlikely that any change to the present 4 Health and Social Services Boards and the 18 Health Social Services Trusts will emerge in the foreseeable future. What can be said with some certainty is that there will be fewer organizations at the end of the process, but beyond observing that greater integration, horizontal and vertical, is an important objective it is difficult to know how this will be secured in Northern Ireland.

The lessons of organizational reform

It is evident from this account that huge organizational change and uncertainty is at play in the UKs health services. Most of it is driven by political philosophy, local circumstance, and experience rather than evidence, not least because hard empirical evidence of what works and what does not is difficult to assemble. At best most evaluations of the changes that have occurred are a combination of informed commentaries, and partial analyses of particular components of rapidly evolving health care systems. In drawing this section of the paper to a conclusion it is only possible to summarise some of the main themes that have emerged from a decade of health care reform and suggest some of the ideas that are currently guiding the development of administrative structures and accountabilities. They are:

It is difficult to find hard evidence that any of the whole system reforms of administrative accountabilities have secured, independently of other actions, the improvements they were intended to achieve; at best they have made a contribution.

Partial implementation of reform is the norm, reflecting the complexity of whole system change and the pressures of political accountability on publicly funded systems.

Internal markets and managed competition has left an enduring legacy that continues to inform the structure and administrative accountabilities of health care systems.

Most countries have retained a separation of ‘commissioning’ and ‘providing’ but have attempted to replace competition with collaboration.

There is some experimentation with new organizational models *within* hitherto wholly public systems, e.g Foundation status but these are in their infancy; the distinctions between public provision, independent not for profit, and private provision in countries where these have been strong in the past are increasingly unimportant to public funders of health care.

The unanticipated consequences of markets and managed competition have had some of the most profound effects, notably the changed role of the State as a

regulator of health care actors, and growth in primary care organizations as new entities in health care systems.

Health care integration, both horizontally and vertically, is now the objective of much health care policy in many countries.

Devolution of decision-making power within health care systems is a stated intention of policy in some countries but is difficult to achieve in the face of strong upward accountability pressures to support political accountability.

'Sticks' outnumber 'carrots' as motivators in post market systems, as it is proving difficult to identify appropriate 'carrots' to replace economic rewards. There also appears to be growing recognition of the contribution of personal accountabilities to health care improvement.

In conclusion it is hard to disagree with Naylor et al [77] that,

'As different countries have gone different [reform] routes, a hard reality has emerged: there are no 'magic bullets' to be had in health care reform. One conclusion - which may be taken as depressing, liberating, or a bit of both - appears to be that improvements in health care are not contingent on the drafting of grand blueprints or the ability of politicians and public servants to pull big policy levers. Health care improvement starts from the ground up. It requires tenacious work to understand what does and does not work in real life and the engagement of countless providers [clinicians] and patients, institutions and communities. Similarly, most policy movement seems to be incremental, driven by experience and evidence, rather than theory or ideology.'

Of the countries reviewed in this paper, **Finland**, **Norway** and **Denmark** appear to be those that have come closest to adopting this approach. As northern European countries with populations of comparable size to Scotland they are valuable comparators. A major difference however is that in Scandinavian countries administrative accountabilities support more local political accountabilities in the form of municipal or county council government. Mays [78] has speculated on an alternative way of legitimating decision making in the space between the remote central state and the individual citizen. He suggests there is a need for '*intermediate institutions*', an idea based on the work of Durkheim, who believed that occupational associations or guilds could extend their roles beyond concerns with trade issues to embrace, amongst other issues, matters of social welfare. In the modern world Mays suggests that the 'latter day equivalent of the guild might be the ethnic community association, the tribe or clan, [or] the mosque' (p125). He points out that in France, Germany and the Netherlands sickness funds grew up around occupational groups, and have evolved into intermediate institutions accountable to their members. The UK health services are notable for the absence of similar intermediate institutions. In some respects the idea of Foundation Trusts advanced by English ministers is an attempt to stimulate the development of such intermediaries.

Naylor et al's [77] conclusion also raises the fundamental question of the *nature* of health care organisations and the systems in which they operate. The advent of internal markets challenged the notion that health care organisations could be adequately conceived as inert components in a hierarchical bureaucracy. Current efforts to refashion the relationships of commissioners and providers through collaborative partnerships suggest a more appropriate model for thinking about health care organisation is to conceive of it in terms of networks. Ferlie and Pettigrew [79] explored this idea in the NHS internal market as it stood in 1994/5, interviewing 70 respondents in a variety of agencies working with nine purchasing organisations. They documented a transition in progress, noting that network management skills – the ability to work across organisational boundaries- were an increasing requirement for organisational leaders [80]. Multiple networks were identified, and a variety of management modes, but Ferlie and Pettigrew were unsure if they were observing a fad or a change of potentially long term consequence. Subsequent experience suggests it was the latter. The concept of partnership that has informed so much of Scottish health policy since 1997 is also the concept of networks. Regrettably there is little empirical evidence on the effect of recently developed networks in the NHS, most published papers being guidance on their creation, subsequent accounts and descriptions of the process, and reflections on them [81,82,83,84,85,86,87,88,89].

Does the embryonic engagement of the NHS with network models mark an important change in concepts of health care management? Not when compared with the ideas of Kernick [90] who offers an alternative perspective based on *complexity theory*, the idea that there are 'hierarchies of interacting systems where change in one element can alter the context for all other elements'. In this 'non-linear' world change is unpredictable, small changes can have large effects (and vice versa), the historical development of a system is important, and systems cannot be understood by reducing them to their component parts. Instead of using machines as metaphors for health care systems it is more appropriate to conceive of them as eco-systems, the task of health care managers being more akin to the gardener than the engineer. Similar ideas have been expressed by Chapman [91] who emphasises the importance of experimentation, evaluation and learning in policy design to deal with policy 'messes', those, 'problems which are unbounded in scope, time and resources, and enjoy no clear agreement on what a solution would even look like, let alone how it would be achieved' (p12).

Outside the health care sector Pettigrew and Fenton [92] have surveyed the change from traditional organizational forms to new ways of organizing adopted by European firms. Eight detailed case studies were also undertaken from which they concluded that these firms were, simultaneously: building hierarchies *and* networks; seeking greater performance accountability upward *and* greater horizontal integration sideways; attempting to centralize strategy *and* decentralize operations; empowering staff *and* holding the ring; standardizing *and* customizing services (p296) a process they describe as the 'management of dualities'. The message is that multiple actions, sometimes apparently contradictory in nature, are necessary to respond effectively to the pressures for change, so,

‘Beware of attempts to improve performance through simple and singular changes. Leading innovation and performance is about delivering a complementary and contextually appropriate set of innovations and not the latest management fad. The quick fix is for the magician and there are few successful magicians in politics, business and the public sector,’ [92].

Information, Performance Measurement and Performance Management.

The exercise of political and administrative accountability needs information. Rights of authority and the social interactions and exchanges inherent to accountability centre on the measurement of performance, and this is dependent on access to data about the activities of those being held to account. One of the striking trends in health care over the past decade has been growth in the amount of data generated with these objectives in mind, embracing the activities of individual clinicians, hospitals, and whole health care systems. This is a global phenomenon, given prominence by the publication of the WHO ‘World Health Report, 2000’ [93] which attempted to measure and rank the performance of every country’s health care system in a single composite indicator. Responses to the report [94] illustrate both the power of information and the complexities of measurement in health care. On the one hand countries ranked lower than they might have wished reacted predictably casting doubts on the value of the exercise, whilst academics and analysts weighed in with technical commentaries on the validity and accuracy of the indicators. Few doubt however, that the Report is something of a turning point that has brought the measurement of health care performance to international prominence. The OECD has launched its own Health Project [95] to respond to the interest in these matters among its members, fuelled by the now widely accepted dictum that, ‘we cannot manage that which we cannot measure’ [77].

Individual countries have developed their own approaches to the gathering of performance information, reflecting the nature of their health care systems and the objectives of governments. In the *USA* with its dependence on numerous separate health care ‘systems’ a Joint Commission on Accreditation of Health Care Organisations (JCAHO) has been in the vanguard developing its Indicator Measurement System (IMS) of 37 indicators of health care quality [96]. A National Committee for Quality Assurance focused on HMOs has produced a set of 92 indicators of HMO performance (HEDIS) [97]. The *Canadian* Council on Health Services Accreditation (CCHSA) and the Canadian Institute for Health Information have produced comparative information on the performance of regional health services covering 90% of the population [98]. Similar initiatives can be documented in *Australia, New Zealand, Sweden* and many other countries, as well as obviously in the countries of the *UK*. Commonly, the gathering of performance data has evolved from routinely collected administrative information and small-scale initiatives supporting interests in health care quality improvement to become a focus of intense action by governments and other health care funders. In those systems that have moved away from competition as a motivator of organizational performance there is now a particular *reliance* on information, performance measurement, and performance management as the drivers of policy implementation. Information has

become a key instrument, ‘the life blood’ [99] of administrative and political accountability.

Nutley and Smith [100] offer a deceptively simple conceptual model of performance measurement that starts from the proposition that organizational (and equally individual or whole health care systems) behaviours affect organizational performance, and that processes of measurement, analysis, and action can produce better performance. This is a plausible, though not uncontested proposition. Goldstein and Spiegelhalter [101] concluded that factors extrinsic to organizations in health care could have a greater influence on outputs than the factors over which they have control. Within the processes of measurement, analysis and action there are also multiple generic issues that influence the real world functioning of Nutley and Smith’s model.

Naylor et al [77] identify five fundamental questions about measurement: who, what, where, when, and how? Respectively these are concerned with the audience for the measurements, the suitability of data, the entity in which activity takes place, the time frame used, and the relevance of the data as a catalyst for change. The complexity of health care performance means that the answers to these questions are infinitely variable, and the limitations of data may mean that it is only feasible to offer imperfect answers. Designing a method of measuring the performance of health care organizations with a single data set to serve multiple audiences (e.g. government, the public, clinicians) and multiple purposes (accountability *and* continuous performance improvement) is especially difficult [102], but this is what is attempted in the various versions of the Performance Assessment Framework’s used in the *UK* health services [3,103] There are inevitably gaps in these data sets, as some aspects of performance are notoriously difficult to measure. Hurst and Jee-Hughes [104] found that in OECD countries least progress had been made in the development of outcome measures, but found evidence of more progress on the measurement of service responsiveness. Slow progress was noted on developing indicators of health system efficiency and equity.

The problems of analysis are equally difficult. Awash with data, health system managers must derive meaning from them. Comparison among peers, time series, achievement against targets, and complex statistical modeling (e.g. Orr [105]) are all commonly adopted as a way of bringing order from the raw data. This has spurred a great interest in the conceptual and technical problems of constructing performance league tables, and composite indicators of overall performance, derivatives that embody judgement as well as statistical science. Unsurprisingly the results have frequently proved to be very contentious [106,107,108].

The remaining problem in Nutley and Smith’s model is how to connect the evidence on performance to action. It is seldom clear how to shift performance in the desired direction, and even if it is, the need to motivate individuals and organisations to change established practice presents its own formidable challenges. Hurst [109] has attempted to classify the extent to which health system actors (consumers, clinicians, managers and government) possess the information, incentives and ability to influence system responsiveness, outcomes, costs, expenditure, and equity in three types of health system -

privately funded and run, social insurance funded and mixed provision, and publicly owned and run systems. Each type has its own relative strengths and weaknesses in aligning information and incentives for each of the actors. UK type health systems are, according to this classification, particularly weak in respect to consumer interests, in other words this group has, compared with others, little information and few incentives to act upon the information which they have. On the other hand, governments in such systems typically have strongly aligned information and incentives to control expenditure when compared to the alignment for health outcomes and service responsiveness. The value of conceptualizing the connections between information and action in this way is that it highlights the relative strengths and weaknesses of existing incentives.

Increasingly the public disclosure of performance information has been adopted as a means of incentivising performance and strengthening the accountability of organizations. In England the Commission for Health Improvement [110] has been given the job of awarding 'stars' to hospital trusts according to their performance on a range of indicators, the results being published in popular formats, and various sanctions (e.g. loss of jobs) and rewards (e.g. freedom from central monitoring - referred to as 'earned autonomy') applied accordingly [111]. The Whitehall Department of Health has recently proposed that the work of CHI should be combined with a number of other audit and inspection bodies (including the Audit Commission) in a new body, The Commission for Health Care Audit and Inspection (CHAI) which will act as an independent arbiter of organizational performance. It is likely that ever increasing amounts of complex performance information will be published it is important to assess the effects of public disclosure?

The United States has the most experience of this policy. The evidence on its effectiveness is mixed. Coulter and Cleary [112] reviewing the experience of the Picker Organisation, which specializes in surveying patients' experience of health care in several advanced countries, are optimistic. Leatherman [111] concludes it has been most effective in changing provider performance, but has had little impact on consumer behaviour. For instance the publication of detailed data relating to the performance of individual clinicians and hospitals in respect to CABGs appears to have had little impact on the provider choices made by patients [114]. It is too soon to know the consequence of the English star rating system but reports suggest that it has provoked action as well as unease in hospital boardrooms across the NHS [115] and there are concerns that the power of public disclosure will distort individual and organizational performance [116]. Le Grand [117] has drawn attention to the danger of powerful extrinsic motivators undermining intrinsic motivators, 'the net effect being to unmotivate the individual. ...[who] may feel reluctantly coerced into activity rather than driven by their own desire to provide a public service. That such reluctance is widespread in the NHS and that it is having damaging consequences are propositions difficult to establish scientifically, however, there are few.....who would doubt their essential truth' (p125). NHSScotland has chosen a comparatively low-key approach to public disclosure of the findings of the Clinical Standards Board for Scotland [118] and its PAF. A valuable research exercise would be to evaluate the experience of these different approaches across the UK. As the

UKs health services immerse themselves in the complexities of measuring performance, the measurement of its effects should not be overlooked.

Conclusion.

The pressures on health care systems are intensifying, as public expectations and scientific advance combine and test their capacity to cope. The importance of health to citizens places those who govern under close scrutiny, and their response has been to search for new ways of extracting higher levels of performance from the systems over which they preside. Two prominent characteristics of the responses are uncertainty and complexity. Frequently there is only partial evidence on the effects, costs, and benefits of actions taken; there are few 'right' answers to the problems of structuring health care systems, but there are many theories, ideas, prejudices, ideologies and experiences on which to draw. The search for new solutions to the recurring dilemmas of matching needs and resources has seen a growing sophistication in the systems used to control health care services, in which complex information is playing an ever-increasing role. It is perhaps appropriate, therefore, to pause and reflect on an inherent quality of accountability relationships – trust. When trust and confidence between the parties in an accountability exchange is broken there is only one outcome, and the day of reckoning will have arrived. The task for health care system designers therefore is to come up with proposals that strengthen trust between those who govern and those who are governed. As the concept of accountability changes, chameleon-like, it becomes necessary to renew the structures that give it form. The extent to which they inspire confidence and trust will determine their success, and since there are no 'right' answers, a practical approach would be to experiment, to evaluate and to learn.

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