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WHICH IS THE BEST HEALTH SYSTEM IN THE WORLD?

It may be nice to find your country at the top of healthcare rankings, but the relevance to policymakers is strictly limited, explains **John Appleby**

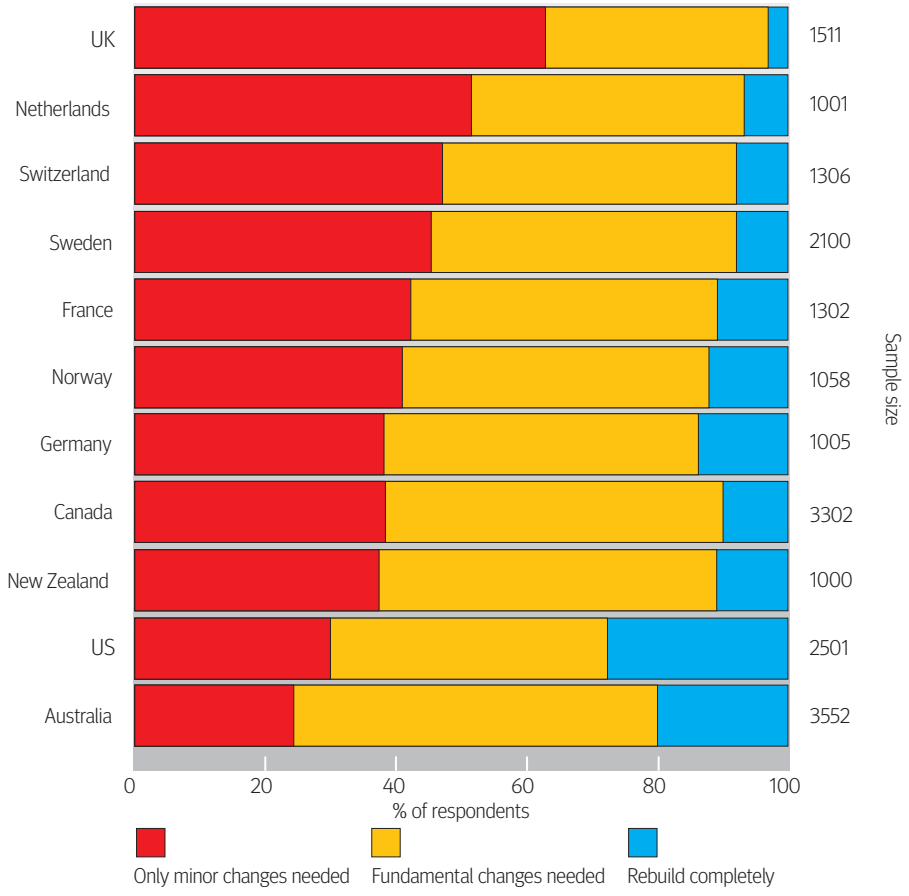

Fig 1 | **Overall public views of the healthcare system, 2010 Commonwealth Fund**[3]

According to the World Health Organization, the country with the best health system overall in the world in 2000 was France, with the UK ranked 18th and Burma (Myanmar) coming last at 190th.[1] In 2009, according to the EuroHealth Consumer Index, France was ranked seventh out of 33 (mainly European countries) and the Netherlands first (UK trailed in at 14th).[2] Meanwhile, last year's regular 11 country survey of health system performance from the Commonwealth Fund in New York suggested that the UK ranked first in terms of the smallest proportion of members of the public polled thinking the system needed fundamental changes or complete rebuilding (fig 1).[3] A parallel Commonwealth Fund survey of seven countries in 2010 ranked the Netherlands top (and the UK second) on a basket of performance dimensions (fig 2).[4]

Although the authors of these surveys are of course aware of the tremendous difficulty in comparing the performance of different countries' health systems, the temptation to reduce the comparison to the equivalent of "marks out of 10" is often too great. The Commonwealth Fund resists in its 11 country comparison[3] but succumbs in the seven country assessment.[4] Different analyses also use different numbers of comparator countries, which makes comparing ranks confusing; coming second out of six is similar to coming 20th out of 60 (that is, both in the top 30%), but the latter ranking sounds much worse. Equally, coming last in a ranking of, say, a small number of elite, Western industrialised countries may not be considered as bad as last in the whole world.

Nevertheless, the question, "Which is the best system?" remains a compelling one to try to answer.

Although it may not feel like it at the moment, reforming healthcare systems is not just an English obsession. While 34% of a sample of the UK public think the health system needs fundamental change according to one Commonwealth Fund survey, people in the 10 other countries surveyed reported higher levels of dissatisfaction (fig 1).[3] Politicians and policymakers in all countries grapple with changes to their systems to tackle public worries. Scouting around for new policy ideas starts with questions about where to look and then naturally to questions about other countries' systems and their performance. Has someone else solved the difficult problems we are facing—spending too much, poor patient care, lack of health impact, poor cost effectiveness?

But here comes a central set of difficulties in answering the comparative question: the performance of healthcare systems is multidimensional; it may, in the end, be about health, but it is also about efficiency and effectiveness and affordability and acceptability . . . .[5] WHO and the EuroHealth Consumer Index recognise this (as do many such comparative surveys) and construct performance "dimensions" populated with varying numbers of statistics (six dimensions and 38 statistics in the case of the EuroHealth survey[2]).

Inevitably, such an approach will mean that countries will do better on some dimensions than on others; the UK ranked second best on the distribution of health across its population in WHO's 2000 health system evaluation but 26th on patient responsiveness. Pulling these measures into one overall number or rank requires some weighting for each individual performance measure—they are unlikely to be of equal importance. But whose values to

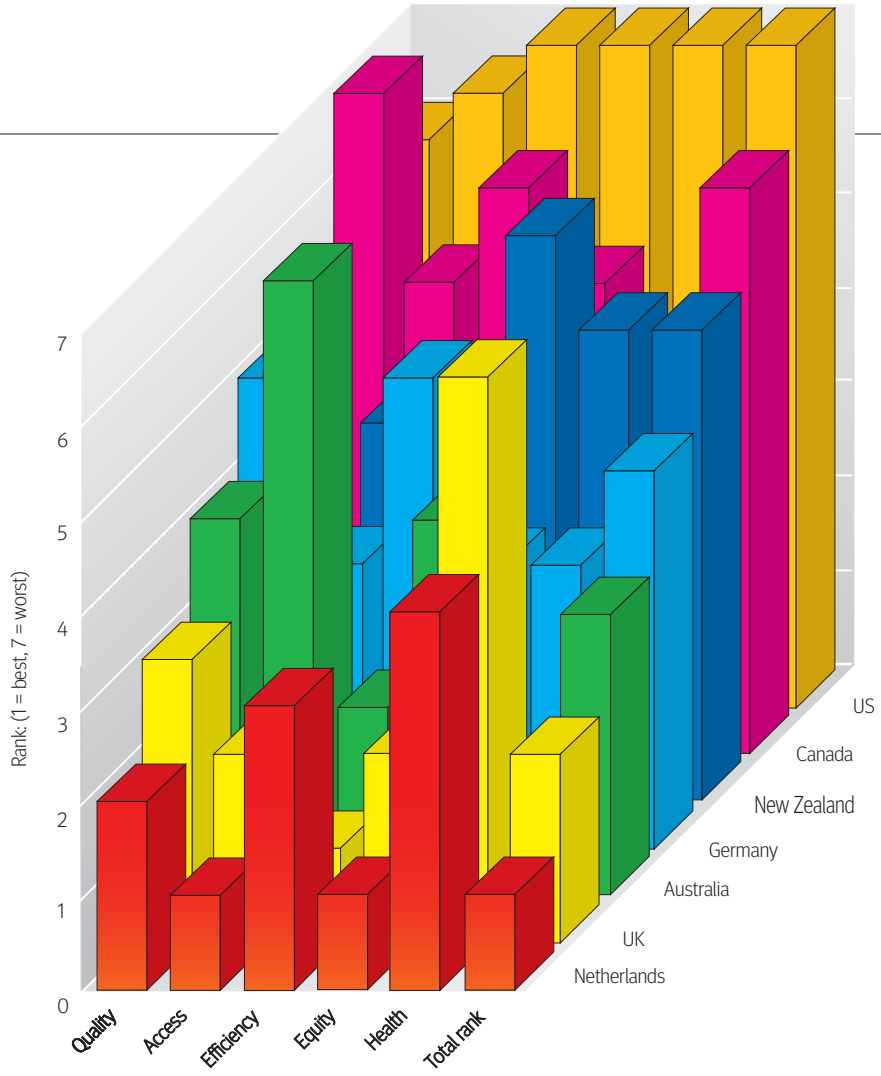

Fig 2 | **Performance ranking of seven countries, 2010[4] Commonwealth Fund**

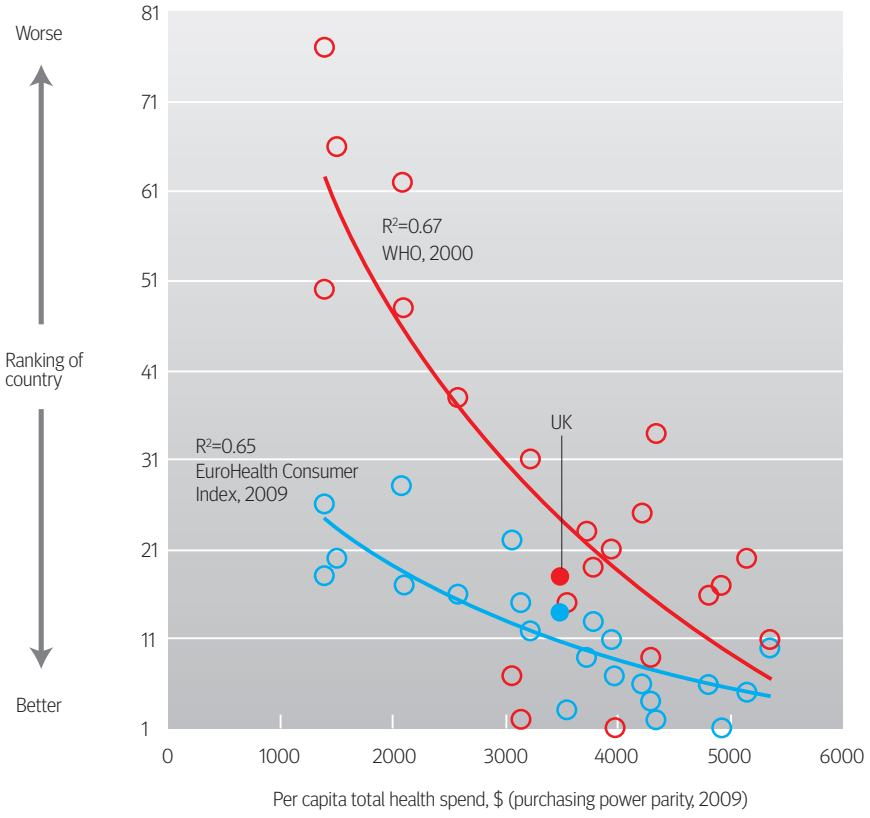

Fig 3 | **Relation between per capita health spend[8] and health system perfomance ranking (see web for further details)**

use? The public's? Policymakers'?[6] And how should we take account of different weightings by different countries' populations?

Even if this and other problems are answered, the next question for policymakers is why France is first (or is it 7th?) and the UK 18th (or 14th or 2nd). While I make no claims for such a simplistic model, it is interesting to note just how strong the relationship is between where a country is ranked (by either WHO or EuroHealth Consumer) and how much it spends per capita on healthcare: no causation is claimed, but it seems that as spending increases, ranking improves (fig 3). Of course, if all countries increased their spending the rankings may be left unaltered; even if performance is increased in all countries, ranking position may remain the same.

Even less claim can be made for the apparent positive correlation between the WHO health system ranking of countries and the FIFA ranking of international football teams; in 2000 both placed France in first position.[7]

Frustratingly, given the importance of the policy questions they raise, perhaps the best that can be said for many comparative ranking exercises is that they provoke a ready headline and can generate debate but fail to provide definitive answers.

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Still a rebel

Can Shirley Williams, one of England's most redoubtable peers, rid the NHS bill of some of its more toxic aspects? **Rebecca Coombes** meets Baroness Williams

The ill starred government bill to reform the NHS in England staggers into one of its final phases in the UK parliament next week.

And as it reaches the House of Lords on 11 October, eyes turn to the leading health rebels among the peers to clear up what critics see as the bill's many flaws. Chief among these rebels is Liberal Democrat grandee Baroness Williams. At 81, Shirley Williams, one of the four founders of the now defunct Social Democratic Party in 1981, remains a serious political voice and is long enough in the tooth not to fear straying from the party line now and then. Sitting in her Lords office, her body language is business-like: leant forward, arms on knees, and strong eye contact.

Baroness Williams aside, the Liberal Democrats have so far failed to exercise a moderating influence on the technocratic, competition embracing bill to shake up the NHS. It took them five months to wake up to the radical nature of health secretary Andrew Lansley's plans. Only then did they force an eight week parliamentary hiatus to allow for a listening exercise, which produced some concessions. An expected Lib Dem rebellion in the House of Commons last month came to naught. There is rising anger, especially among English doctors, at the bill's provision to increase competition and the role of the private sector in the NHS. So can they really expect much in the way of salvation from the Lords?

"Oh, I think there'll be substantial opposition," says Williams, rattling off a series of eminent medical men and women who sit in the Lords, including Lord Walton of Detchant, a former president of the BMA. She is angry that the bill comes to the peers "effectively unscrutinised." When the redrafted bill came back to the House of Commons last month, MPs were given just over three days to consider 1000 amendments.

She says the pressure is on for the Lords to cast a forensic eye over the bill. "At the beginning MPs didn't realise how radical the bill was. They were not able to give it anything like adequate scrutiny, and a lot of them have a bad conscience about that. They feel the Lords have got to exercise every element of energy to look at it very, very carefully indeed."

She's angry too that the Department of Health is pressing ahead with the abolition of primary care trusts and strategic health authorities when "the bloody bill hasn't even passed yet."

"I have a real worry about how far the department and the ministers have gone beyond what they had constitutionally the right to do," she says. There is little point in scrapping the bill as a *BMJ* editorial (*BMJ* 2011;342:d4050) argued in June, she adds, because the reform pendulum has swung too far.

"One voice says this is such an awful bill. Let's just scrap it and go back to the beginning again. And the other voice says no we can't. There isn't any beginning again because a lot of what was the NHS

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structure is either undermined or is very rocky now."

She is candid about the fact that Liberal Democrat politicians realised the dangers of the bill only when medical members blew the whistle.

"Initially the bill got a kind of free pass. Then a group of Lib Dem doctors, like Graham Winyard (a former NHS deputy chief medical officer for England) actually did read the whole bill. They did start asking questions and saying we can't possibly let this go."

The crisis really bubbled up at the party's spring conference when the party faithful "got stirred up by the scale of the NHS reorganisation." Until then the leadership thought the bill was "just quiet rearrangement going through . . . now they have really started getting worried."

Williams's biggest fear is that the bill will drive the NHS to become a market system like that in the United States. A professor at Harvard University for 10 years from the mid-1980s, she is appalled at how UK ministers have become "bewitched" by the US system.

"My (late) husband had some quite serious conditions. I was able to see firsthand how all those great hospitals operated, and we were in Massachusetts, which is one of the best states for medical care. And I was deeply under-impressed."

With that in mind, in the Lords she wants to reinstate the cap on how much income hospitals can get from treating private patients. As the bill stands, there's nothing to stop a foundation trust taking a majority of private patients. It's a fight, she confides, peers might have already won.

"We've wrung from the Department of Health an agreement to look again at a cap. You just have to put in law that you cannot be other than an NHS majority hospital."

Ministers have promised to amend the bill, she says, to this effect—and Monitor, the NHS trust regulator, will be able to negotiate a different cap for each hospital, "because obviously we don't want a situation where [the proportion of private patients] whizzes up from 2.5% to 44% without stopping." Peers will also attempt to tighten safeguards in the bill to prevent private companies "cherry picking" contracts dealing with non-complex services.

Williams's second key concern is the so called "autonomy clause," which appeared in the redrafted bill last month. This clause suggests the health secretary would no longer be legally and constitutionally responsible for the provision of key NHS services such as hospital accommodation and nursing. He would have to monitor provision and intervene only in times of "significant failure."

Williams says: "I think you can't talk about a comprehensive health system available to all, free at the point of need, without somebody being there saying, 'Yes, I'm responsible for that.' Now you're talking about £80bn plus. And [what happens if] you don't have a minister who clearly can be asked to answer for what he does? The secretary of state can't walk out of that hole.

"We've said to the Department of Health that a 'significant failure,' is too high a level. You've got to allow intervention in a situation where a commissioning body or a hospital is showing signs of stress—sort of like the stress tests for banks." She's clear that ministers have now promised to amend this part of the bill.

Williams, a lifelong NHS user, including for a hip replacement operation, bridles at the suggestion that her party, along with the Tories, could go down in history as the ones who ended the NHS.

"The beginning of the privatisation of the NHS does not date from the day the coalition government was elected. It dates from Tony Blair. It sort of stopped with Gordon Brown, and then it started again. But between 2004 and 2007 you got very extensive privatisation of the NHS by a Labour government. There is an astonishing list of ways in which the NHS has steadily seeped away." Any amendments in the Lords can be removed when the bill returns to the Commons after Christmas; the government has the votes. It's a fact Williams is not, for the moment, prepared to entertain.

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