What Can We Learn from the UK's "Natural Experiments" of the Benefits of Regions?

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ABSTRACT

Marchildon highlights the lack of evidence on policies of regionalization in Canada: with regionalization being in favour in the 2000s followed by disillusion and the abolition of regions by some provincial governments. This paper looks at evidence from the UK's single-payer system of the impacts of regions on the performance of the delivery of healthcare. In England, regions were an important part of the hierarchical structure of the National Health Service (NHS) from its beginning, in 1948, to the introduction of provider competition, in the 1990s. Since then, in England, governments have understood that the NHS cannot be run from Whitehall and have tried to replace hierarchical control by provider competition. The consequence was that regions in England were subjected to frequent reorganizations from the mid-1990s with their abolition being announced in 2010. In contrast, the devolved countries of the UK have always been organized as "regions" in the form of their historic national boundaries. This paper argues that changes in the NHS in the UK in the 1990s and 2000s offer three "natural experiments," in terms of funding, organization and models of governance, that give evidence of the impacts of stable regions in the UK. It also considers the lessons of this evidence for Canada.

Introduction

According to my reading of Marchildon's (2016) account of policies on the introduction of regional health authorities (RHAs) in Canadian provinces in the 2000s, it was hoped they would better enable the provinces to make many kinds of improvements in the delivery of healthcare: better integration and coordination of a broad range of health services; more redistribution of resources from acute hospital services to illness prevention; greater use of evidence-based medicine to reduce unwarranted variations and improve quality of care; better allocation of resources to the needs of populations; greater participation in decision-making and accountability for performance. If these were indeed what provinces were hoping for, then it is understandable that they would be disappointed with the failure of regions to resolve abiding problems of all healthcare systems. This paper argues that the National Health Service (NHS) in the different countries of the UK offer an intriguing "natural experiment" as to the impacts of a stable region under different models of governance. In the English NHS, if we define regions as the next level below that of the nation, then, from the mid-1990s, the English NHS has tried to deliver healthcare to a population of over 50 million without a stable region. But in each of the UK's three devolved "countries" – Scotland, Wales and Ireland – each NHS has a stable region in the form of their historic national boundaries (with populations of 5 million, 3 million and nearly 2 million, respectively).

The following sections explain the nature of three natural experiments between England and the devolved countries that enable comparisons to be made from having stable regions, summarize evidence from studies of these experiments and discuss the implications of that evidence for the debate about regionalization.

Regions in England and the Devolved Countries

It seems that the predilection of politicians in Canada to impose top-down structural reforms in the absence of evidence to justify them, as described by Marchildon (2016), is an even more serious problem in England. Indeed, Timmins (2013: 6) suggests that the "disease" of the English NHS might be described as "organisation, reorganisation and redisorganisation." So, if Jane Austen were to chronicle the recent story of the NHS in England, she might well begin by saying: "It is a truth universally acknowledged that a Secretary of State for Health in possession of the English NHS is in want of a top-down reorganisation." This "truth" was put to the test when the Conservative and Liberal parties, in forming the Coalition Government after the 2010 elections, agreed and published their program for the government of May 2010, stating their second priority for the NHS in England to be: "We will stop the top-down reorganisations of the NHS that have got in the way of patient care" (Cabinet Office 2010: 24). But this public commitment by the Coalition Government did not deter the new Secretary of State for Health in England, Andrew Lansley, whose white paper, *Equity and Excellence: Liberating the NHS* (State for Health 2010) published in July 2010, "launched arguably the biggest restructuring it (the NHS) had seen in its 63-year history" (Timmins 2012: 3). The Chief Executive of the NHS famously described this organizational change as so big "you could probably see it from space" (Nicholson 2010).

From the start of the NHS in 1948 to the 1974 reorganization, there was, however, minimal organizational change. The 1974 reorganization was justified in aiming to remedy flaws in the original organization design of the NHS in England and Wales, as created in 1948, in which providers were divided into four

organizational silos (and these divisions were mirrored in Scotland and Northern Ireland) for: teaching hospitals, non-teaching hospitals, general practitioners (GPs) and community health services. The 1974 reorganization created organizations defined by populations, not providers across the countries of the UK. In England, undergraduate teaching hospitals were moved into the regional structure of 14 RHAs, and three sub-regional organizations were defined for the same geographical areas in the hope that this would better enable a basis for the close working between hospital and community health services, primary healthcare, and social services. However, those geographical identities were lost by the 1982 reorganization of hospital and community health services (Levitt and Wall 1984).

The destabilization of regions in England followed the introduction of the "internal market" in 1991. This changed the NHS in each country from a hierarchical structure to a market, with "purchasers" that contracted with, rather than ran, "providers" (Secretaries of State for Health, Wales, Northern Ireland and Scotland 1989). In England, RHAs, were abolished in 1996 and replaced by eight regional offices (Ham 2000: 1); which in turn, in the 2000s, were succeeded by four regional directorates of health and social care, then 28 and later 10 Strategic Health Authorities (SHA) (Audit Commission and Healthcare Commission 2008: 16). The Lansley reforms proposed in 2010 aimed to empower GPs as purchasers to choose between any qualified provider subject to national regulators. These reforms saw no role for any regional presence in its organizational chart for its new system of governance (Secretary of State for Health 2010: 29). In contrast to England, each devolved country had a stable region defined by national boundaries.

The (New) Labour government elected in 1997 made four major policy decisions that had a profound influence on the health systems

of the UK for the following decade: First, it abolished the idea of provider competition, but maintained the purchaser/provider split in England and Wales. Second, it enacted devolution to Scotland, Wales and Northern Ireland so each country's government could decide its own policies for its NHS. Third, it increased NHS spending in England in real terms by five per cent a year, which fed through (by the Barnett formula) to increased spending on each country's NHS. Fourth, it introduced into the English NHS the system of annual performance (star) ratings with sanctions for failure and rewards for success. Scotland led the way for the devolved countries in abandoning the purchaser/provider and going back to a hierarchical system in which their Health Boards ran providers. From 2006, the government reintroduced provider competition into the English NHS, and the Lansley reforms sought to entrench that policy in primary legislation (Bevan 2014; Timmins 2012).

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Three Different Natural Experiments in the Health Systems of the UK

This section explains how the period from 1996 to 2012 offers three different kinds of natural experiments for examining the impacts of regions. These three periods were as follows:

1. *1991 to 1996: before devolution.* In this period, the English NHS was administered by RHAs and all countries had implemented the policies of the internal market. The natural experiment was in differences in per capita spending on the NHS, which was markedly higher in Scotland (by 25%) and Wales

(by 18%) than in England (Dixon et al. 1999).

2. *2000 to 2006: immediately after devolution.* In this period, no government sought to improve performance by provider competition. Although England still had lower per capita spending on healthcare than the devolved countries, the more interesting natural experiment was in the governance of performance against targets. England was the odd man out in two ways: First, its regions lacked stability; second, only in England was failure by providers to achieve government targets for quicker access to health services penalized through public reporting and performance management (in what became the regime of annual "star ratings") (Secretary of State for Health 2000). In the devolved countries, such failure was widely perceived to be rewarded with extra funding (Bevan et al. 2014).

3. *2006 to 2012: when devolution has become well established.* In this period, levels of per capita funding in the northeast region of England were by 2011/12 similar to that of Scotland and the most interesting natural experiment was between different models of governance that had developed in England and Scotland. In England, the policy emphasis for improving performance was on provider competition without a stable region (Secretary of State for Health 2002). In Scotland, the government emphasized a "tougher and more sophisticated approach to performance management" in which performance was systematically monitored with support and intervention when necessary (Steel and Cylus 2012: 113-114). In Wales and Northern Ireland, there was no evidence of similar regional governance of performance (Bevan 2014).

The Outcomes of the Three Natural Experiments

Dixon et al (1999), using data from 1995/96, examined the first natural experiment and found that crude productivity of doctors and nurses in terms of patients seen and treated were lower for doctors and nurses in Scotland and Wales than in England. Hence, the higher levels of funding in Scotland and Wales appear to have resulted in an easier working life for producers than more care for patients.

Alvarez-Roseté et al. (2005), using data from 2002/03 and Connolly et al. (2011), using data from 2006/07, examined the second natural experiment. Both studies found that providers in the English NHS still appeared to have higher rates of crude productivity. And there had been dramatic improvements in England in reducing long waiting times for access to the NHS and quicker response times by ambulance services to potentially life-threatening emergencies (Category A calls), which was not matched by the devolved countries.

Bevan et al. (2013), using time series of data, mostly up to 2011/12, for the third natural experiment, found a marked improvement in Scotland's performance, so that it broadly matched England's for hospital waiting times and ambulance response times to Category A calls. The performance in Wales and Northern Ireland on those measures still lagged behind England and Scotland. There was little evidence that the effort expended in England on provider competition had delivered improvements in performance. The third natural experiment suggests that when the regional government in Scotland did operate a system with sanctions for failure and rewards for success, this had the potential to outperform a system in England based on provider competition without a stable region.

Discussion

Evidence from the UK suggests that: two models of governance have proved to be ineffective, namely, stable regional governance with perverse incentives for rewarding failure, and provider competition; and an effective model is to create stable regional governance with systems of normal incentives that reward success and penalize failure. The government in England now recognizes that the English NHS cannot be run well either from Whitehall or by a regulated provider market (NHS England 2014). But there is no enthusiasm for going back to the 1974 hierarchical organizational structure. Instead, the intention is to find other means of achieving its objectives of tackling silo working. An important pilot is where the Mayor of Manchester is leading changes to integrate health and social services for the region of Greater Manchester. There seem to be two messages for the provinces of Canada: first, try to develop herd immunity from the English disease of redisorganisation; second, that the presence or absence of regions in a province is less important than the model of governance that is being applied.

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