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Trans-Atlantic Experiences in Health Reform: The United Kingdom's National Health Service and the United States Veterans Health Administration

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The PricewaterhouseCoopers Endowment for
The Business of Government

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Foreword

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On behalf of The PricewaterhouseCoopers Endowment for The Business of Government, we are pleased to present this report by Marilyn DeLuca entitled "Trans-Atlantic Experiences in Health Reform: The United Kingdom's National Health Service and the United States Veterans Health Administration." This is the first report by the Endowment that presents a cross-national analysis of organizational reform.

Health reform is a subject that has worldwide interest. This report examines the recent reforms in the two largest public health systems in the world: the 1991 reforms in the UK's National Health Service (NHS) and the 1995 reforms in the U.S. Veterans Health Administration (VHA). The study compares the origins and impacts of both reforms.

The NHS and VHA had distinct approaches to reform that reflected their culture and past practices. In addition, both organizations responded to windows for change within their own country. The report highlights valuable lessons for organizations that are considering large-scale reform. We hope that it will be helpful to government executives on both sides of the Atlantic.

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Executive Summary

Health reform challenges national policy making across the globe. Despite the current vogue of market-based reform, reform strategies remain subject to local political and institutional environments. Moreover, while evaluation of reform policies is essential in order to understand the effectiveness of such strategies, assessing the impact of reforms is confounded by the political desire to present successful outcomes and the complexities of unraveling reform effects.

This study examines the recent reforms in the two largest public healthcare systems worldwide: the 1991 reforms in the United Kingdom's National Health Service (NHS) and the 1995 reforms in the United States Veterans Health Administration (VHA), the largest component of the U.S. Department of Veterans Affairs (DVA). While their reform strategies differed, there is much to learn from these efforts in transforming large public health systems. The NHS reforms were based on managed competition and a market model of public administration; the VHA's reforms relied on managed care strategies and a deregulation model of governance. Several questions motivated this work. What factors account for the NHS and VHA reforms? That is, how did societal values, political conditions, and institutional contexts shape the reforms and implementation strategies? How did the reforms affect health service delivery, medical education and training, and research, as well as human resources in each setting? Did the reforms achieve their stated goals? And finally, what were the byproducts and unexpected consequences of the reforms?

The two case studies drew data from secondary as well as primary sources. The primary data sources included 44 in-depth interviews, other various contacts, and participant observer experiences (VHA).

The findings included:

- Subsequent to the reforms, there was convergence of the NHS and VHA in several areas:

  health service delivery:
  reduced beds; increased outpatient services; persistence of long waiting lists and times; decreased access to long term and mental health services

  medical education and training:
  increased tensions with affiliates; pressure on staff for clinical service

  research:
  decreased managerial support; pressure on staff for clinical service over academic time

- The VHA reforms produced more significant changes in health service delivery for the measures examined.

- With regard to *human resources,* the VHA reforms generated more significant change, which included staff reductions, impaired communications, and morale problems.

- The NHS and VHA reforms produced similar byproducts, which included power shifts, decreased access for some patients, and change in the balance among health service

delivery, medical education and training, and research missions.

The findings suggest that while divergent socioeconomic and political factors opened windows for reform of the UK's NHS and the U.S. VHA, the windows varied in duration and characteristics. The respective governmental structure, institutional context, and interest groups influenced reform in each system. In contrast to the NHS's reliance on an internal market, the VHA's use of performance measures and performance contracts encouraged strategies and managerial responses that significantly altered health service delivery.

Introduction*

Health system reform is a topic of current worldwide interest. The confluence of economic pressures, growing demands, aging populations, and rapidly developing technologies force governments and policy makers to examine policy options, adjust the "public-private mix," and consider the introduction of seemingly similar market mechanisms. While the recent trend in reform demonstrates a reliance on market-based strategies such as managed care and other competitive arrangements, growing evidence finds such models often have unfavorable impacts on access to and the quality of health services (*Health Affairs,* September/October 1997, January/February, 1998; *Journal of Health Politics, Policy and Law,* October 1999; Light 1995, 1997; Ikegami 1991).

This study examines the recent reforms in the world's largest public healthcare systems, the 1991 reforms in the National Health Service (NHS) in the United Kingdom and the 1995 reforms in the Veterans Health Administration (VHA) in the United States Department of Veterans Affairs. Although they differed in aims and specific strategies, the NHS and VHA reforms were influenced by cross-national trends for market-based reform and reflect the pressures and politics of the British and U.S. governments. The NHS wanted to improve access to services and contain costs; the VHA wanted to reduce costs and increase the number of veterans served. Overshadowing the introduction of both reform efforts was concern over the future viability of both systems.

The 1991 NHS reform policies emanated from a review established by Prime Minister Thatcher in 1988 and were outlined in *Working for Patients* (UK Secretaries of State for Health 1989). The NHS reforms, which were formally implemented in April 1991, introduced an internal market into the NHS and were based on the work of Enthoven (1985) and managed competition, which "forces providers to compete for price, efficiency, and value for money" (Light 1994, 1197), and General Practitioner fundholding (Maynard 1986). The NHS internal market split purchasers (NHS Health Authorities and GP fundholders) from providers (hospital and community service providers and NHS Trusts).

The VHA reforms followed the failed U.S. health reform debates of 1993-94 and were outlined in *Vision for Change* (U.S. DVA 1995). The VHA reforms, formally adopted in October 1995, were drawn from recommendations of earlier VHA appointed advisory groups and were based on managed-care models or "institutional arrangements whereby all (or nearly all) services are coordinated under one administrative roof " (Light 1994, 1198) and which use an array of techniques to contain costs. The VHA reform techniques included cost reduction strategies, provider gatekeeping, use of performance measures, national price setting, and internal competition over fixed resources. The VHA centered its reform strategies on structural

** This report is based on the research done in the course of the doctoral dissertation:* Health Reform in Public Systems: Recent Reforms in the UK's National Health Service and the U.S. Veterans Health Administration*, Marilyn A. DeLuca, Robert F. Wagner School of Public Service, New York University, January 2000.*

reorganization and the establishment of 22 Veterans Integrated Service Networks (VISNs), and, in an American technocratic fashion, developed an elaborate implementation plan that drove the reform objectives by linking them to performance measures.

The Health Systems

The NHS and VHA health systems share some features and have similar missions in delivery, medical education and training, and research. Both the NHS and VHA are government owned and operated systems that were established to ensure access to health services.

Both systems are primarily financed by general taxation.[1] However, the NHS is a large national health system in a relatively small nation; the VHA is the largest U.S. public healthcare system and exists alongside the mix of private and public U.S. health systems. Both the NHS and VHA provide health services to a disproportionate share of their respective populations that cannot afford health insurance.

The NHS

The NHS was created in 1948 following prior attempts for health reform, most notably the seminal proposal set forth in 1942 by Britain's Health Minister Beveridge calling for a national health service. Before the NHS was established, health services in the UK were uncoordinated and inadequate. The successful operation of England's Emergency Medical Service (EMS) during World War II brought together voluntary and area health authority hospitals under the direction of the British government and demonstrated the benefits of coordinated healthcare planning. This wartime experience helped to coalesce Britain's prior reform efforts for a national health system.

The NHS is an integrated national delivery system that provides inpatient and outpatient services free to all with the exception of small co-payments for select services, such as prescription co-payments, eyeglasses, and dental care. The NHS, a near monopoly, is available to all who reside in the UK. Of the 58 million people who live in the UK, 51.5 million people are residents of Britain, and the majority, 48.5 million, reside in England (UK OHE 1995). UK residents and visitors who want their care in the NHS register with a General Practitioner (GP), who is the point of referral for specialty and hospital services. There is a modest private health sector in the UK, which represented 3.4 percent of total UK health expenditures at the start of the reforms in 1991. The private sector primarily serves as a backup to the NHS and is used to bypass the long waiting lists in the NHS.

NHS health services are firmly based in primary care, with less emphasis on the provision of tertiary care and special services (Aaron and Schwartz 1984; Klein 1994) as provided by the VHA, which mirrors American medical practice with its comparatively high utilization of health services. The NHS provides health services to a proportionately larger number of women and children and offers maternity and pediatric services, which are not part of the VHA mission.

The VHA

Although the first mention of the U.S. government's responsibility for veterans was in 1636 in colonial laws, the Veterans Administration (VA) was formally established in 1930 to provide medical care and veterans' services for honorably discharged veterans. The VA underwent major expansion following World War II. Large numbers of returning veterans prompted the 1946 reorganization of VA medical programs from administrative to medical management under the VA's new Department of Medicine and Surgery (DM&S). At the same time, affiliation of VA hospitals with U.S. medical schools expanded the size, scope, and missions of the VA. In 1989, the VA was designated the Department of Veterans Affairs (DVA), the 14th cabinet department, which encompasses the Veterans Health Administration (VHA) as well as the Veterans Benefits Administration (VBA).

[1] *Although the NHS is primarily supported by general taxes, since 1948 there has been an increasing reliance on NHS contributions, patient charges, and other income. In 1995, 82 percent of NHS funding was derived from general taxes, 12 percent from NHS contributions, 2 percent from charges for items such as dentures and eyeglasses, 3 percent from capital refunds, and 1 percent from miscellaneous sources (UK NHS Health Service Confederation 1998, 76). Through contracts with the private sector, a percentage of capital costs are derived through the Private Finance Initiative (PFI).*

The VHA is funded from congressional appropriations of general tax revenues. Small amounts of funds are from means-tested co-payments for treatment of veterans' non-service-connected conditions and, since 1986, third party insurance collections. As of 1998, VHA medical centers were permitted to retain the third party insurance collections rather than return them to the U.S. Treasury.

Market penetration differs between the VHA and the NHS. The VHA is an exclusive health provider that serves approximately 1 percent of the U.S. population and just over 10 percent of all living veterans. The VHA competes with other more dominant U.S. health systems. In recent years, the growth of managed care, which varies state by state, affects that competition. Veterans' use of the VHA is limited by misunderstanding of veteran eligibility for VHA care and public perceptions that VHA health services are only for the poor or those that cannot afford private health insurance. In recent years, there has been modest growth in the number of veterans who use the VHA. Over the years prior to implementation of the VHA reforms from FY 1991 to FY 1995, there was an increase of 100,000 veterans, representing 2.7 percent of veterans who received health services in the VHA.

A vertically integrated health system since its inception, the VHA provides care across the spectrum of health delivery from acute, state-of-the-art tertiary care and outpatient services to long term and home care services. The VHA services exclude pediatric and maternity care. To this day, and particularly in urban areas, the VHA serves as a safety net providing health services to veterans with limited incomes and those who would otherwise be among the under-served. This role is of increasing importance in light of the recent U.S. health industry changes, growing costs of private health insurance, and the contraction in Medicaid and Medicare funding and local government spending.

Both the NHS and VHA provide major support to medical education, the training of allied health professionals, and basic and clinical research. The NHS supports all medical trainees in England; 60 percent of all U.S.-trained physicians have some part of their training in the VHA.

Glossary of Terms

Consultants: Physician specialists who have training in specialty areas. Consultants are salaried employees of the National Health Service, but may also have private practices.

Cost Weighted Activity Index (CWAI): Introduced with the 1991 NHS reforms, CWAI is a weighted resource allocation formula that uses age, morbidity, local costs, and hospital utilization patterns to guide the local distribution of NHS resources.

General Practitioners (GPs): Self-employed physician practitioners paid out of public funds to provide primary care services to NHS patients who register on their lists.

GP Fundholders: As part of the 1991 NHS reforms, GPs with a certain patient list size could become fundholders and receive NHS appropriated funds to purchase select hospital and community services, prescription drugs, and provide salaries for non-medical practice staff. The GP fundholders retained unused funds to reinvest in their practices.

Health Authorities (HAs): New organizational structures established by NHS in 1995 following the 1991 reforms. Each of the 100 HAs in the United Kingdom is responsible for the health planning needs of the area population and the purchasing the bulk of health services for residents of the community.

National Health Service (NHS): The United Kingdom's NHS is a government owned and operated healthcare system financed by general taxes. The NHS provides services free of charge, with the exception of small co-payments, to residents of the United Kingdom who register with a General Practitioner.

NHS Trusts: Established as part of the 1991 reforms, NHS Trusts include NHS hospitals and community service providers. These self-governing Trusts contract with purchasers of health services, namely Health Authorities and GP fundholders, to provide defined services. NHS Trusts are permitted to retain excess revenues from contracts to reinvest in patient services.

Primary Care Groups and Trusts (PCGs/PCGTs): As of 1999, under the Labour government's "new NHS," PCGs and PCGTs replaced GP Fundholders. PCGs of qualifying patient size could hold funds for purchasing services for resident populations.

Veterans Equitable Resource Allocation (VERA): A new resource allocation formula implemented by VHA in 1997, this capitation-based system uses national price per patient group, where average cost is used for national price, and is adjusted for geographic differences in select labor, research and education, equipment, and non-recurring maintenance costs. VERA is used to distribute budgets to the VISNs.

Veterans Health Administration (VHA): The VHA is a federally funded public healthcare system. The VHA, the largest component of the Department of Veterans Affairs, provides healthcare to eligible veterans. A vertically integrated system since its inception, the VHA provides inpatient care, outpatient care, long term care, and home health services.

Veterans Integrated Service Networks (VISNs or Networks): The new organizational structure established in 1995 as part of the VHA reforms, the 22 Networks replaced the four prior Regions. The VISNs assumed responsibility for veteran population-based planning and health service delivery. The head of each VISN has budget control for the VHA hospitals and clinics in their areas.

VHA Community Based Outreach Clinics (CBOCs): VISNs were authorized in 1995 to establish CBOCs to improve access for veterans who lived a distance from VHA facilities.

Study Findings

The NHS Reforms: Overview

The need to reform the NHS grew during the 1980s. In the early 1980s, the Conservative Thatcher government considered the introduction of private insurance schemes, but realizing the lack of popular and political support abandoned that reform plan. However, pressure for reform of the NHS increased due to problems over funding, reflected by long waiting lists and access issues. By the late 1980s, the pressures from professionals and the public reached a critical level. In 1988, Prime Minister Thatcher announced a review of the NHS. She pushed through the review of the NHS and won Parliamentary approval of the reforms before the runup to the 1990 election. The resulting policy paper, *Working for Patients,* which outlined the reforms, was approved by Parliament in 1990. The key goals of the NHS reform were to improve access and contain costs. Formal implementation of the reforms occurred in April 1991. However, despite the push for rapid approval, implementation of the NHS reforms was slow compared to the VHA reforms.

1991 NHS Reforms

Precipitators:

Problems with access

Under-funding

Professional and public pressure

Policy document:

Working for Patients (1989)

Reform aims:

Improve access to services

Cost containment

Formal implementation date:

April 1, 1991

The NHS reforms were based on managed competition, which forces providers to compete for price, efficiency, and value for money. The reforms introduced an internal market into the NHS, which split the purchasers of services (Health Authorities and GP fundholders) from hospital and community service providers. NHS hospitals and community service providers could apply to become "quasi-independent" NHS Trusts and were promised more autonomy in hiring and firing staff and setting salary levels. As a last minute add-on to the reforms, General Practitioners could apply to become fundholders and purchase certain services for the patients on their lists. As part of the reforms, the Department of Health for the NHS introduced a new resource allocation formula — the Cost Weighted Activity Index (CWAI) — which uses census data to allocate area funding.

The NHS reforms reflect the preference of Britain's Conservative government under Thatcher for a market model approach in public administration (Peters 1996, 19-25). The NHS reform efforts focused more on the process of setting new structures in motion (Trusts, GP fundholding, Health

Authorities) rather than on outcomes. This emphasis differed from that in the VHA, where the reform strategies reflect a model of deregulating government (Ibid., 34-38), with a focus on results (Thompson and Riccucci 1998, 235-237).

Features of the NHS Reforms

- Created an internal market to increase competition
- Split purchasers of services from providers
- Created Trust status for NHS hospitals and community service providers
- Provided option for General Practitioners to become fundholders

The Conservative government continued under the leadership of Prime Minister Major for seven years following the formal implementation of the reforms. These years were filled with challenges for Major as well as internecine struggles within the Conservative Party (Sullivan 1999, 41-42). Perhaps the implementation of the NHS reforms might have been more focused on outcomes had these confounding political pressures and distractions not clouded the reform implementation period.

The NHS reforms did not achieve all they set out to accomplish: waiting lists grew, and there was little change in patient choice, measures of clinical efficiency, or employee satisfaction. The most successful aspect of the NHS reforms was the separation of purchasers and providers. This finding was substantiated by both primary and secondary data. In a study of 22 Health Authorities in the West Midlands area conducted from 1989 to 1991, the initial years following announcement of the reforms, 87 percent of the District General Managers approved of the separation of purchaser and provider (Appleby et al. 1994).

GP fundholding, the "wild card" of the 1991 reforms, served as a large demonstration project that produced favorable outcomes and earned the confidence of the new Labour government. The experience with GP fundholding paved the way for Labour's current strategies for the "new NHS" and total commissioning (UK DOH 1997). In the long run, it may become evident that fundholding was the biggest success among the 1991 reform strategies. Despite the consensus from both primary and secondary data sources that regard the internal market as a failure, the purchaser provider split was the winning strategy and remains central to Labour's new commissioning model (Dobson 1999, 40; UK DOH 1997). While commissioning is currently being touted as the replacement for competition, the value of such political word-smithing will reside in its ability to modulate the negative forces of market mechanisms (Light 1998) if lessons have been derived from the 1991 reforms.

There is less enthusiasm over the other aspects of the internal market (Appleby et al.1994, 32) and, in addition, evidence of the government's frequent need to manage the market. There were persistent pleas for close monitoring and critical evaluation of the reform impacts (Robinson and Le Grand 1994). The evidence indicates that NHS reform decisions were made for the short term. Yet, such short-term planning bypassed modeling the long-term impacts of the reforms, which would have helped anticipate the perverse incentives fostered by the reform strategies (Whitehead 1994).

The VHA Reforms: Overview

The antecedent for the VHA reforms was the 1993-94 U.S. attempt at national health reform. The VHA had participated in the national reform deliberations, and following those efforts, recognized the need to demonstrate improved clinical efficiency.

The VHA reforms were outlined in *Vision for Change* and approved by Congress in September 1995. The key aims of the reforms were to improve clinical efficiency and shift care from the hospital to outpatient settings. Formal implementation started in October 1995. Compared with the NHS, the VHA's reforms were fast-paced. They were timed for approval before the 1996 election campaign took off and were implemented quickly between election cycles.

The VHA reforms were based on managed care models, inspired by the recommendations of earlier VHA commissioned advisory groups. The VHA built its reform strategies around structural reorganization and the establishment of 22 Veterans

1995 VHA Reforms

Precipitators:

Perceived clinical inefficiency

U.S. national reform debate

Policy document:

Vision for Change (1995)

Reform aims:

Improve "clinical value" for expenditures
Shift care from hospital to outpatient settings

Formal implementation date:

October 1, 1995

Integrated Service Networks. Early in the plans for reform, Congress confirmed the appointment of a new Under Secretary for Health for the Department of Veterans Affairs from outside the VHA, Dr. Kenneth Kizer. Congruent with reinventing government techniques, the VHA developed an elaborate implementation plan that drove the reform objectives by linking them to performance measures.

Features of the VHA Reforms

- Adopted managed-care principles
- Created VISN structure and decentralized decision-making
- Recruited a new VHA Under Secretary for Health
- Relied on performance contracts and performance measures for change

The VHA's new resource allocation model VERA, which was adopted soon after the start of the reforms, fostered changes in resource distribution to Networks. As a result, VERA precipitated management practices that undermined access and equity for several vulnerable populations — namely, elderly veterans and those in need of long-term care, and complex and chronic patients such as the seriously mentally ill and substance abuse patients (US GAO 1999; US VSOs 1999). The VHA reduced the apparent demand from chronic patients by downsizing programs and cutting beds in response to performance measures and the VERA model and its use of national allocation rates. And, just as the effects of VERA varied across the country, the responses of managers and staff were often linked to the level of Network funding.

The rapid pace of the VHA reforms reflects the relatively brief window of opportunity that the VHA had for reform. Compared to the NHS reforms, which relied on a market model (Peters 1996, 19-25), the VHA reforms were based on a model of deregulating government (Ibid., 34-37). Yet, Peters (1996) urges caution in the use of deregulation in public program areas "that deal with the basic rights of citizens" (Ibid., 38). And while the VHA benefits are not basic rights, but part of discretionary government spending, they represent a government commitment to veterans for military service, a commitment that is perceived by veterans as an entitlement. Devolution of authority, results orientation and use of performance contracts, and emphasis on competition and customer service, despite questionable effects, reflect strategies common to reinventing government (Thompson and Riccucci 1998, 235-237). These strategies had bipartisan appeal and helped to support the opportunity for reform of the VHA.

The VHA was successful in changing the focus of VHA care from hospital care to healthcare. Aided by VA eligibility reform (U.S. Congress 1996) — which removed restrictions on the provision of outpatient services for most categories of veterans — and primary-care initiatives, more veterans are now treated by the VHA.[2] Yet, while the VHA was successful in decreasing costs in response to federal budget constraints and the reform strategies, these pressures spawned problems across the VHA missions of delivery, medical education and training, and research, and impacted the workforce.

The VHA achieved many of the stated reform targets. Yet, the VHA reforms were controversial among Veterans Service Organizations (VSOs). By late 1998, there was increasing political fallout over the effects of the VHA reforms. Dr. Kizer was

[2] *Before 1996, with the exception of three categories of high-priority service-connected veterans, veterans could only be treated as VHA outpatients if they had been inpatients or were in another high-priority discretionary eligibility category.*

not re-confirmed by Congress for a full term in October 1998 and resigned on June 30, 1999.

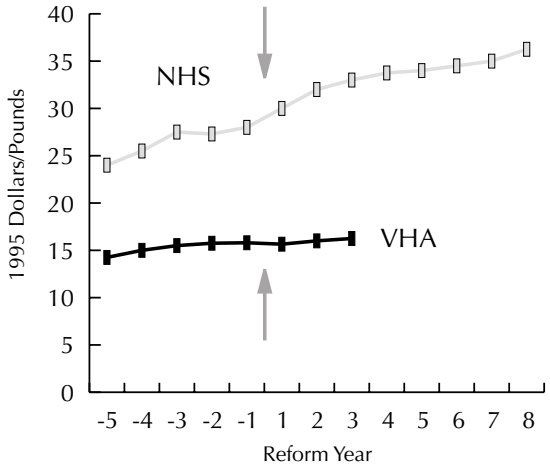
The NHS and VHA incorporated several shared strategies in their reform interventions: (1) adopted market-based reform strategies; (2) reshaped the organization and moved operational authority from the center (the NHS Executive and VHA Headquarters) to the periphery (Health Authorities in NHS and Networks in VHA); (3) introduced new weighted capitation models for resource allocation within fixed global budgets — CWAI in the NHS, VERA in the VHA; (4) set incentives to change clinical practice, which includes the expansion of primary care and adoption of clinical pathways, and tightly controlled drug formularies; and (5) modified missions through changes in the balance within and among delivery, medical education and training, and research.

Shared NHS and VHA Reform Strategies

- Adopted market-inspired reform models
- Reconfigured regions and devolved power
- Introduced new allocation models
- Established incentives to change clinical practice
- Re-evaluated missions

The NHS expenditures increased gradually before the reforms, and continued to increase in a similar gradual pattern following the reforms. However, during the early years of the reforms, infusion of additional funds facilitated reform implementation. The VHA budget, which had very minimally increased before the reforms, completely flat-lined as a result of the 1997 Balanced Budget Amendment (Figure 1). And given the VHA's expansion into new outpatient areas as a result of the reforms, this amounted to a relative decrease in funding. After adjusting for inflation, the NHS expenditures increased 21 percent (1989-1993) and the VHA expenditures increased 3 percent (1994-1998).

Figure 1: NHS and VHA Expenditures
Constant Pounds/Dollars in Billions (1995)



Structures

The establishment of NHS Health Authorities (HAs) came relatively late in the reforms. Health Authorities were key in shepherding change and serving as organizational anchors during times of flux; they served as the interface between policy and implementation and mediated new roles with Trusts and GP fundholders. The NHS Executive artfully devolved power and responsibility to Health Authorities, and the HAs responded with remarkable skill given their limited experience in the newly established quasi-markets. The NHS was primarily "being shaped, not so much by competition or consumer preferences as by Health Authority planners using purchasing as their tool" (Redmayne, Day and Klein 1995, 9). The future of Health Authorities is uncertain both with respect to their role and number. However, future evaluation of Health Authorities will be based not only on their role in health service planning, but also on measures of health outcomes.

The long tenure of the NHS Executive and longevity of the Conservative party's dominance in the UK, compared with the leadership in VHA Headquarters and given the U.S. political structure, provided continuity to establish the NHS reforms and gain experience with GP fundholding.

The creation of Veterans Integrated Service Networks was key in the VHA reforms. The use of performance measures and contracts to achieve the objectives of the reforms introduced a new level of central control

Table 1: NHS and VHA Reforms: Areas of Convergence and Divergence in Health Policy

Health Policy/Strategy Area	Convergence		Divergence	
	NHS	VHA	NHS	VHA
Planning the reform strategies			↓	♦↑↑
Funding			♦↑	♦=
Change in resource allocation model	♦	♦		
Population-based planning	♦	♦		
National allocation rate per patient			=	♦↓
Geographic shift in resource allocation	♦↑	♦↑↑↑		
Market mechanisms			♦	♦
New sources of private funding	♦	♦		
Use of performance contracts			=	♦↑↑↑↑
Use of performance measures			=	♦↑↑↑↑
Evaluation of reforms	♦↓↓↓↓	♦↓↓↓		

Key:

↑ = slight use/increase; ↑↑ = moderate use/increase; ↑↑↑ = great use/increase; ↑↑↑↑ = extreme use/increase

↓ = slight use/decrease; ↓↓ = moderate use/decrease; ↓↓↓ = great use/decrease; ↓↓↓↓ = extreme use/decrease

♦ = key reform strategy; = = unchanged

Arrows (↑) indicate the relative degree of reliance on or the direction of change a particular strategy elicited. The number of arrows assigned is an approximation based on the synthesis of the quantitative and qualitative data gathered and reviewed.

despite the flattening of the organization and the devolution of operational responsibility to the Networks. The Network structure was accompanied by a new form of competition that was compounded by scarce resources due to VHA's constrained budget and the adoption of VERA. Both secondary and primary data prompt questions over the pace and evaluation of the VHA reforms. These questions suggest that the VHA underwent substantive and rapid change, and in the context of the newly devolved authority to Networks and pressures for performance, the need existed for better information, national coordination and oversight of health services, and evaluation of the effects of reform at the local level.

Health Service Delivery

Changes in health service delivery were more pronounced in the VHA than in the NHS. In the VHA, the numbers of hospital admissions and beds dropped dramatically, whereas the number of patients and the provision of outpatient services showed marked increases. Both systems expanded primary care, with greater change in the VHA. And both the NHS and VHA introduced strategies to decrease clinical cost variations such as clinical pathways and controlled drug formularies.

Several factors constrain the ability to assess the NHS post-reform change in the delivery of health services. First, frustration exists among reviewers of the NHS reforms over the lack of information and the need for systematic evaluation of the reforms. Given the limitations of information, in general, the scope of the NHS health services are similar to those in 1989, if not 1948: Healthcare remains a local decision at the discretion of the provider (Klein 1995, 311). Exceptions to this are the erosion of government support for the NHS provision of long term care and the problems with coordination of community services in the care of the mentally ill despite the growing demand for services among the elderly and frequent crises in the care of the seriously mentally ill.

The reforms were not successful in improving waiting times in a significant and sustained way, and they were ineffective in increasing patient choice. They did achieve improvements in care, access, and quality for the patients of GP fundholders, demonstrating the efficiencies and value to be derived from organizational rearrangements that promote ownership and enhance the achievement of common goals. However, the lack of continuity of care from primary to tertiary settings raises concerns over future clinical efficiency and quality.

The evidence of the impact of the reforms on equity reveals mixed findings. The change in policy for non-acute long term care has adversely affected many individuals and precipitated financial hardship (Whitehead 1994, 231-240). However, claims of cream skimming have produced equivocal findings. Le Grand notes that, for fundholders, the policy provision to protect practices from the cost of expensive patients (above 5,000 pounds) reduced the incentive to limit complex patients from their lists (Le Grand 1999, 31).

The only evidence of change in overall efficiency is demonstrated by an increase in the cost-weighted activity index (CWAI), the overall indicator of NHS

Changes in Clinical Practice

- Trends in health service delivery

	NHS (1989-1993)	VHA (1994-1998)
- hospital admissions	+ 7%	– 23%
- reduced beds	– 19%	– 48%
- increased number of patients	~	+ 20%
- increased outpatient services	+ 8%	+ 35%

- Expanded primary and outpatient care
- Introduced clinical pathways and drug formularies

efficiency. The CWAI — which measures volume of health services, but not case-mix, quality, or effectiveness of outcomes — grew 4.4 percent from 1991 to 1995, compared to a 2.3 percent growth in the decade from 1980 through 1990. When adjusted for the changes in resources over these periods, the average annual change in productivity efficiency, or volume of health services, was 2 percent following the reforms compared to 1.5 percent in the decade prior to the reforms (Mulligan 1998, 24; Le Grand, Mays, and Dixon 1998, 120).

As summarized by Le Grand (1994, 259), much of the direct research on the reforms indicates little change in quality, efficiency, choice, responsiveness, and equity in the first two years following the reforms. Hunter (1997) echoed this assertion later in the course of the implementation of the reforms noting however, that the NHS reforms suffer from the lack of systematic evaluation. In his most recent assessment of the NHS, Le Grand (1999, 32) reconfirmed his earlier observations that little change occurred. Perhaps this lack of change fits with the Conservative agenda: contain costs and satisfy public unrest over the NHS, but avoid cumbersome regulation. In the end, there was little measurable change in health service delivery in the NHS following the 1991 reforms.

The effects of the VHA reforms on the delivery of health services are mixed. While the VHA is now treating more patients than prior to the 1995 reforms, it does not appear that access for the more indigent veterans has improved. In fact, the evidence suggests that support of these patients eroded. The assumption by many managers was that the VHA was inefficient in all areas of health service delivery; this assumption may reflect a lack of appreciation among such managers for the differences between and among veteran populations.

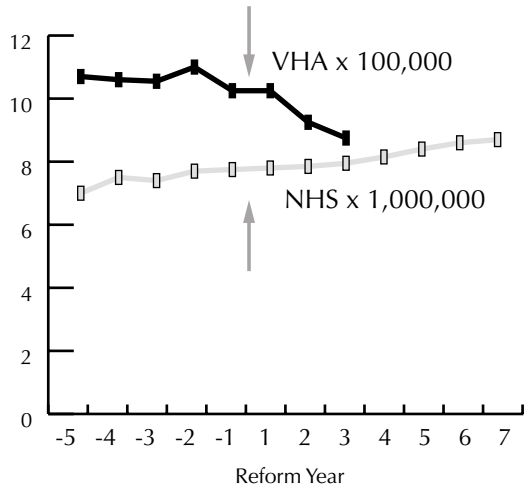
The reforms fostered changes in the delivery of VHA health services. The number of veterans cared for increased and bed days of care fell. However, there is evidence of uneven access to costly programs and that the VHA must carefully reassess that balance among its clinical programs in light of the veterans it serves, their needs, and the recommendations of concerned interest groups (US VSOs 1999; US GAO 1998, 1999; Cohen 1999).

The VHA made strides in expanding primary care programs and integrating primary care through all levels of care. In terms of integrating care, the VHA and NHS differ. Most primary care providers are VHA employees and many VHA clinics are situated on the site of VA medical centers, which offers a geographical convenience that encourages communication. This differs from the NHS, where GP-provided care is distinct from NHS inpatient, acute, and specialty care. However, as the number of VHA Community Based Outreach Clinics (CBOCs) grows, and with many CBOCs staffed by non-VHA employees, the challenges that face the VHA may mimic those of the NHS in integrating primary and hospital-based care.

While the quality of VHA care appears good compared with other health systems, following the reforms, the VHA limited what they systematically measure and set aside established quality management programs that assessed the quality of care and detected sentinel events (US Senate Minority Staff 1997). The findings of recent reviews (US DVA OIG 1998, 1999; US Senate Minority Staff 1997) encouraged the VHA to rebuild its quality management programs to reliably assess access, equity, and outcomes of health services given the magnitude of changes the reforms introduced into VHA health service delivery.

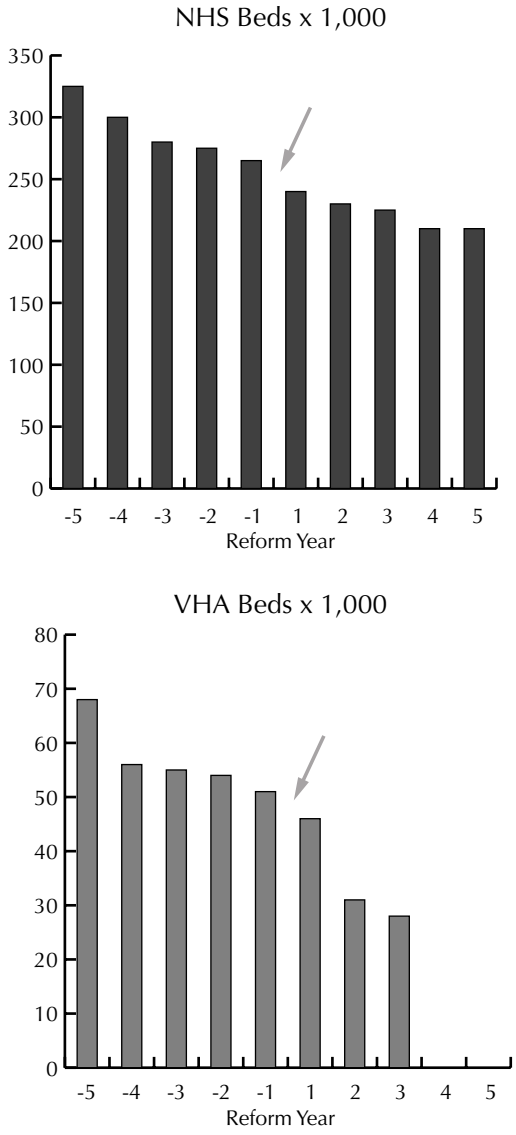
In the NHS, following the reforms, the number of admissions continued to increase at the same rate as before. In addition, the number of day cases increased. The decrease in the number of VHA admissions reflects the VHA's shift in care from hospital to outpatient settings (Figure 2).

Figure 2: NHS and VHA Hospital Admissions



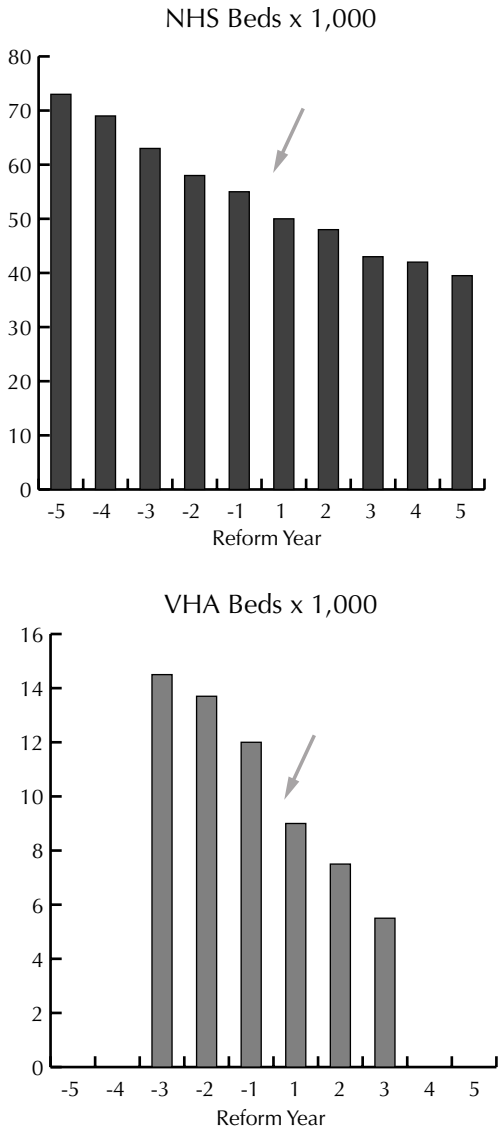
In both systems, there were noticeable bed reductions in the early years of the reform. Bed reductions in the VHA were much more pronounced than in the NHS (Figure 3).

Figure 3: Total Hospital Beds



The reductions in mental health beds were more pronounced in the VHA than in the NHS (Figure 4). The adverse impacts of these rapid closures drew so much public criticism that in the VHA, control of mental health resources was recently re-centralized; in the NHS, there was a call for a national review.

Figure 4: Mental Health Beds



In the past, the NHS did not maintain data on the number of individuals cared for in the NHS. The NHS reforms had no incentive to treat more patients, and the number of patients, as can best be estimated, was essentially unchanged. The VHA increased the number of new veterans it cared for by 20 percent from 1994 to 1998 (Figure 5). One of the VHA's reform aims was to increase the number of veterans cared for to drive down apparent cost per capita and move more in line with a managed care setting. The VHA was successful in accomplishing that goal aided by eligibility reform. VHA officials won congressional support for eligibility reform early in the reforms, which rationalized the provision of outpatient care and allowed veterans to be cared for without prior hospitalization. In addition, the new VERA allocation model rewarded facilities similar to HMO models, with resources for treating new, especially inexpensive, patients.

Outpatient activity increased in both systems, but the increases were steeper for the VHA (Figure 6). These differences may be attributable to the VHA's goals and reform incentives, as well as pre-reform market penetration.

Figure 5: NHS and VHA Patient Population (x Million)

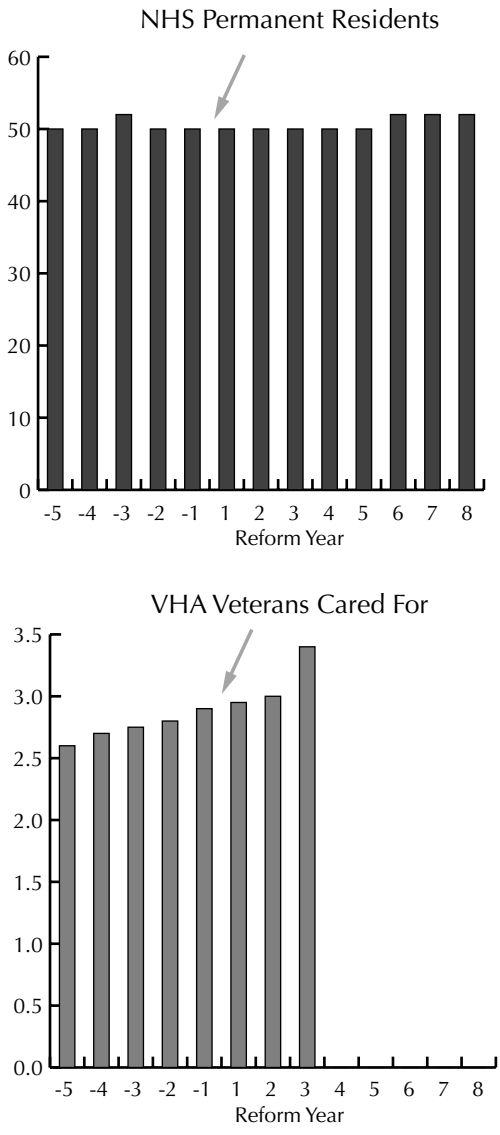


Figure 6: Outpatient Activity (x Million Visits)

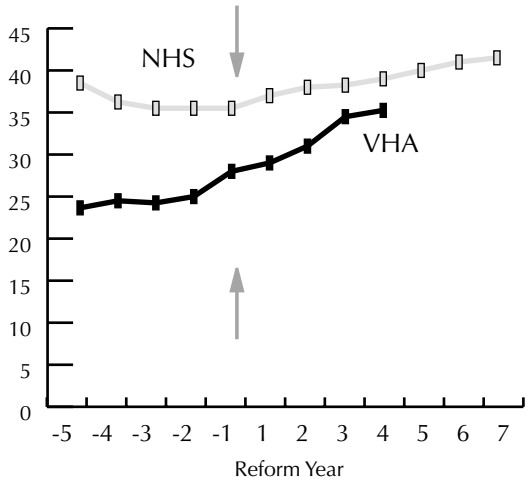


Table 2: NHS and VHA: Areas of Convergence and Divergence in Health Service Delivery Following Reform

Health Service Delivery/Strategy Area	Convergence		Divergence	
	NHS	VHA	NHS	VHA
Reduced number of beds	♦↓	♦↓↓↓		
Reduced length of stay/BDOC/1,000 pts	♦↓↓	♦↓↓↓		
Integrated/merged hospitals	♦↑	♦↑↑		
Change in number of patients treated/yr			=↑	♦↑↑
Change in number of enrollees			=↑	♦↑↑
Change in access to long-term care	♦↓↓	♦↓↓		
Change in access to mental health services	♦↓↓	♦↓↓		
Change in access to outpatient services	↑	↑↑↑		
Primary care: coordinated/comprehensive			=	♦↑↑
Pharmaceutical controls	♦	♦		
National strategic planning	↓↓	↓↓↓		
Rationing	↑↑	↑		
Quality of care	?	?		
Quality Management Program			♦↑↑	♦↓↓↓
Waiting lists/times	↑/↓	? /?		
Patient satisfaction			=?	↓↓

Key:

↑ = slight use/increase; ↑↑ = moderate use/increase; ↑↑↑ = great use/increase

↓ = slight use/decrease; ↓↓ = moderate use/decrease; ↓↓↓ = great use/decrease

♦ = key reform strategy ? = uncertain = = unchanged

Arrows (↑) indicate the relative degree of reliance on or the direction of change that a particular strategy elicited. The number of arrows assigned is an approximation based on the synthesis of the quantitative and qualitative data gathered and reviewed for this research.

Medical Education & Training and Research

The reforms ushered in new pressures between the NHS and VHA and their affiliated universities and medical schools. In both settings, external changes in medical education, such as changes in training requirements and restricted work hours for trainees, confounded implementation of the reforms. Although the NHS environment differs from that of the VHA, where there are competing health systems to serve as affiliates, the confluence of the NHS reforms and growing pressures in medical education and training, and research impacted physician roles and affiliate relationships. Concerned over the impact of the reforms on medical education and research, the vice-chancellors of NHS affiliates, through lobbying efforts with Parliament, gained membership on Health Authority and NHS Trust Boards. Among the more palpable changes in medical education and training, and research is the impact on individual faculty and consultants for clinical service, which infringes on academic time.

It will take a number of years to correct the current physician shortage in Britain given the recent approval to increase the number of medical trainee slots. More significantly, it appears that the British government needs to respond to current pressures to increase the NHS budget if they are to appease professionals and retain trained physicians in the UK. The current environment requires both political skill and wisdom to learn from the past strife between the government and clinicians over funding of health services.

The VHA reforms introduced change that has challenged the VHA's commitment to medical education and training, and research — two key missions

Table 3: NHS and VHA: Areas of Convergence and Divergence in Medical Education and Training Following Reform

Medical Education and Training/Strategy Area	Convergence		Divergence	
	NHS	VHA	NHS	VHA
Number of medical education affiliates			NA	↓
Change in number of medical students			↑↑	↓
Change in number of medical residents			↑↑	↓
Change in number of allied trainees/programs			NA	↓
Change in support of faculty in medical education	↓	↓		
Pressure on faculty for delivery versus education	♦↑↑	♦↑↑		
Medical education emphasis on primary care	↑	↑↑		

Key:

↑ = slight use/increase; ↑↑ = moderate use/increase

↓ = slight use/decrease; ↓↓ = moderate use/decrease

♦ = use of strategy NA = not available

Arrows (↑) indicate the relative degree of reliance on or the direction of change that a particular strategy elicited. The number of arrows assigned is an approximation based on the synthesis of the quantitative and qualitative data gathered and reviewed for this research.

Table 4: NHS and VHA: Areas of Convergence and Divergence in Research Following Reform

Research/Strategy Area	Convergence		Divergence	
	NHS	VHA	NHS	VHA
Evaluation of research mission	↑↑	↑↑		
Total research funding change	?	↑		
NHS and VHA research funding/operational support	?/↓	↑/↓		
Control of funds	♦	♦		
Change in research focus	♦↑	♦↑↑		
Increase in HSR&D	♦↑	♦↑		
National influences on research agenda (Prevention/institutional)	♦↑↑	♦↑↑		
Pressure on staff for clinical time over research	♦↑↑↑	♦↑↑↑		
New initiatives for research program planning	♦	♦		
New initiatives for research	♦↑	♦↑		

Key:

↑ = slight use/increase; ↑↑ = moderate use/increase; ↑↑↑ = great use/increase

↓ = slight use/decrease; ↓↓ = moderate use/decrease; ↓↓↓ = great use/decrease

♦ = key reform strategy ? = uncertain

Arrows (↑) indicate the relative degree of reliance on or the direction of change that a particular strategy elicited. The number of arrows assigned is an approximation based on the synthesis of the quantitative and qualitative data gathered and reviewed for this research.

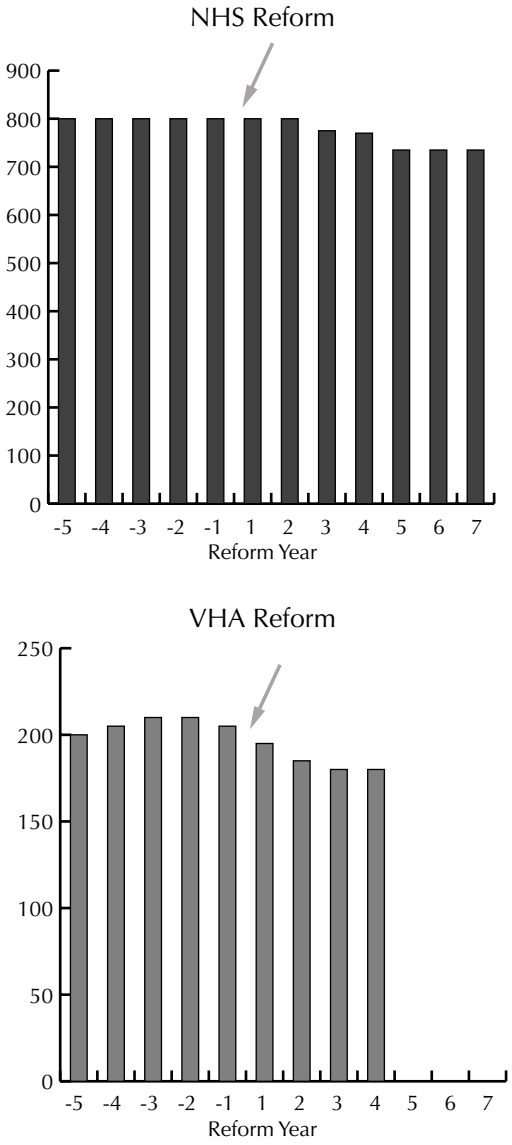
that have helped define the VHA health system and contribute to the quality of its services. Like the NHS, funding pressures and dwindling support of management for research and education followed the reforms and discouraged VHA clinicians. In addition to the reforms transforming the VHA, the scope and nature of the changes associated with the reforms have altered the historic and traditional relationships between medical schools and VHA medical centers (Cohen 1999). In 1998, out of concern for the tensions between the VHA and its academic affiliates, the Association of American Medical Colleges (AAMC) surveyed deans of medical schools on the health of their affiliations with the VHA. Half of the deans who responded indicated that they were extremely dissatisfied with their Network director and one foresaw the likely possibility of disaffiliating from the VHA. In November 1998, at the AAMC 109th annual meeting, a joint meeting gathered members of the AAMC's Council of Deans and Network directors for a half-day airing of views and discussion. The deans again reiterated the need for their involvement in VHA's planning processes (Ibid.).

Human Resources

The reforms generated anxiety for NHS and VHA staff. Fears over privatization or demise of each health system; change in roles and status; staff cuts; and changes in medical education and training, and research impacted the workforce in both systems.

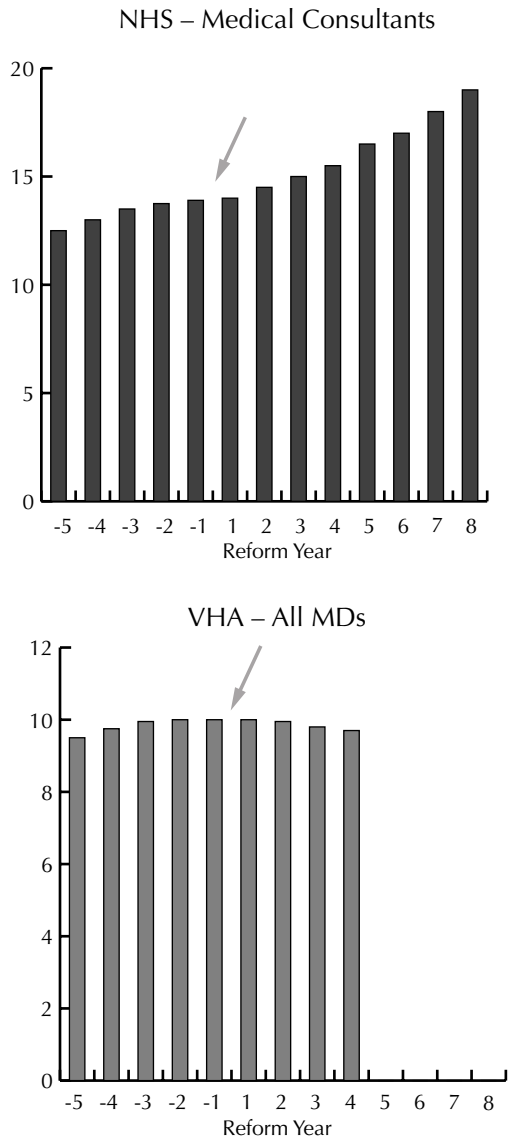
Following the reforms, there were staff reductions, morale problems, and strained communications in both systems. The reductions in staff were more pronounced in the VHA and varied by VISN depending on the impact of the VERA resource allocation model (Figure 7).

Figure 7: Total Staff (x 1,000)



At the start of their respective reforms, the NHS was comparatively understaffed by physician specialists while the VHA was physician-rich. Following the reforms, the number of NHS Consultants was increased to reduce waiting lists and increase the availability of services. The VHA, after several years of hiring physicians, began to reduce physicians (Figure 8).

Figure 8: Medical Staff (x 1,000)



The NHS reforms were not successful in increasing employee satisfaction. The reform process and constrained resources seriously eroded employee and GP confidence and satisfaction. While professional gaps between GPs and Consultants improved, the

future promises numerous interdisciplinary challenges as Primary Care Groups expand their roles and interactions with NHS Hospital and Community Trusts and Consultants. Moreover, the NHS faces crucial issues related to its workforce: professional staff shortages and recruitment problems persist, and training deficiencies, inequities in pay, and work conditions are inextricably linked to competencies and professional satisfaction. The health of the NHS depends on the ability of the government to rectify the past by thoughtfully tackling these areas, or suffer the ills of a disgruntled workforce and further staff losses.

The VHA reforms have had significant effects on their employees. In part because of the pace and goals of the VHA reforms, these problems were experienced as being more severe in the VHA than in the NHS. Rapid implementation of the reform strategies, large reductions in staff, and limited and poor communications impacted employee morale. While the evidence found that employee issues and low morale varied by geographic area, the overall morale of the VHA workforce suffered as a result of the reforms. There was little evidence of true empowerment of front-line staff.

Table 5: NHS and VHA: Areas of Convergence and Divergence in Human Resources Following Reform

	Convergence		Divergence	
Human Resource Area/Strategy	**NHS**	**VHA**	**NHS**	**VHA**
Number of staff	↓↓	♦↓↓↓		
Early retirements	↑↑	♦↑↑↑		
Buy-outs incentives to leave system			?	♦↑↑
Staff morale	↓↓	↓↓↓		
Communications	↓↓	↓↓↓↓		
Professional staff involvement in reforms	♦↓↓	♦↓↓↓↓		
Staff empowerment	♦↓	♦↓↓↓		

Key:

↑ = slight use/increase; ↑↑ = moderate use/increase; ↑↑↑ = great use/increase; ↑↑↑↑ = extreme use/increase

↓ = slight use/decrease; ↓↓ = moderate use/decrease; ↓↓↓ = great use/decrease; ↓↓↓↓ = extreme use/decrease

♦ = use of strategy ? = uncertain

Arrows (↑) indicate the relative degree of reliance on or the direction of change that a particular strategy elicited. The number of arrows assigned is an approximation based on the synthesis of the quantitative and qualitative data gathered and reviewed.

Organizational Change

The window for reform appears to have impacted the organizational culture of the NHS more than the quantitative measures of health service delivery. The reforms provided the groundwork for the 1998 Labour government's move to a "softer," "new NHS," and adoption of total GP commissioning through the creation of Primary Care Groups and Trusts. The 1991 reforms "fast forwarded" the prior pace of incremental change in the NHS and made a significant statement regarding the diminishing role of the welfare state. Still, ubiquitous issues persist for the NHS: timeliness of services, equity, and underfunding. The current concerns over care of the chronically mentally ill and provision of long term care for the elderly and special populations highlight a sample of the inequities and resource needs.

> "… Even in an ideal world, there are rarely simple answers to apparently simple questions — usually because, as in this case, the questions are not actually simple. The reforms embrace a wide variety of organizational changes, each of which involves different aspects of the NHS, affects different players and agents within the service, and ideally should be subject to its own evaluation process."
>
> (Le Grand 1994, 243)

Labour's "new NHS" appears committed to integrating care, diminishing inequalities (UK Independent Inquiry 1998), and raising the quality of care by setting national standards through the National Institute for Clinical Excellence (NICE) and oversight by the Commission for Health Improvement (CHI) (UK DOH 1998). The message of the new government is for less command and control and a commitment to increase NHS funding by 4.7 percent a year in real terms (Dobson 1999, 40-41). It remains to be seen if this proposed increase in funding will be both realized and sufficient.

The past accommodation of British medical practice to NHS appropriations raises the question of whether this method of rationing will continue to manage the increased demand for NHS services as advances in medical technology, coupled with better informed patients, compound the NHS "supply crisis." Today's young British generation expects a more affluent lifestyle than that of its parents'; it is unlikely that it will be as complacent a generation in its expectations for healthcare.

The experience from an earlier study of the effects of the 1991 reforms is instructive for the future (Salter 1994). The struggle between the old and new structures as prior Regional Health Authorities faded and District Health Authorities gained control created destructive tensions between ambitious managers and physicians over perennial concerns about the rationing of healthcare (Ibid.). As the NHS moves forward, it is essential to strategically plan and intervene as new vulnerabilities resurrect old tensions. Still, the overarching theme persists: The NHS is comparatively underfunded and, as such, is hard-pressed to face the coming challenges of technologically advanced heath care in the 21st century. Aesthetic repairs "at the margins," despite the dramatic reorganization, have not improved the fundamental ability of the NHS to provide timely, state-of-the-art care for all groups. While it was not expected that the reforms would decrease cost, it appears that value for money is improving in areas such as services to patients of fundholders. Yet, additional resources are required to continue that process. In the future, as it has been in the past, it will be important to distinguish "between political need to claim success and, on the other hand, evidence of improved efficiency — which is incomplete at best, and ambiguous and uncertain at worst" (Maynard and Bloor 1996, 607).

Finally, the NHS reforms have been described as an Americanized reform model: an emphasis on market forces; the use of the internal markets for contracting; the establishment of Trusts to transform hospitals similar to non-profits; and efforts to promote health (Mechanic 1995). As a counter argument, another perspective of the 1991 reforms proposes that the NHS has been Americanized by the use of tax breaks that provide discounts on health insurance at taxpayers' expense; the fostering of two-tier access to vital services; the transfer of public property to investors at favorable rates; the use of public dollars to pay for private services with built-in profits; and the erosion of services for individuals with chronic problems despite an increase in those requiring such support (Light 1997, 333-334). Perhaps the current change that is underway in the NHS will provide the evidence to settle this policy debate.

The questions remain: Can the British government sculpt constructive incentives, adequately fund the NHS, and provide sufficient guidance to improve access, efficiency, and quality in the NHS? Time and better information are needed to determine the answers. The 1991 reforms generated significant change and set a foundation for future improvements of the NHS that mostly will depend on adequate resources, effective strategies, and organizational will. While many of the stated objectives of the reforms were not achieved, progress was made in several areas. The essence of the 1991 reform experience is that the NHS continues to reinvent itself and that the lessons learned over the past 10 years have enabled the imminent changes in the NHS under Labour's plan for a "new NHS."

One of the most successful aspects of the VHA reforms was to move the VHA further into the mainstream of the mix of U.S. health systems. Through the use of market principles and initiatives to improve the utilization of health services, the reforms advanced several changes that improved patient care and fostered continuity, which include expanded access to outpatient services and community-based clinics. In addition, the reforms revitalized the agency's energy and introduced an unprecedented process of change that some thought not possible. The VHA reforms, like the NHS reforms, shifted the organizational balance. And, as in the NHS, power shifted away from the professionals to the managers. The VHA relied on managers rather than clinicians, perhaps more so than in the NHS, to adjust health-service planning and delivery to budgetary appropriations. In this regard, the VHA differed from the NHS, where the tradition has been to rely on British medical practice to accommodate available NHS resources and to allow comparatively more professional input.

Still, like the NHS, the VHA has significant issues still to address. Waiting times remain problematic and new challenges have developed regarding access and equity for some veterans. In addition, with the departure of Dr. Kizer as Under Secretary for Health, the VHA's future is, once again, uncertain. It remains to be seen who will be appointed as a successor and if the new Under Secretary will continue to guide the VHA along the course of the 1995 reform strategies. Perhaps the more significant question is: Will the new Under Secretary enjoy the congressional support afforded his predecessor? In light of the upcoming presidential election in November 2000, the appointment of an Under Secretary will most likely be postponed. Once more, the institutional context and the political environment will influence the VHA's future agenda. It appears that the window has closed, at least for now, on the transformation of the VHA.

The NHS and VHA reforms were associated with convergent and divergent reform strategies and consequences in the areas of health policy; health service delivery; medical education and training; research; human resources; and byproducts or unexpected consequences of the reforms (Tables 1-6). The NHS reforms reflect the Conservative government's market model orientation in public administration (Peters 1996, 19-21), while the VHA reforms best fit with a deregulating model of government (Ibid., 34-37), which matched the bipartisan U.S. objectives associated with the "reinvention of government" (US National Performance Review 1993; Osborne and Graebler 1992).

Byproducts of the Reforms

Both the NHS and VHA reforms precipitated byproducts and unexpected consequences, and several of these consequences were similar: power shifts, changes in organizational culture, dominance of area planning over national coordination, changes in communications, and impacts on staff morale (Table 6). The evidence from both cases suggests that the NHS and VHA reforms were dependent on a window for reform, but circumstances around the windows differed.

Table 6: Byproducts of the NHS and VHA Reforms

	Strategy/Area	NHS	VHA
P	Power shifts		↑↑ To PC from Specialists
		↑↑ To HA	↑↑↑↑ To Network
		↑↑ To NHS Executive	↑↑↑↑ To Headquarters
P	Strategic national planning	↓↓ Impact of HAs	↓↓↓ Impact of Networks
P	Incrementalism	↑↑ "New NHS" in 1998	?
P	Perverse incentives from performance contracts	? Not apparent	↑↑ Performance contracts/ bonuses
P	Quality management	↑↑	↓↓↓
D	Change in mission	↑	↑↑
D	Rationing	↑↑	↑
D	Access	↓↓ Long term care; mental health; waiting lists grew	↓↓↓ Acute care; long term care; mental health; substance abuse; waiting lists appear to remain problematic
D	Patient satisfaction	=?	↓↓
ME	Management support of Medical Educ. and Training	↓	↓↓
R	Management support of Research	↓	↓↓
HR	Human Resources	↓↓ Staff morale; staff shortages	↓↓↓ Staff morale; staff losses
HR	Communications	↓↓	↓↓↓↓
HR	Organizational culture change	↑↑ Manager dominated; cost consciousness	↑↑ Manager dominated; cost consciousness
HR	Creative energies	↑↑ Some Trusts; GP fundholders	↑ Some Networks

Key:

P = policy; D = delivery; ME = medical education & training; R = research; HR = human resources

↑ = slight increase/use; ↑↑ = moderate increase/use; ↑↑↑ = great increase/use; ↑↑↑↑ = extreme increase/use

↓ = slight decrease/use ↓↓ = moderate decrease/use ↓↓↓ = great decrease/use ↓↓↓↓ = extreme decrease/use

? = uncertain = = unchanged

Arrows (↑) indicate the relative degree of reliance on or the direction of change that a particular strategy elicited. The number of arrows assigned is an approximation based on the synthesis of the quantitative and qualitative data gathered and reviewed.

Summary

The structure of the British government and the Conservative agenda under Thatcher influenced both the choice of reform strategies and the pace of the NHS reforms. Managed competition fit with the Conservative government's aim to reduce or, in the case of the NHS, at least contain welfare spending. The Conservative government, in the runup to an election, pushed through a review of the NHS that won approval of Parliament in 1990; yet, the implementation of the reforms proceeded slowly. Choosing competition over regulation, the British government placed the onus on providers and purchasers to derive more value from NHS appropriations.

The VHA chose a managed care approach, which mirrored U.S. health industry trends; managed competition models had been set aside with the Clinton administration's failed attempt for national reform. The evidence suggests that the pace of the VHA reforms was in response to the political context. Clinton faced an upcoming election in 1996. Rapid congressional approval of the VHA 1995 reforms was needed and was obtained before campaign issues flourished in 1996. The comparably fast pace of the VHA reforms fit with the relatively brief window of support of the Republican Congress as again, in 1999, the political focus would be on the upcoming presidential election.

The evidence suggests that the differences in the U.S. and British governmental structures and political agendas help explain the distinctions in the NHS and VHA reform strategies. The British Government had been successful in containing costs in the NHS, but wanted to diffuse the angry public and professional sentiments toward funding and waiting lists. A reform strategy that had competition as its base resonated with the Thatcher government, which aimed to increase the effectiveness of NHS expenditures (Glennerster 1993, 66-67). The VHA wanted and needed rapid results; the use of performance contracts and measures helped achieve those aims.

Conclusions

The NHS and VHA reforms demonstrate the ability of large public systems to take on significant reforms. The magnitude of these changes is unparalleled in the history of the NHS and VHA. The convergence of various conditions provided both the NHS and the VHA the necessary windows for reform. Their individual approaches to reform reflect not only the past practices and culture of the NHS and VHA, but their respective institutional and political contexts.

While some changes following the reforms cannot be unraveled with certainty from environmental influences and simultaneous changes in the health industry, particularly the changes in health service utilization, other changes are directly attributable to the reforms. These include the reorganization of Health Authorities and VISNs; creation of the NHS internal market; introduction of VHA performance contracts; devolution of power; and change in the role of GPs. The following conclusions highlight the distinctions, as well as areas of convergence, in NHS and VHA reforms.

1. The VHA had more notable changes in health service delivery than the NHS.
Differences in health service delivery in the NHS and VHA following the reforms can be described in inputs and outputs. The NHS had steady or slightly increased inputs (as measured by expenditures) and maintained approximately the same, or slightly increased, outputs (as measured by the number of patients, admissions, outpatient attendance, and day cases). By contrast, the VHA decreased inputs (flat budget appropriation, decreased cost per patient, staff cuts) and increased outputs (numbers of unique patients, number of clinics, outpatient visits). The VHA expanded primary care and enhanced the importance of the role of the primary-care providers. The expansion of primary care in the VHA shifted power and status from specialists to primary care providers and is similar to the effects of the NHS reforms.

2. The NHS GP fundholding was the main success of the reforms.
The NHS, through its introduction of GP fundholding, rearranged power structures, and the status and function of GPs, which improved services for the patients of fundholders. However, GP fundholding appears to have contributed to two tiers of service in the NHS. Fundholding, which increased the power of GP gatekeepers in order to contain costs and improve services, brought General Practitioners back into the forefront of care in the UK. The success of GP fundholding, as well as some impacts of fundholding, which generated two tiers of service, were underestimated by policy makers.

3. Neither the NHS nor VHA was successful in reducing waiting lists. Similarly, access to chronic costly care, such as long-term care and mental health, decreased.
The failure to reduce the number of patients on NHS waiting lists and the wait for outpatient appointments in the VHA suggests the need for other policy measures, which may include the need for additional resources or the use of different incentives.

Significant Findings

Reform Windows and Strategies

- The timing and duration of the reform windows influenced the reform strategy and effects.
- Differences between NHS and VHA goals and strategies appear congruent with their respective reliance on market versus deregulation models of public governance.
- Managed competition had little impact on the health service delivery as measured.
- The VHA's use of performance contracts promoted change.

Mission Impacts

- GP fundholding was successful in improving care for patients; however, it fostered "two tiers" of service.
- The expansion of primary care increased the continuity of care for veterans.
- Access decreased for costly patients (NHS and VHA) and increased for inexpensive patients (VHA).
- The reforms failed to improve waiting lists.
- The shift in primary versus specialty mix reflects pre-reform baselines.
- The reforms in both systems increased reliance on primary care providers.
- Market-inspired reforms focused on short-term goals at the expense of long-term missions.
- Reform damaged staff morale.

The evidence suggests that following the reforms some patients were made better off, but some were made worse off. Several strategies fostered changes that appear to have diminished access for the mentally ill and those with long term care needs.

Although these changes may have been logical consequences of policy aims to reduce costs, there is an irony in that the NHS and VHA, which started as government interventions for market failures, have, in their incremental metamorphoses, adopted reform strategies that, as the evidence suggests, appear to be creating "public system failures" in terms of access for these vulnerable populations.

4. The NHS and VHA reforms posed challenges to the commitment to medical education and training, and research.

The balance among health service delivery, medical education and training, and research missions was altered following the reforms in both the NHS and VHA.

Pressure for short-term change and cost containment caused these systems to emphasize health service delivery. In the process, the regard for medical education and training and research — missions associated with long-term benefits — diminished.

The confluence of reform pressures with external factors in medical education and training confounded the implementation of reform in both systems. External events, simultaneous to the reforms, impacted medical education and training in the NHS ("New Deal," physician shortages, and redesign of medical education) and the VHA (pressures for increased resident supervision, growth of primary care training, and decrease in specialty training). Both the NHS and VHA relied on the use of in locum physicians and foreign medical graduate physicians to augment clinical delivery where resident/trainee time decreased. Following the reforms, pressure for short-term results increased pressure on physicians for clinical service in both the NHS and VHA.

5. The workforce was impacted by the reforms.

Poor communications, marginalization of professionals from the policy process, and the downsizing of staff resulted in staff dissatisfaction and damaged morale.

The NHS and VHA had different responses to staffing following the reforms: the NHS increased the number of Consultants and continues to struggle with a

national nursing shortage; the VHA staff reductions were larger, and the VHA decreased the number of physicians and nurses following the reforms.

Staff adjustments following reform in the NHS and VHA reflect pre-reform supply and the agendas for cost reduction. The accommodation of professionals by health system reform may be a function of supply and demand of professionals, as well as a reflection of the established political-cultural contexts and accords between professionals and the health setting.

Lessons Learned

Several lessons emerge from these case studies that are instructive to organizations and agencies considering large-scale change or reform.

Lesson 1: Assess whether there is a window of opportunity

Various environmental factors, which include socioeconomic and political conditions, and pressure from the public or interests groups, often prompt the need for organizational transformation. These factors help build a window for change. Windows vary in duration and may be a function of the political cycle or the support of interest groups and constituencies. The conditions for and duration of the windows for reform differed in the NHS and VHA.

The NHS reforms were precipitated by growing public and professional unrest over chronic low funding levels of the NHS. Constrained resources compounded long waiting lists and problems with access to health service delivery. By the late 1980s, the pressures from professionals and the public reached a critical level. In 1988, Prime Minister Thatcher announced a review of the NHS and won Parliamentary approval of the reforms before the runup to the 1990 election. The resulting policy paper, *Working for Patients*, which outlined the NHS reforms, was approved by Parliament in 1990, with formal implementation of the reforms in April 1991. However, despite the push for rapid approval, implementation of the NHS reforms was slow compared to the VHA reforms. Yet, the long tenure of the Conservative Party in the UK, compared to U.S. political cycles, provided the continuity to establish the reforms and gain experience with the internal market and GP fundholding.

The antecedent for the VHA reforms was the 1993-94 U.S. attempt at national health reform. The VHA had participated in the national reform deliberations and, following those efforts, recognized the need to demonstrate improved clinical efficiency.

The VHA reforms were outlined in *Vision for Change* and approved by Congress in September 1995, with formal implementation commencing in October 1995. Compared with the NHS, the VHA's reforms were fast-paced. They were timed for approval before the 1996 election campaign took off and were implemented quickly between election cycles.

Lesson 2: Establish and clearly communicate goals and strategies

Transformation of large systems is best accomplished by setting goals and communicating those objectives both within the organization and to interest groups. Goals, which are best linked to the agency's mission, allow measures for performance and evaluation. Specific goals and strategies may be controversial within the organization as well as with interest groups.

The NHS reforms created an internal market in the NHS that split purchasers from providers of service and introduced competition among providers. The reforms emphasized patient choice, devolved responsibility to providers, and sought better value for money. Yet, the key policy document *Working for*

Patients (UK Secretaries of State 1989), was remarkable in its lack of detail. By comparison with the VHA, the NHS set few specific targets or measurable goals. While there was pressure for change, there was more focus on process — namely, establishing the internal market — than on outcomes. The reforms were met with mixed reactions: resistance among providers, NHS employees, and the public, and support within the NHS and government.

The VHA, drawing on work of prior advisory groups and greatly influenced by the managed-care movement and reinventing government, established a list of targets around cost reduction and clinical efficiency. These objectives were tied to performance evaluation of VHA executives. While the goals were clearly communicated to the VISN and medical center executives, communication varied across other levels of staff and was often lacking to interest groups.

Lesson 3: Evaluate and modify the organizational design as needed

Large-scale change may necessitate organizational redesign. The agency's structure should facilitate reform, and consideration should be given to the function, size, and organizational placement of various managerial and advisory units within the organization. The distance between the agency "center" and "field" is important to ensure sound communication and exchange of information. As too much change can create chaos, thoughtfully planned and executed redesign is key. Such redesign should consider the reform objectives as well as the organizational culture and the existing productive linkages.

The NHS reforms focused on process, and the early NHS reform incentives promised increased freedom for Trusts and financial rewards for Trusts and GP fundholders. Over time, the NHS streamlined its administrative structures, but the main share of the administrative reorganization came later in the reform process compared with the VHA reforms. It was not until 1995, several years into the reforms, that 100 Health Authorities were established from the merger of the over 235 District and Family Health Services Authorities. This redesign was to improve administrative effectiveness, and Health Authorities were given enhanced responsibility for population-based planning. While Health Authorities have been key in shepherding change, they have been viewed by some as centers of command and control and remain closely linked to the central government.

As a key component of the reforms, the VHA reorganized four large regions into 22 Veteran Integrated Service Networks and devolved authority for health service planning to these newly formed Networks. Given the operational authority of the Networks, VHA medical centers became less autonomous following the reforms.

Central control and new structures were key to the implementation of VHA's reforms. The VHA built its reform strategies on establishment of the 22 VISNs. Recruitment of staff and getting the Networks operational was the priority in the early days of the reforms. As part of its strategies, the VHA developed a management framework to integrate strategic planning and operations with new performance targets and the VHA budget process. The use of performance measures and contracts introduced a new level of central control despite the organizational flattening. The new Network structures created a new form of competition in the VHA, which was compounded by scarce resources due to VHA's constrained funding levels and the adoption of VERA, a new resource allocation model.

The brief window that the VHA had for reform appears to have encouraged the VHA's reliance on central control and the use of performance contracts and measures to achieve change. Performance contracts fostered rapid implementation of reform strategies and focused on results, which significantly altered health service delivery.

Lesson 4: Anticipate byproducts and unexpected consequences

Policy interventions and organizational change can have unintended effects. In addition, reform can accomplish an implicit agenda that is not explicitly expressed or described in formal policy documents. The purpose of an implicit agenda can be a response to the institutional or political context, to appease interest groups, or to produce effects that are too controversial to formalize as part of the formal policy. The described unexpected consequences and byproducts of the NHS and VHA reforms are the perceived effects that were unintended or not explicitly described in the NHS and VHA reform policies and strategies.

The NHS and VHA reforms precipitated several similar byproducts that were greater in magnitude and/or more problematic than anticipated: power shifts, changes in national planning, impacts on staff morale, communications problems, and changes in organizational culture. For both the NHS and VHA, reform strategies that reduced access to services caused dissatisfaction among patients, interest groups, and providers. Despite the differences in the NHS and VHA institutional contexts, the convergence in the nature of unexpected consequences appears to reflect similar responses to the reforms in terms of organizational and managerial behaviors as well as staff reactions.

Lesson 5: Engage and empower staff in the process
The manner in which reform is introduced, particularly regarding staff involvement and communication, affects the response of staff to the reform process. Leaders should be knowledgeable and sensitive to the process of change as well as the desired objectives. Employees who are empowered and engaged in the change are more involved in the reform process.

The reforms generated anxiety for NHS and VHA staff. Fears over privatization or demise of each health system, change in roles and status, staff cuts, changes in medical education and training, and research impacted the workforce in both systems.

Communication in both the NHS and VHA suffered as a result of the reform, and employees were marginalized. Following the reforms, there were staff reductions, morale problems, and strained communications in both systems. The reductions in staff were more pronounced in the VHA. However, the NHS's bottom-up market approach to reform, given its political, cultural, and institutional contexts, generated less tension among staff than the VHA's top-down deregulation strategies, which were associated with fast-paced change in a more strained environment.

Lesson 6: Involve interest groups
Involve interest groups and the pertinent community members in reform discussions and debates around workable strategies. While interest-group participation may be perceived as slowing the change process or, more commonly, be restricted due to concerns that these groups may derail or undermine change, exclusion of interest groups limits the effectiveness of the reforms in the long run. Cooperative partnerships that permit participation in change, an emphasis on communication, and avoidance of perverse incentives minimize dissatisfaction and tension among staff as well as interest groups.

Both the NHS and VHA limited the involvement of interest groups, professionals, affiliates, and the public from the reforms. Over time, the NHS and VHA reforms generated distinct interest-group reactions that had political implications. The NHS reforms, although controversial, aimed to contain costs and reduce public criticism and were followed by comparatively less change in health service delivery. In the end, NHS affiliates were more successful than their VHA counterparts in gaining a place on Health Authority Boards.

The VHA reforms aimed at and accomplished reducing costs and increasing the number of veterans cared for. However, several VHA reform strategies produced unpopular change from the perspective of interest groups. Pressure from the more influential interest groups resulted in reversal and/or change in some reform policy, most notably the recent recentralization of the Spinal Cord Injury and Transplant Programs, as well as the recentralization of authority for changes in mental health programs.

Lesson 7: Evaluate the reforms
Evaluation of reform moves beyond descriptive accounts of policy intent and attempts to assess the impacts and effects, as they can best be unraveled. Implementation of policy completes the policy process and often determines the nature of reform strategies. Comprehensive evaluation can provide information on the intended effects as well as unexpected byproducts of reform. Yet, the urgency for change and the associated costs, both in time and resources, frequently discourage evaluation.

Both the NHS and VHA needed to demonstrate success through their reform interventions. However, political and institutional agendas in the NHS and VHA suppressed evaluation. In addition, both systems have data constraints related to availability and reliability. Interest in and concerns about the impacts of the reforms prompted numerous reviews by other government agencies (VHA), academic policy analysis and evaluation (NHS), as well as comments from the media.

Implications for the Future

What lessons can the NHS and VHA share with each other as well as with other health systems entertaining reform? What could each system have done differently to improve the effectiveness of the reforms and take full advantage of the window for change?

Both the NHS and VHA experiences point to the need to preserve the large picture through national planning and coordination of health services and other agency missions, which include education and training of the future workforce and research. Agency goals and adequate controls are needed to balance long-term objectives with the immediate pressures for change. The experience of both health systems demonstrates the importance of a sound quality management structure and reliable data.

Several common areas emerge for the NHS and VHA to address in the future: (1) continued improvement of inpatient and outpatient care; (2) integration of information across health service measures and evidenced-based medicine; (3) assurance of health service access for vulnerable and costly patient populations; (4) evaluation of the future directions for partnering with interest groups, employees, and the public; (5) assessment of the long-term commitment to medical education and training and to research in light of the urgency for short-term results; and (6) development of strategies to promote public health in coordination with the community. Future change in the NHS and VHA depends on the balance among the perceived need for change, managerial effectiveness, and political forces. Moreover, future reform initiatives will benefit by reflecting on the lessons learned from these reform efforts.

The findings of this work prompt further study on various aspects of the NHS and VHA reforms and health reform in public systems. Areas for future inquiry include: (1) the role of the windows for reform and their influence on reform strategies and impacts; (2) the relationships among policy implementation, managerial performance, and performance evaluation; (3) the influence of an individual leader on health system change; (4) the effects of the reforms at the NHS hospital and VHA medical center levels; (5) the factors that shaped the individual responses of Health Authorities and Networks to the reforms; (6) the impact of reform strategies on vulnerable patient populations in market versus deregulation models of public administration; (7) the impact of reform strategies on staff morale in market versus deregulation models of public administration; and (8) the long-term impacts of reform strategies on affiliations, medical education and training, and research missions.

Finally, this research is intended to encourage cross-national studies on health reform in other public systems. The reforms, which introduced market mechanisms and managed care strategies into these public systems, precipitated their own caveats. While the reforms transformed the NHS and VHA, improved services for fundholder patients (NHS), and reduced patient costs (VHA), the introduction of market-inspired strategies, the

preoccupation with costs, and budget constraints challenged the commitment of these public systems to underserved populations. This finding reiterates the need to evaluate the effects of market-based strategies in regards to the effects on equity (Saltman 1994). The perverse incentives created by the use of performance measures and contracts (VHA), coupled with the lack of comprehensive assessment of expected as well as unexpected reform consequences, posed risks to the success of these expensive policy experiments. In order to minimize untoward consequences, the success of future health reform interventions resides in recruiting the proper number and mix of leaders, setting productive incentives, and assuring the organizational supervision to promote desired outcomes.

The NHS and VHA are large, comparatively well-organized and sophisticated health systems, both in terms of the scope and complexity of their missions. The NHS and VHA reforms demonstrate the ability of large public systems to undertake significant reform interventions. The magnitude of these changes are unparalleled in the history of the NHS and the VHA, with the exception, perhaps, of when, in 1946, the VA was reorganized into the Department of Medicine and Surgery and began its affiliations with U.S. medical schools. Their reform interventions reflect not only the past practices and organizational cultures of the NHS and VHA, but their respective institutional and political contexts and how each system responded to a window for reform. The impacts of the recent reform interventions on their missions of health service delivery, medical education and training, and research, as well as on the workforce, offer insight for future interventions and are instructive to other systems.

The lessons from this research have implications for other settings as national health systems face similar challenges and assess the public-private mix of funding and provision of health services. Increased demand, emerging and costly technologies, and concern for the health needs of the poor and underserved will continue to challenge policy making. Carefully designed policy interventions that promote accountability, ensure access to appropriate clinical services, and balance short-term agendas with long-term goals will strengthen the future effectiveness of public healthcare systems as they respond to windows for change.

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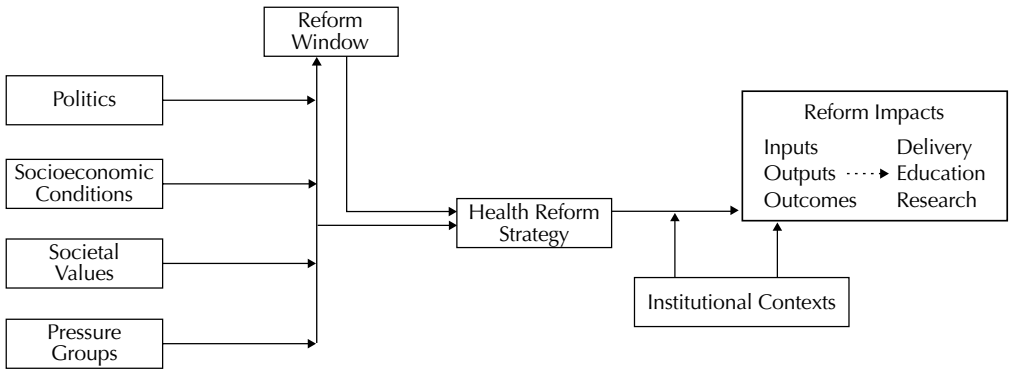
Appendix A: Study Framework

The study's framework draws on the role of political institutions and governmental structures in the health policy process (Immergut 1992; Klein 1995; Jacobs 1993; Campbell 1992). The framework posits that socioeconomic, political, and societal factors, as well as pressure groups, can influence health reform policy and open a window for reform. Occasionally, the convergence of socioeconomic and political conditions and events opens a window for "extraordinary" political redirection and policy reform (Keeler 1993; Kingdon 1984; Goodin 1977; Bunce 1981). The window for reform allows the usual constraints that hamper governments to be put aside (Kingdon 1984). In short, the conceptual framework proposes: (1) reform interventions are permitted by salient political conditions (Keeler 1993; Kingdon 1984; Goodin 1977; Bunce 1981); (2) reform policies and their implementation strategies reflect institutional and political contexts (Pressman and Wildavsky 1984; March and Olsen 1989; Scharpf 1986; Immergut 1992) and are products of stated as well as unstated reform intents, which are derived from and shaped by the institutional context of policy formation through implementation; and (3) reforms can affect health care delivery, medical education and research, and human resources (Figure 9).

Furthermore, while it may appear that there is growing convergence in health policy, particularly around market models, significant divergence exists in the content and aims of health reform strategies (Jacobs 1998). This divergence reflects the influence of the institutional setting, the design of political institutions, and the different ideological orientations of the ruling party, as well as the influence of the pre-reform health system (Ibid.).

Figure 9: Causal Model to Assess Health Reform



Appendix B: Study Methods

A multiple (two) case study design was used to examine the NHS and VHA reforms. The unit of analysis for the research was the health system, specifically the NHS and VHA health systems. The research employed a mixed-methods design, the triangulation of qualitative and quantitative data and multiple sources to enhance construct validity and reliability. The comparative logic of the study design included before/after within case (NHS) (VHA) comparisons, and between case (NHS & VHA) comparisons to assess areas of convergence and divergence. The majority of the data were derived through document analyses from secondary data sources and included archival records, published articles and studies, agency documents and databases, survey and audit reports, and media articles. Primary data collection included 44 in-depth interviews with policy makers, staff, providers, and academics employed by, or knowledgeable in, the NHS and VHA. In addition, other data gathering and fact finding included preliminary interviews; numerous contacts via phone, electronic mail, and letter correspondences; and participant-observer experiences (VHA).[3]

The quantitative data examined included annual data on expenditures, inpatient and outpatient utilization, bed numbers, waiting times, performance measures, and staffing data. These data span the five years (NHS: 1986-1990; VHA: 1991-1995) prior to the formal implementation of the reforms and the respective seven-year (NHS: 1991-1997) and three-year periods (VHA: 1996-1998) following the start of formal implementation. The post-reform periods of seven (NHS) and three years (VHA) reflect the years of available post-reform data. For each system, the corresponding fiscal year calendar was used, which begins on April 1 for the NHS and

Table 7: Quantitative Study Data by Calendar Year

	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998
NHS	1	2	3	4	5	X^r=6	7	8	9	10	11	12	
VHA						1	2	3	4	5	X^r=6	7	8

X^r= formal date for implementation of reform

on October 1 for the VHA. The NHS analysis stopped with the end of fiscal year 1997 (March 1998). The election of the new Labour government in May 1997 began a phase of new policies that included implementation of the "new NHS" (UK DOH 1997). These changes impact various aspects of the 1991 reforms, affect purchaser-provider arrangements and fundholding, and introduced Primary Care Group commissioning (Ibid.). Given these events, the inclusion of NHS data after fiscal year 1997 would have confounded analyses of the effects of the 1991 reforms.

[3] *Participant-observer experiences, which occurred during the time that the researcher was an employee of the VHA from 1971 through 1996, include the years just prior to as well as during the early phase of the implementation of the VHA reforms. Experiences included daily contact with staff, managers, and executive level officials in two urban affiliated VA medical centers in the Northeast, as well as in a Network office. Other "typical" employee activities included participation in meetings and conferences. There was frequent contact with officials in Headquarters in Washington, D.C., and occasional contact with staff and managers from VHA sites across the U.S. The participant-observer experience helped identify relevant areas and data for the VHA case. The researcher did not have the same opportunity to observe the NHS, which is a limitation of the study. However, the research attempted to augment data for the NHS by review of the extensive literature on the NHS, as well as through comparably numerous preliminary interviews and ongoing informal and electronic contacts with those knowledgeable in the NHS and the reforms.*

About the Author

Marilyn A. DeLuca is a consultant in health policy and health systems management. Her interests include international health and comparative health system analysis.

Dr. DeLuca has substantial managerial and clinical experience in public healthcare systems, most notably in the Veterans Health Administration, where she held several leadership positions. Dr. DeLuca served as Chief Operations Officer of the VHA NY/NJ Network, a health system with over 170,000 veteran patients; 13,000 employees; and an operating budget of $1 billion. She also served as Special Assistant to the Director at the Bronx VHA (1985-1996) and New York VA Medical Centers (1984-1985) as well as in various clinical and leadership roles in critical care (1971-1984).

Dr. DeLuca holds a master's in public administration (NYU 1995) and a master's in nursing (NYU 1976) as well as a bachelor of science in nursing (Hunter College CUNY 1971). Dr. DeLuca recently completed a Ph.D. in public administration with a concentration in comparative health systems at New York University, Robert F. Wagner Graduate School of Public Service. Her dissertation is entitled: *Health Reform in Public Systems: Recent Reforms in the UK's National Health Service and the US Veterans Health Administration.*

Dr. DeLuca has had various teaching positions at the graduate and undergraduate levels. Her publications include chapters in two texts, one on critical care and the second on primary-care nursing. Dr. DeLuca was principal investigator on research projects, which include a study on organizational climate and professional satisfaction, and one on congestive heart failure and length of stay. She has served on numerous local and national VHA committees as well as committees in the New York City healthcare community.

Dr. DeLuca is a long-standing member of Sigma Theta Tau, the national nursing honor society. She has held her American Nurse Association Certification in nursing administration since 1984 and was listed in Who's Who in American Nursing. She is the recipient of numerous awards for program management and innovative leadership.

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