

Anne Mason

Centre for Health Economics, University of York, Heslington, York, UK

# Does the English NHS have a ‘Health Benefit Basket’?

The English National Health Service (NHS) was established in 1948 to provide healthcare for all, free at the point of use and irrespective of ability to pay. Legislation outlines the broad categories of healthcare service that should or could be provided within the NHS. However, the legal duties and powers of provision are not absolute, but tempered by powers of discretion as to what is a ‘reasonable requirement’ and by the right to take into account NHS financial capacity. Strictly speaking, this means that patients have no entitlement to specific services; this partly explains the existence of variation in local provision known as the ‘postcode lottery’ [1]. Furthermore, the courts have established that NHS organisations may not operate a ‘blanket ban’ on the provision of particular services [2]. Consequently there are few services that are explicitly unavailable to all NHS patients.

Within a health service with no specific entitlements but few explicit exclusions, internal quality control mechanisms are important to ensure that citizens’ rights to health care, established under international law, are honoured [3]. National standards, embodied in guidance from National Service Frameworks (NSFs), the National Institute for Health and Clinical Excellence (NICE) and waiting time guarantees, are regulated by the Healthcare Commission, which monitors NHS organisations’ compliance. The regulatory framework contributes to what may be considered as ‘reasonable requirements’ for health care provision and helps to specify entitlement. Fixed charges or payments, whilst in no way guaranteeing provision, implic-

itely brand services with an ‘NHS’ label and may therefore also serve to signal the service is, or should, be in the health basket. Incentive payments for clinicians may be seen in a similar light.

This paper describes the statutory and regulatory frameworks and discusses how these may impact upon patient entitlement to NHS ‘services of curative care’, ‘HC1’ of the International Classification for Health Accounts (ICHA) taxonomy [4]. An overview of the legal and regulatory framework defining benefits for England is given in ■ **Table 1**.

## England’s ‘Health Benefit Basket’: the case of services of curative care

Services of curative care are defined as those where the principal medical intent of care is to relieve symptoms or reduce severity or protect against exacerbation or complication of illness or injury. In addition to in-patient and day care, HC1 includes ‘out-patient care’, defined as basic medical and diagnostic services, out-patient dental care and other specialist health care provided to outpatients by physicians or paramedics, including services provided at home [4].

## The legal framework

Primary legislation addresses the establishment and promotion of ‘a comprehensive health service’, requiring the Secretary of State for Health ‘to provide or secure the effective provision of services’. However, discretion is at the heart of these duties and

politicians are entitled to take into account the resources available to them.

Under the 1977 National Health Service Act (chap. 49), the Secretary of State has a *duty* to provide ‘to such extent as he considers necessary to meet all reasonable requirements’: (a) hospital accommodation [s. 3 (1(a))], including high security psychiatric services (s. 4); (b) other accommodation necessary for the purpose of any other services required by the Act [s. 3 (1(b))]; (c) medical, dental and nursing services [s. 3 (1(c))] (N.B.: ‘medical’ includes ‘surgical’); and (d) such other services as are required for the treatment of illness [s. 3 (1(f))] (N.B.: ‘illness’ includes a mental disorder and any injury or disability requiring medical or dental treatment or nursing). The Secretary of State for Health also has *powers* to provide ‘as he considers appropriate’ facilities for the care of persons suffering from illness [s. 3 (1(e))]. The responsibility for providing these services has passed to local health authorities, which in the current organisational structure are known as Primary Care Trusts (PCTs). The 1977 NHS Act also places a *duty* on PCTs to provide general medical services (s. 29), general dental services (s. 35), pharmaceutical services (s. 41) and general ophthalmic services (s. 38).

In the law courts “R v NW Lancashire Health authority, ex p A, D and G” examined the case of three applicants suffering from ‘gender identity dysphoria’ [2]. The Health Authority had identified this illness as amongst the bottom 10% in terms of need (together with cosmetic surgery, reversal of sterilisation, correction of myopia and most ‘alternative’ medicines) and

Table 1

## Documents defining the English Health Basket, 2005

Catalogue: type of document, actors and contents					Criteria used for defining benefits					
Type of document	Legally binding	Positive/negative definition of benefits	Degree of explicitness <sup>a</sup>	Updating	N	C	E	CE	B	Other
Acts of Parliament	Yes	P	1	Irregular, amended by further legislation	+	-	-	-	-	Political judgement 'necessary to meet all reasonable requirements'
Statutory instruments (SI)	Yes	P or N	1-3	Irregular, amended by further legislation	+	-	+	+	+	Safety
Directions	Yes	P	2	No	+	-	+	-	+	-
National Service Frameworks	No	P	2 or 3	Unclear	+	-	+	-	-	-
NICE technology appraisals	Yes <sup>b</sup>	P or N	3	Every 4 years	-	+	+	+	-	-
NICE clinical guidelines	No	P	2 or 3	Every 4 to 6 years	-	+	+	+	-	-
NICE interventional procedures	No	P or N	3	Unclear	-	-	+	-	-	Safety
Contracts	Yes	P	1-3	Infrequent-although small amendments more frequent	+	-	-	-	+	-
Waiting time guarantees <sup>c</sup>	No	P	2	Irregular	+	-	+	-	-	-
HRG tariffs	No	P	2 or 3	Still evolving	-	+	-	-	+	-
Devices tariff	No	P	3	Monthly	-	+	-	+	+	Safety, quality, appropriateness
Fee schedules	No	P	3	Annually (at least)	+	-	-	-	+	-

N need, C costs, E effectiveness, CE cost-effectiveness, B budget (from [1, 2, 3], DH website (<http://www.dh.gov.uk/home/fs/en>), HMSO website (<http://www.hmso.gov.uk/>), expert advice (see Acknowledgements))

<sup>a</sup> "Explicit is subdivided as 1: all necessary"; 2: areas of care; 3: items.

<sup>b</sup> The statutory duty is upon PCTs to ensure funding is available to facilitate implementation, not upon doctors to adopt the approved technology.

<sup>c</sup> The dominant instrument for securing these are performance ratings prepared by the Healthcare Commission.

therefore transsexual surgery would be provided only in cases of 'overriding clinical need'. The court acknowledged the need for priority setting in which issues of effectiveness, the seriousness of the condition and cost were taken into account. However, the court found that the Health Authority had in practice adopted a 'blanket ban' and recommended the authorities introduced a fair and consistent policy for decision making that adequately assessed exceptional cases by considering each request for treatment on its individual merits. The case therefore made it illegal for health authorities to refuse to provide specific services, with the possible exception of a treatment where 'the clinical evidence of its inefficacy is overwhelming' [2]. The

case implies that costs and benefits should be evaluated on an individual patient basis, rather basing entitlement on the typical or average case.

Primary legislation and case law have therefore not prescribed which services are to be included in or excluded from the English health basket. However, secondary legislation on professional contracts goes some way towards defining entitlement to specific services. For example, the 2004 National Health Service (General Medical Services Contracts) Regulations provide details of the terms of service for general practitioners (GPs) and state that 'essential services' must be provided, covering emergency treatment and treatment for patients with chronic, terminal and self-

limiting disease [National Health Service, General Medical Services Contracts, regulation SI 2004/291, reg. 15 (3;5;6;8), 2004; see ■ Table 2].

For dental practitioners the National NHS (General Dental Services) Regulations 1992 make provision for the Secretary of State for Health to determine dentists' remuneration, including a 'scale of fees' for providing particular services [reg. 19 (1)]. Updated at least annually, the Statement of Dental Remuneration describes over 400 services covered by the fees, including clinical examinations and treatment planning, diagnostic procedures, such as radiographic examinations, preventative, periodontal, conservation and surgical treatments and the sup-

Anne Mason

## Does the English NHS have a 'Health Benefit Basket'?

### Abstract

A 'health benefit basket' is a range of publicly entitled health-related goods and services. Primary legislation ensures the provision of broad categories of healthcare, but this provision is subject to political discretion. Case law has established that healthcare organisations may not operate a 'blanket ban' for particular services. This means that the English health basket currently has very few specific services explicitly included or excluded. Regulation may, however, be important in determining citizens' rights. With reference to 'services of curative care', this paper explores whether the NHS is moving towards a more explicit definition of a health basket.

### Keywords

Health Services · National Health Programmes · United Kingdom · Health Benefit Plans · Public Policy

ply of prostheses; patients pay 80% of the charge up to a stated maximum, although some exemptions apply (Department of Health, Statement of Dental Remuneration, amendment no. 93, 2005). The Doctors' and Dentists' Review Body reviews existing fee scales and makes recommendations regarding uplift. The Department of Health then considers these recommendations and the Chief Dental Officer for England notifies Strategic Health authorities, PCTs, NHS Trusts (groups of NHS hospitals, each operating as a single legal entity) and all general dental practitioners of the updated fee scales (*ibid.*).

Similarly, the 1986 NHS (General Ophthalmic Services) Regulations make provision for opticians and ophthalmic medical practitioners to charge for sight tests and for optical appliances (National Health Service, General Ophthalmic Services, regulation SI 1986/975, 1986). Charges are determined by the Secretary of State in consultation with professional bodies, updated at least annually and amended by secondary legislation. For certain patients vouchers are available that reduce or remove the charge incurred by patients. Eligibility for general ophthalmic services, outlined in section 13 of the Health and Medicines Act 1988, is determined by age, disease (or risk of disease) or income. Voucher values are updated at least annually by secondary legislation.

### Quasi-law

In addition to legislation, NHS provision is shaped by a considerable amount of 'quasi-law'. Quasi-law is defined as 'rules which are not usually legally binding, although they may have some legal force, but which will in practice determine the way in which people act' [3]. Amongst the regulation helping to define patient entitlement to services are NSFs, NICE guidance, waiting time guarantees, fee schedules, and incentive schemes. The Healthcare Commission is the key regulator, assessing the performance of NHS organisations against national standards in its 'annual health check', a monitoring process that assesses both existing performance ('core' standards) and capacity to improve ('developmental' standards) [5].

The programme of NSFs, launched by the Department of Health in April 1998,

usually produces one new framework a year. NSFs set national standards, identify key interventions for a defined service or care group that should be available, establish strategies to support implementation and outline ways to ensure progress within an agreed time scale [6]. Frameworks cover some services of curative care (■ **Table 3**). Each NSF is developed with the assistance of an external reference group (ERG), which seeks to engage a range of views from health professionals, service users and carers, health service managers, partner agencies and other advocates. However, the economic input into NSFs is sometimes weak. The Department of Health supports the ERGs and manages the overall process. It is unclear how NSFs are to be updated to reflect changes in the evidence base that underpins them.

There is no statutory obligation on health care organisations to implement NSF standards. However, the Health And Social Care (Community Health And Standards) Act 2003 [Health and Social Care (Community Health and Standards) Act, Chap. 43, 2003] gave the Secretary of State powers to publish standards for health care [s. 46 (1)] that NHS bodies are bound to take into account [s. 46 (4)]; NSFs could inform these standards. Furthermore, the Healthcare Commission reviews health care organisations' implementation of NSFs as part of its annual health check [5], reinforcing the quasi-legislative nature of NSF guidance.

NICE, the organisation responsible for assessing whether new or existing technologies should be available on the NHS, produces three types of guidance which help define the availability of NHS services of curative care. Firstly, technology appraisals give guidance on the use of new and existing treatments within the NHS. Of the 91 technology appraisals published to date (July 2005) some relate to in-patient care, such as Appraisal No. 11 (the use of implantable cardioverter defibrillators for arrhythmias); to day care, such as Appraisal No. 48 (home compared with hospital haemodialysis for patients with end-stage renal failure); and to out-patient care, such as Appraisal No. 24 (debriding agents for difficult to heal surgical wounds). Secondly, NICE clinical guidelines offer guidance on the appropri-

Table 2

**Eligibility for primary care 'essential services' under the 2004 General Medical Services Contract (from [19])**

Type of essential service	Eligibility for treatment
Immediate and necessary emergency treatment	'Any person to whom the contractor has been requested to provide treatment... at any place in its practice area' [reg.15 (6)]
Management of terminal illness	Registered patients and temporary residents
Treatment of conditions from which recovery is generally expected	Registered patients and temporary residents
Treatment of chronic disease	Registered patients and temporary residents
Advice in connection with the patient's health, including relevant health promotion advice	Registered patients and temporary residents
Referral of the patient for other services under the 1977 Act	Registered patients and temporary residents
Home visits	Where contractor considers it inappropriate, because of a patient's medical condition, for the patient to attend the practice premises
Annual health checks	<ul style="list-style-type: none"> <li>• Patients aged over 75 years</li> <li>• Patients not seen within 3 years; newly registered patients</li> </ul>

Table 3

**Services of curative care covered by selected National Service Frameworks; ICHA category HC.1: services of curative care**

Category	Services
Children	<ul style="list-style-type: none"> <li>• Standard 7: Guidance on hospital-based services for children</li> <li>• Standard 3: Guidance on community-based care</li> </ul>
Coronary heart disease	Standard 7: NHS Trusts to provide appropriate investigations and treatments for patients with suspected or confirmed coronary heart disease
Diabetes	Standard 7: NHS to provide rapid and effective treatment for diabetic emergencies
Mental health	In-patient hospital beds for persons needing a short period of intensive intervention and observation
Elderly	<ul style="list-style-type: none"> <li>• Standard 4: Need for appropriate specialist care</li> <li>• Standard 7: Effective diagnosis, treatment and support for those with mental health problems</li> </ul>
Renal disease	<ul style="list-style-type: none"> <li>• Quality requirement 2: Timely, appropriate and effective investigation, treatment and follow-up for those with chronic kidney disease</li> <li>• Standard 5: All likely to benefit from a kidney transplant to receive a high quality service which supports them in managing their transplant</li> </ul>

(from: DH website, [http://www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/HealthAndSocialCareArticle/fs/en?CONTENT\\_ID=4070951&chk=W3ar/W](http://www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/HealthAndSocialCareArticle/fs/en?CONTENT_ID=4070951&chk=W3ar/W), accessed 12 July 2005)

ate treatment and care of people with specific diseases and conditions within the NHS. Clinical guidelines are based on the best available evidence and are intended to help health care professionals in their work but not to replace their knowledge and skills. Services of curative treatment are included amongst the 40 currently published guidelines. For example, the dyspepsia guideline (Clinical Guideline, CG, 18) recommends life-style advice and appropriate medication as secondary preventative measures and the guideline on head injury (CG4) specifies treatment pathways covering emergency, out-patient and in-patient care. Thirdly, NICE produces

guidance on whether interventional procedures used for diagnosis or treatment are sufficiently safe and effective for routine use in the NHS. Of the 127 currently published topics most relate to hospital-based care, such as radiotherapy for age-related macular degeneration (Interventional Procedure Guidance, IPG, 048) and auditory brainstem implants (IPG108).

The three types of NICE guidance are developed and updated using distinct methodologies. Guidance on technology appraisals is formulated by the NICE Appraisal Committee, an independent advisory body with individuals from a range of professional backgrounds. Preliminary

guidance is based on evidence from an academic assessment group and from company submissions. Following consultation, the Final Appraisal Determination is developed, approved by the NICE Guidance Executive and put out again for consultation. An appeal process may ensue, after which the guidance is published. All guidance is reviewed at regular intervals [7]. To develop a guideline, NICE commissions one of the National Collaborating Centres to establish a Guideline Development Group. The Group appraises clinical and cost-effectiveness evidence from systematic reviews of the research evidence. Views of clinicians, consumers and stakeholders

also inform the guideline [8]. To produce guidance on interventional procedures, the Interventional Procedures Advisory Committee, an independent body of 24 members with a range of expertise, considers the safety and efficacy of procedures, but does not examine clinical or cost effectiveness [9]. The Committee produces a Consultation document and published guidance reflects comments received over the 4-week consultation period.

NICE guidance generally acts as quasi-law, but one aspect of guidance on technology appraisals is supported by statute. If NICE guidance is that a new technology should be made available to certain NHS patients, the funding bodies (PCTs) are obliged by law to ensure there are adequate resources to facilitate the implementation of NICE guidance (Secretary of State for Health "National Health Service Act 1977: Directions to Health Authorities, Primary Care Trusts and NHS Trusts in England", 2001). However, the guidance is not binding on individual clinicians, who must assess whether the technology is appropriate for the patients they treat [10].

Another illustration of quality standards impacting upon patient rights is Public Service Agreements. Published annually, these specify national goals within the public sector, including waiting time targets (or 'guarantees') for the NHS [11]: (a) By the end of 2005, patients will wait a maximum of 6 months for in-patient admission and no more than 13 weeks for an out-patient appointment. (b) By the end of 2008 the maximum wait from GP referral to hospital treatment will be 18 weeks.

Targets that should already be achieved, and henceforth maintained, include the 4-hour maximum wait for emergency care and the 24/48 target for accessing primary care. (The 24/48 target refers to patients being able to see a general practitioner within 2 working days or another primary care professional within 1 working day, whilst the 4-hour wait target is that patients should spend no more than 4 hours in an accident and emergency hospital department from arrival to admission, transfer or discharge.)

Where fee schedules exist for NHS care, patient 'entitlement' to services might be inferred. For example, the new national tariff system of payments for hospital ser-

vices, whilst in no way guaranteeing provision, 'suggests' services that should be accessible on the NHS. The national price schedule for patient services is classified by Health Care Resource Group (HRG) codes. A range of clinical procedures, treatments and diagnoses is included in the current list of 550 HRG tariffs for elective in-patient care [12].

The Quality and Outcomes Framework, part of the GP contract, is a voluntary mechanism for encouraging primary care provision of some services of curative care, such as antiplatelets for patients with coronary heart disease [13]. With total payments amounting to 15–20% of available total practice remuneration [14], there is a clear incentive for GPs to make these services available to NHS patients.

## Discussion

The NHS is a complex and heavily regulated health care system in which the roles of actors are in general clearly defined. As the primary emphasis has historically been upon local cost control rather than quality or access issues, geographical variations in quality and quantity of provision have emerged [1]. The lack of explicitness in the definition of the health basket has led to a great deal of uncertainty about entitlement.

Even if there is a statutory duty governing provision, this does not necessarily guarantee access to NHS services. For example, the 1977 NHS Act obliges PCTs to provide, or to arrange for the provision of, general dental services (National Health Service Act, Chap. 49, 1977). However, a large proportion of the population is unable to access NHS dental services because of a shortage of dentists willing to provide these services for the NHS. The rapid growth of private practice since 1992 was apparently precipitated by a 7% cut in NHS fees, which was designed to redress perceived excessive income [15, 16]. Access problems to NHS dentistry have triggered an urgent review of the regulations governing the dentists' terms of service with a recent cash injection of over £350 (€504) million, aimed at increasing the number of dentists working for the NHS [17]. The British Dental Association is negotiating with the Department of Health to

develop a new contract which is expected in April 2006. This example illustrates the general principle that private practice flourishes where there are access or quality problems within the NHS.

The use of regulation to address quality and access issues has had mixed results. A national evaluation of compliance by NHS organisations with NICE guidance found variable implementation. Looking at rates of prescribing and use of procedures and medical devices, the time-series analysis found significantly increased prescribing of some taxanes for cancer and orlistat for obesity in line with guidance. However, prescribing practice frequently appeared to have little relation to detailed guidance [18]. NICE guidance specifies entitlement in terms of patient groups and PCTs are obliged to provide funding only for these patients. Whether this practice is equivalent to the PCT operating a 'blanket ban' for patients whose condition lies outside the specified guidance is debatable and has not been tested in the courts.

Over the past decade the growth in 'quasi-law' suggests that the English system is heading towards a more formal statement of benefits and entitlements. NICE guidance on new and existing technologies is in effect establishing a 'positive list' of technologies that the NHS should fund; NSFs describe interventions that should be implemented to achieve standards of care. The Payment by Results system will be expanded to cover non-elective care and the Healthcare Commission will increasingly encourage NICE and NSF implementation, reinforcing standards through the 'annual health check' [5]. These factors together will take the NHS forward in defining a more explicit health basket for England. However, variations in local capacity to comply with national standards may result in a more explicit rationing of health-care services at the local level.

## Corresponding author

Anne Mason

Centre for Health Economics,  
University of York, UK  
e-mail: arm10@york.ac.uk

## Acknowledgements

The results presented here are based on the project "Health Benefits and Service Costs in Europe—HealthBASKET" which is funded by the European Commission within the Sixth Framework Research Programme (grant no. SP21-CT-2004-501588). I thank the following individuals for their helpful and pertinent comments on an earlier draft: Norman Ballantyne (Public Private Partnerships Programme), Karen Bloor (University of York); Brian Ferguson (Yorkshire and Humber Public Health Observatory); Caroline Glendinning (University of York); Maria Goddard (University of York); Nicky Illiott (ABPI); James Mason (University of Durham); Adam Oliver (London School of Economics); Phill O'Neill (ABPI); Mark Sculpher (University of York); Andrew Street (University of York); and Jon Sussex (Office of Health Economics). Peter Smith supervised the work and Mike Drummond (University of York) provided supportive advice. All remaining inaccuracies and omissions are my own.

## References

1. Department of Health (2000) The NHS plan: a plan for investment, a plan for reform. Stationery Office Limited: London
2. Newdick C (2005) Who should we treat? Rights, rationing and resources in the NHS. Oxford University Press: Oxford
3. Montgomery J (2002) Health care law. Oxford University Press: Oxford
4. Organisation for Economic Cooperation and Development (2000) A system of health accounts. OECD: Paris
5. Healthcare Commission (2005) Assessment for improvement: the annual health check – measuring what matters. Healthcare Commission: London
6. Department of Health (1997) The new NHS: modern, dependable. Cm 3807. HMSO: London
7. National Institute for Clinical Excellence (2004) Guide to the methods of technology appraisal. NICE: London
8. National Institute for Clinical Excellence (2004) The guideline development process: an overview for stakeholders, the public and the NHS. NICE: London
9. National Institute for Clinical Excellence (2004) The interventional procedures programme. NICE: London
10. Newdick C (2005) Evaluating new health technology in the English National Health Service. In: Jost TS (ed) Health care coverage: an international comparative study. Open University Press: Maidenhead
11. Treasury HM (2004) 2004 spending review: public service agreements 2005–2008. HMSO, London
12. Department of Health (2005) Implementing payment by results: technical guidance 2005/06. Department of Health: London
13. Department of Health (2004) Quality and outcomes framework: guidance (updated August 2004). Department of Health: London
14. Anonymous (2005) CCA calls for closer working between GPs and pharmacy. Pharm J 274:667
15. Oliver A (2002) Reforming public sector dentistry in the UK. BJHC 8:212–216
16. Department of Health (2004) NSH dentistry: delivering change. Report by the Chief Dental Officer. Department of Health: London
17. Department of Health (2004) Reforms with bite: 1000 more NHS dentists by October 2005: Reid unveils £368m funding injection for NHS dentistry. Press release, 2004/0265. Department of Health: London
18. Sheldon TA, Cullum N, Dawson D, Lankshear A, Lowson K, Watt I, West P, Wright D, Wright J (2004) What's the evidence that NICE guidance has been implemented? Results from a national evaluation using time series analysis, audit of patients' notes, and interviews. BMJ 329: doi:10.1136/bmj.329.7473.9992004;329:999
19. Department of Health (2003) Delivering Investment in general practice: implementing the new GMS contract. Department of Health: London

Hier steht eine Anzeige

 Springer