Operational independence for the NHS

Ara Darzi didn’t suggest freedom from government control in his review of the English NHS, but it might sound attractive to many health workers. Rhema Vaithianathan and Geraint Lewis show how it could work using the theoretical framework of independent central banks.

The long term interests of the National Health Service are often undermined by its political governance structure. Health ministers are diverted by the exigencies of a short electoral cycle and by the perception of personal responsibility for all failings. This has compelled them to interfere with health technology recommendations, to reorganise the NHS repeatedly, and to interject on transient, local issues.

In the late 20th century, monetary policy likewise suffered from unhelpful ministerial interventions. The concept of an independent central bank arose from the belief that an independent agency would promote a politically neutral, long term approach.

In 1997, the Bank of England was given operational independence from ministers, and it has since been highly effective in maintaining price stability. This has led several commentators to call for the NHS to be given operational independence, which would preserve its founding principles (free health care for all with revenue generated through general taxation) but would shift power away from politicians to an independent board. But does the NHS face comparable problems to those of monetary policy?

We argue that only certain health policy issues are analogous to monetary policy, and that delegation of these particular issues would indeed be warranted, but that independence would require several NHS boards—each responsible for a different area of healthcare policy.

**Dynamic inconsistency**

Sustained economic growth requires low inflation. However, allowing inflation to rise can temporarily boost growth and employment—but at the cost of harming long term price stability and hence long term growth. When politically elected governments control monetary policy (for example, determine interest rates or the money supply), they start out with the intention of maintaining low inflation. However, in response to political imperatives they often become tempted to allowing inflation to rise. As with Ulysses and the sirens, governments would benefit in the long term from tying themselves to the mast of low inflation.

This difficulty to commit to a long term optimal policy is referred to as dynamic inconsistency—a situation where decision makers yield to short term temptations against their better long term judgment. An independent central bank solves the problem because it is not party political and will therefore not be tempted to sacrifice long term price stability for short term economic growth.

Several areas of NHS policy similarly produce dynamic inconsistency and so might also benefit long term from binding to the mast. However, these benefits must outweigh the reduced democratic accountability that ensues: shifting decision making powers away from elected officials cannot be justified simply on the grounds of dislike for political interference. Table 1 lists some examples of healthcare issues where we believe the benefits of independence do warrant the costs.

**Levers, targets, outcomes**

Independent decision making is not the only concept from monetary policy that could be useful for the NHS. The following taxonomy can help clarify responsibilities:

- **Levers**—interventions that are controlled by the independent board in order to achieve its targets
- **Targets**—measurable variables, set by parliament, that offer short term indications of how well the system is delivering the desired outcomes; and
- **Outcomes**—long term objectives that the government wants to achieve.

For example, in order to secure long term price stability, the government set the Bank of England’s monetary policy committee a target (2% inflation) and granted it exclusive use of a lever (setting of interest rates) to achieve this target. We would envisage a similar approach for the NHS. Parliament would determine the governance structure and the targets for the independent board, together with specific procedures for revising these targets and for dealing with failure to...
Healthcare generates both expected adverse events (for example, screening errors) and unexpected ones (for example, nosocomial infections). A rational politician would set out to intervene only over a policy response, and systemic failures that do (such as nosocomial infections due to inadequate sterilisation). A rational politician would set out to intervene only over a systemic failing, and never over expected, random events. But as every adverse incident is currently portrayed by the opposition and media as a systemic failure, ministers now prioritise appeasing the public over improving the safety of the system.

### Multiple boards

Previous proponents of NHS independence have called for a single independent board, but we believe that this would create new problems. An all encompassing independent NHS board would be responsible for mutually inconsistent aims. These exist in any health system—for example, hospitals need to be operationally efficient and at the same time have spare bed capacity. But if the mechanisms for resolving such tensions are to be delegated away from politicians, we believe they must be explicit and transparent. For example, the European Central Bank has a clear hierarchy of objectives in which “overriding importance” is assigned to price stability, with employment and growth as secondary considerations. A single NHS board would have so many conflicting objectives that ranking its priorities in such an explicit manner would be impossible.

A second reason for opposing one large board is the need to achieve expertise in both the deployment of levers and in resisting external lobbying pressure. Only by keeping a board small and focused can these aims be achieved optimally.

### Credibility

A final concept that is usefuly borrowed from monetary policy is that of credibility,—that is, the degree to which a government can convince the actors in a system that it will not interfere in the operation of an independent board. The mechanism that maximises credibility is legislation. For example, the Bank of England Act 1998 established both the constitution of the monetary policy committee and its 2% inflation target.

A legislative footing would make the proposed independent NHS boards more credible. Although parliament could theoretically revoke the act that established them, the process would be complex and public. A private handshake between the health secretary and the chair of a board could not alter a legislated target. Additional ways of signalling credibility that could also be adopted from the monetary policy committee include appointing a politically neutral chair for each board, using transparent mechanisms for setting targets, publishing the minutes of all board meetings, and announcing the voting records of board members.

### Practical implementation

To illustrate our approach, table 2 sets out how the examples in table 1 might be delegated to independent NHS boards. Although NICE is already ostensibly independent, its recommendations are currently rather opaque because it uses a fuzzy range of acceptable cost effectiveness values. Moreover, primary care trusts may fund a technology that is not approved by NICE—and in the case of trastuzumab for late stage breast cancer, they were directed to do so by the secretary of state. We recommend establishing a new legislative foundation for NICE, transforming it into an independent NHS board. It would be set a transparent cost effectiveness threshold by parliament (which might include such factors as cost utility, weight of evidence, and equity) and its rulings would be exclusive and binding on primary care trusts, with predetermined sanctions on them if its rulings were ignored.

For reorganisation of NHS structures and organisation, the levers and targets are well aligned so one board could potentially cover both. Indeed, the Independent Reconfiguration Panel already exists to advise ministers on these issues. However, it is not fully independent and its decisions are not binding, so it does not solve the dynamic inconsistency problem. If the panel became an independent board, with its recommendations being exclusive and legally enforceable, the political furor about hospital reconfigurations would be diffused. A precedent for such an independent body is the Electoral Commission.
which determines the configuration of local authorities (such as unitary authorities versus boroughs and counties) and electoral boundaries.

Finally, for patient safety the National Patient Safety Authority already has the remit to “improve patient care through the analysis of patient safety incidents, rapid response to incidents and the development of actions.” But the Healthcare Commission has a similar remit: “To promote and drive improvement in the quality of healthcare and public health,” and, “To carry out investigations of serious incidents.”

Neither body has exclusive use of a binding policy lever. We propose amalgamating the overlapping aspects of the two agencies through legislation to form a new NHS board whose recommendations are binding across the NHS and establish sanctions for healthcare providers that fail to implement them.

**Counter arguments**

There are three principal arguments against NHS operational independence. The first is that the annual NHS expenditure of £100bn should be subject to democratic checks and balances. We agree. This is why we propose that only those areas that produce dynamic balances. We agree. This is why we propose amalgamating the overlapping aspects of the two agencies through legislation to form a new NHS board whose recommendations are binding across the NHS and establish sanctions for healthcare providers that fail to implement them.

The final argument is that an independent NHS could not cope with a crisis. As a source for Gordon Brown put it, “The problem of handing over total financial control is what you do if it goes very badly wrong. If Great Ormond Street [Children’s Hospital] goes bankrupt, for example, who’s going to pick up the pieces?”

The legislative framework envisaged would specify exactly what happens when a board fails to meet its targets. We acknowledge that crises are a possibility, even in the limited areas that we have identified for independence. But we believe that the fear of crises should not itself be a barrier to independence. Independence requires self discipline from ministers, and when crises occur, ministers will have to maintain the arm’s length relationships prescribed by legislation. Clearly at times this will be challenging—for example, if the board recommended that a hospital be closed in a marginal constituency late in the electoral cycle. This is analogous to the Bank of England raising interest rates close to an election. As was the case in monetary policy, we would expect a culture of independence to emerge where even the opposition recognises that these specific healthcare policy areas are beyond the remit of the government. There are, in fact, very few issues where the NHS is at risk of a true crisis—although artificial, politically fuelled crises abound.

**SUMMARY POINTS**

An independent board is useful when political pressure stops a government adhering to optimal policy in health care, independent boards would be useful for technology assessment, NHS structural reorganisation, hospital closures, and patient safety. Each board should be set clear targets by parliament and have exclusive control over levers for achieving them.

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**Table 2: Illustrative framework for NHS operational independence**

<table>
<thead>
<tr>
<th>Outcomes</th>
<th>Health technology assessment</th>
<th>Provider reconfiguration</th>
<th>Structural reorganisation</th>
<th>Patient safety</th>
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<tbody>
<tr>
<td>Value for money</td>
<td>High efficiency, quality, equity, and access</td>
<td>Reorganise the NHS when the costs are justified by the expected improvements</td>
<td>Effective managerial structure</td>
<td>Safety</td>
</tr>
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Levers

- Maximise cost effectiveness according to explicit criteria
- Maintain efficiency and quality while minimising minimum equity and access standards
- Sanction which technologies primary care trusts should fund
- Sanction hospital openings, mergers, and closures
- Sanction restructuring proposals

Existing NHS organisations

- NICE: National Institute for Health and Clinical Excellence
- NPSA: National Patient Safety Agency
- HCC: Healthcare Commission


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**ANALYSIS**