

FTGA

14

Essential Brief
November 10

Liberal -Conservative Coalition Health Policy – Radical Change or Continued Progress on a well-trodden track?



**Foundation Trust
Governors' Association**

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These Essential Briefs have been planned and written for foundation trust governors. They are designed to provide you with the essentials in key relevant areas to support you in your role as a governor.

Introduction and Context

The creation of foundation trusts (FTs), and their governance structures allowed governors (as representatives of the membership) to influence the long-term plans of their trust by giving them the right to be consulted by the board of directors on strategic developments and significant changes in their trust's business plans¹.

In order to maximise their influence and ensure a long-term perspective, governors must have an appreciation of the current British government's health strategy and an awareness of the context of recent trends in health policy. This Essential Brief 14 aims to give governors up-to-date information on current government policy and provides a short review of recent health policy trends.

Structure

The first section of this Essential Brief outlines how, over the past 20 years (irrespective of the political persuasion of government), English health policy has been moving towards an internal/social market for health services. It then looks at the policy proposals in the Liberal–Conservative government's health strategy (Coalition Strategy) in the context of that trend and identifies any key changes in direction on which governors might wish to focus.

Previous Headline Briefs on both the White Paper and the revised Operating Framework have highlighted key issues for governors around information, payment systems, choice and market consolidation. This Essential Brief will look in more detail at the proposals around general practitioner (GP) consortia, the NHS Commissioning Board and health care regulation and the issues these may raise for governors.

¹ Your Statutory Duties, Monitor (2009)

The Policy Train Remains on Track?

Build-Up to Reform

Before 1990 the NHS was often described as a paternalistic service with limited choice for patients other than the option to purchase additional private health insurance. Patients registered with the GP covering their geographical area, and acute services were provided by the local district general hospital.

The motivation for change occurred in the late 1980s. The then Prime Minister, Margaret Thatcher, had established a policy of controlling public spending, and a powerful Treasury, led by Nigel Lawson, had succeeded in reducing the expenditure on the NHS from 5.6 per cent of GDP in 1980 to 5.1 in 1987². So effective had been the control of cash to the NHS that the finance director of the NHS at that time noted that the organisation was technically insolvent³. At the same time, demand for NHS services had continued to rise, leaving 96,000 NHS patients waiting more than two years for hospital admission by 1989⁴.

Internal Market

Against the backdrop of a government committed to public spending control, a leading US health economist Alain Enthoven (at the invitation of the Thatcher government) conducted a review of the NHS and recommended the creation of an internal market as he believed that price mechanisms would allow for a better allocation of resources. Although Enthoven's proposals were not fully adopted, in April 1991 Ken Clarke (the current Justice Secretary and then Secretary of State for Health), introduced an 'internal market' into the NHS.

The key elements of an internal market are set out in Figure 1. Key characteristics are:

- * the providers of care (private and public) and the purchasers of services (commissioners) should be separated

2 Cutting NHS Waiting Times, The King's Fund (2005)

3 The Executive Years of the NHS, The Nuffield Trust (2005)

4 Cutting NHS Waiting Times, The King's Fund (2005)

- * that patients should have a choice as to who provides services to them
- * that sufficient information should be available to patients to allow them to exercise that choice.

As we will discuss later, all these elements remain the focus of the Coalition Strategy. In essence, the grit within the system was to be patients exercising choice, which would impact on the contracts providers received from commissioners, effectively driving performance. The fourth key element in the diagram (a payment mechanism) was introduced by New Labour in 2003.

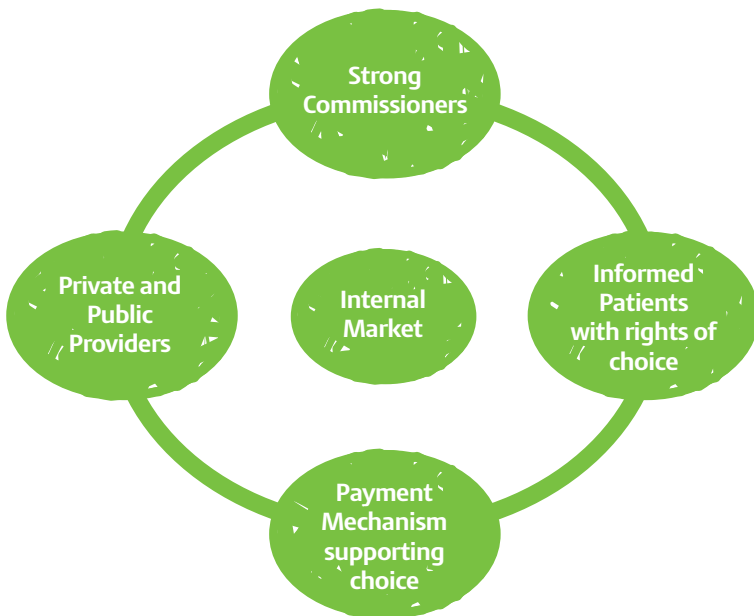


Figure 1
Main Elements of Internal Market

The commissioners of services for patients were, in the first instance, local strategic health authorities (LSHA) (effectively carrying out the commissioning function of the primary care trusts (PCTs) under the

current structure) and had the main commissioning power in the system. GPs were given the ability to become GP fundholders, which allowed them to commission some services directly for patients. The GP fundholders are effectively the genesis for the Coalition Strategy of requiring GPs to form GP consortia (to be discussed later).

The main limitations of Clarke's internal market, which later governments continue to address were: LSHAs (acting as commissioners) continued to enter into large unbundled contracts (i.e. hospitals were commissioned to provide all acute treatment for a community irrespective of the quality of individual services) with existing providers (making minimal changes in commissioning); provider performance was judged according to activity rather than the outcomes the trusts achieved for patients; and trusts had limited ability to be flexible and innovative (a combination of political interference in day-to-day management of the NHS, restrictions imposed by national wage bargaining; and an inability to borrow and have financial flexibility). New Labour addressed some of these issues, and the Coalition Strategy intends to make further progress.

Public-Private Mix

The internal market also required the creation of independent providers of services from both the private and public sectors. Public providers were transformed from directly managed hospitals (subject to Department of Health control) into independent NHS trusts. What did not materialise in the 1990s' reforms (and which became a focus of New Labour) was the entry of private providers into the market seeking contracts from NHS commissioners to deliver services direct to NHS patients.

In 2000 Alan Milburn, Secretary of State for Health, introduced the NHS Plan in an attempt to address the increasing lack of public confidence in the NHS. The NHS Plan aimed to improve both access and clinical outcomes, particularly mortality surrounding heart disease and cancer. After conducting a review of elective surgery capacity

in England, the government decided that there was insufficient NHS capacity to deliver improved access to treatment. The need for additional hospital capacity was clear.

Milburn took this opportunity to stimulate private sector delivery of care to NHS patients by removing two key barriers to market entry. First, the Department of Health negotiated five-year contracts, with guaranteed activity levels (i.e. effectively guaranteeing income) with private companies willing to develop and run independent sector treatment centres (ISTCs). This provided commercial certainty to the private sector. Second, the Department agreed to pay the ISTCs for activity at prices above the tariff paid to NHS hospitals carrying out the same work. For the first wave of ISTCs, which opened from 2003 onwards, this was on average an 11.2 per cent premium. This acted as a clear incentive to enter the market. More than 105,000 elective operations⁵ are now carried out by ISTCs (costing about £5.9 billion in 2007/8⁶). In addition, PCTs were increasingly required to 'market test' major contracts, which might once have been automatically entered into with local NHS providers, by opening them to private sector bids.

Commissioning and Choice

For the internal market to be effective in driving performance, the patient must be able to exercise choice. Traditionally in the NHS 'choice' has been interpreted as the choice of hospital for treatment. To exercise choice patients must have enough information and advice to make decisions about their care and to know they have the right to choose.

The Clarke stage of reform did not deliver direct choice to individual patients, but offered commissioners the chance to choose providers on the patient's behalf. In London, where large numbers of providers competed to deliver services, commissioners did move demand between major teaching hospitals, causing reductions in income of up to 20 per cent for some hospitals. Politicians intervened to stop the policy, creating short-term instability in London's health care provision.

⁵ Independent Sector Treatment Centre Briefing, The King's Fund (2009)

⁶ Is the Treatment Working, Audit Commission (2008)

In other parts of the NHS, LSHA commissioners continued to enter into block contracts with existing trusts (largely business as usual). As Chris Ham (Chief Executive of The King's Fund) noted, this transformed a policy which should have seen patients exercising choice and commissioners purchasing services for patients ('money follows the patient') into a policy that meant patients were obliged to be treated at trusts where the commissioners had already purchased the activity ('patient follows the money')⁷.

GP fundholders also showed a mixed willingness to change commissioning behaviour, with some practices continuing to deal with providers along traditional commissioning patterns while others (particularly the possibly more dynamic earlier adopters of GP fundholding) did change their commissioning behaviour.⁸

When New Labour came to power in 1997 the government publicly rejected the internal market and GP fundholding (based on concerns about equality of access to services and the high transaction costs associated with the contracting process) but nevertheless continued the internal market policy of the purchaser-provider split. Labour merged the two key commissioning functions, GP fundholding and LSHA commissioning, into new commissioners which became the primary care trusts (PCTs) we know today. The PCTs were to reflect the interests of GP commissioning by ensuring clinical leaders (both GPs and other health professionals) were included in the key decision-making committees of the PCT. What PCTs do not offer – which GP fundholders did – is close proximity between the patient and the commissioner. But the purchaser-provider split of the internal market was and is alive and well.

In respect of choice, Labour governments significantly extended patients' right to choose a hospital. By January 2006 patients had been given the right to choose from four hospitals for any specialist outpatient consultation and from April 2008 all patients have had a choice of any NHS hospital or registered independent sector provider.

7 Health Care Reform, Ham (1998)

8 [The New Politics of the NHS, Klein (2001)]

Information and Choice

For patients to be able to exercise choice they clearly need access to information, not least on the relative quality of the services provided. To tackle this issue the Blair/Brown governments introduced an electronic choose and book system into GP surgeries (which allowed GPs to book appointments for their patients at hospitals direct) and developed a website – NHS Choices – which provides information to patients on the relative quality of services at different providers (i.e. access times and regulatory assessments of the overall quality).

Research by the Picker Institute Europe (and others) in early 2009 indicated that despite this facilitation of choice more than half of patients do not recall being offered a choice of provider and less than 4 per cent of patients used the key information tool – NHS Choices – to assess the quality of care at different providers.⁹ This indicates that the Labour government's intention that patients would judge the quality of different providers, and choose to be treated at the best quality hospital, has not been realised. The whole basis of the internal market is that choice rewards the best performers, forcing the underachievers to improve or exit the market.

Payment Mechanisms

As mentioned earlier, a limitation of Clarke's internal market was the tendency for commissioners to continue to use block contracts rather than respond to patients' choices by moving services to alternative providers. A key reason for this behaviour was probably not only natural inertia or the desire not to de-stabilise providers, but also the lack of an effective means for commissioners to dis-aggregate contracts and move funds for specific activity between trusts.

In 2003 the first version of Payment by Results (PbR) was introduced into the NHS. PbR allowed commissioners and providers to allocate a price/cost for a specific treatment. Contracts could now be broken down into their constituent parts and therefore commissioners

⁹ Choice at the point of referral, The King's Fund (2009)

could more easily commission services from different providers, private and public.

PbR was intended to incentivise trusts to compete for patients on the basis of the quality of the services they provided not on variations in price. A criticism of PbR has been that rather than being a 'payment by results' – i.e. rewarding quality – it is really 'payment for activity' – i.e. rewarding quantity.

To tackle these criticisms, between 2008 and 2010 the Labour government developed PbR to reward quality. For instance, best practice pathways of care have been developed for several conditions; providers will receive an enhanced payment under PbR if the process of care for the condition meets certain criteria. For hip fractures, for example, starting surgery within 36 hours of admission. In addition, providers can achieve a small enhancement to the PbR tariff (1.5 per cent in 2010/11) for delivering quality objectives agreed with local commissioners. These reforms represented a start towards the tariff rewarding quality.

Change or Continuation

Is the Coalition's Strategy a radical change which will need your board of directors, and you as governors, to reflect in radical new strategies and business plans for your trusts, or is it continuation of an existing theme?

The strategy announces that:

'Patients... will have more choice and control, helped by easy access to the information they need about the best GPs and hospitals.'

In overview, Figure 2 overleaf shows the proposals in the Coalition Strategy distilled into the key elements of the internal/social market previously discussed (and summarised in figure 1) – i.e. purchaser-provider split, choice, information, and payment mechanism.

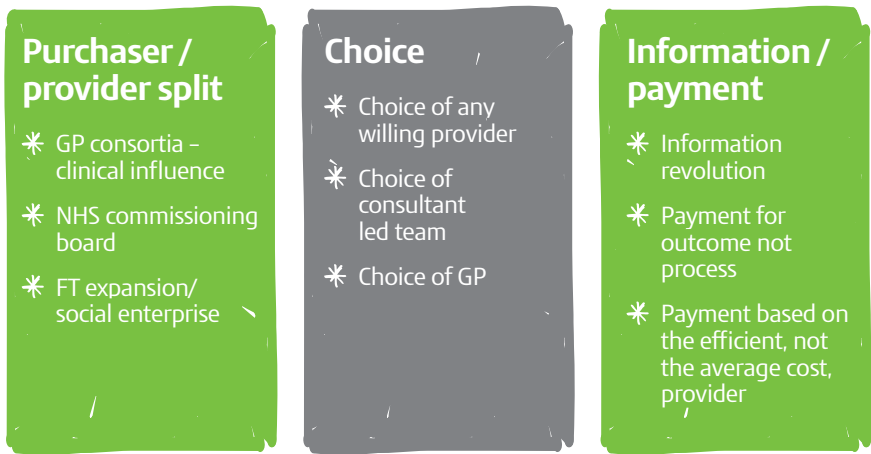


Figure 2

We can see that the major themes of the Coalition Strategy build on the internal/social market. In particular, development of the purchaser–provider split (with the creation of the NHS Commissioning Board and GP consortia taking responsibility for commissioning) with a renewed commitment towards a larger FT sector (all NHS trusts to become FTs or to merge).

Choice for patients is further developed with patients being able to select not only hospital, but consultant-led team, and GP. Finally, there is a continuation of the commitment to the development of accessible information on quality, to support patient choice, with a payment system for trusts which rewards the quality of outcomes rather than merely activity.

In addition to the themes in Figure 2 the internal/social market will also be facilitated by a streamlining of regulation so that the regulatory framework can be applied to both public and private sector providers equally. This is a key issue for governors and is dealt with later.

The direction of the Coalition Strategy is therefore in line with previous health policies of Conservative and Labour governments. FT strategies may need to adjust to the tougher financial environment and the pace of change, but a more information-driven, competitive, consolidated (i.e. reduced number of providers) market supported by an outcome-driven payment system should not be a surprise.

GP Consortia - Key Concerns

The abolition of the 152 PCTs who currently commission services, replacing them with about 500 GP consortia created and controlled by GPs, is an attempt to ensure the commissioners of services are as close as possible to patients and therefore commission services to reflect patient choice. Commentators are focusing on two main concerns: the commissioning skills of GPs and financial control.

Commissioning Skills

The risk for FTs (and the wider NHS) is that historically GPs (as independent contractors) have not been heavily involved in the planning, managing and commissioning of large-scale health services. Commissioners need to have a clear strategy to allow FTs to plan and develop services. If, as is likely, the skills and strategy of GP consortia take time to establish, this will constrain service developments by FTs as providers will want to be clear about what consortia wish to commission in the long term. These developments are of direct interest to the membership of FTs and so governors should watch for the tendency to postpone developments and constructively challenge and should understand the reasons for delay.

Finance

GP consortia will be at the centre of decisions about commissioning budgets and the rationing of services to patients. At a time when NHS budgets are under pressure, GPs are expressing concern at being explicitly involved in the rationing process.

Evidence from a recently published data sample for practice-based commissioning in 2009/10¹⁰ shows that GPs in that programme who held indicative budgets overspent by an average of 2.5 per cent when funding was in relative plenty (nationally that would be translated into about £2 billion of unfunded activity).

For the average FT this could be a significant concern. If GP consortia commission services from FTs without sufficient funds, then at the very least FTs could face end-of-year cash flow concerns (non-payment of 2.5 per cent of activity would amount to about £5 million for your average FT) as payment of staff and suppliers becomes an issue for weaker FTs; in some cases the provider might have to forego the income altogether and treat it as a bad debt.

Under the tight funding conditions of future years FTs will, at best, be generating very small surpluses (average FT income and expenditure margins have dropped by a quarter in the past year¹¹), they will therefore need to be assured of the financial stability and ability to manage demand in the GP consortia.

Although governors should not replicate the role of the management, they should ensure their board of directors has the skills, ability and energy to operate in different market conditions; governors must have confidence that the directors have a strategic appreciation of changing market conditions and are maintaining robust financial control.

NHS Commissioning Board – Continuing Uncertainty

The creation of the NHS Commissioning Board is an interesting development, but currently lacks substance. What is known is that the Board is likely to have three main functions:

- * GP consortia budget-setting: it will allocate funds to each consortium to be used to purchase services from providers, including FTs

¹⁰ GPs' £2bn threat to commissioning budget, Health Service Journal (August 2010)

¹¹ Foundation Trust Sector Overview, Monitor (September 2010)

- * GP consortia accountability: it will hold consortia to account for 'outcomes and financial management'.¹² Consortia will have full financial responsibility by April 2013. It is proposed the Board will have a reserve power to allocate GP practices to a specific consortium if required
- * National commissioning: it will directly commission national and regional services as well as dentistry, community pharmacy and primary ophthalmic services. FTs that provide specialist services could therefore have a direct commissioning relationship with the Board

Impact on FTs

The real importance of the NHS Commissioning Board for FTs and their governors will be the objectives it sets the GP consortia for achieving outcomes and the level of funding it allocates to them to commission services from FTs.

The directions given by the Board to consortia may be of strategic importance to FTs. For instance, if consortia were given an outcome measure (target) for reducing emergency re-admission of their treated patients, it is possible that GP consortia may stop commissioning services from any FTs (or other providers) with high re-admission rates. This could cause significant short-term shifts in demand, produce financial instability for FTs and threaten the sustainability of individual services. Governors may therefore wish to maintain a high-level understanding of the Board's commissioning priorities as they will be critical in determining the business plans and strategies of FTs.

Regulation

The final area this Essential Brief considers is regulation. The Coalition Strategy is to remove 'day-to-day political interference' from the NHS, in respect of both commissioners and providers, restricting the Secretary of State's powers in primary legislation; this implicitly reduces political accountability for the running of the NHS.

¹² Written answer and statement, Simon Burns, Minister of State, House of Commons (9 September 2010)

For this reduction in political accountability to be sustainable, effective regulation is essential. This, along with the desire to reduce the amount of bureaucracy in the NHS, appears to have led to a realignment of health care regulation. The functions, and interaction, of the two lead regulators for health care providers (including FTs) – Monitor and the Care Quality Commission (CQC) – are to be streamlined so that a joint licence will be issued from the regulators (Monitor focusing on financial issues while the CQC reviews provider quality). The second element of regulatory change is the reduction in bureaucracy by the removal of quangos – for example, the National Patient Safety Agency (NPSA), the NHS Institute and the Audit Commission. In effect this represents reduced regulation and control of the public sector providers of health services.

Monitor

The change in role for Monitor could be very significant for FTs and their governors. To date Monitor has acted as an authorising authority for FTs and some would argue it has been the effective custodian of the reputation of the FT movement by its robust regulation and promotion of the FT brand and independence. In particular, it has been instrumental in ensuring that governors have been supported in their role by its code of governance and it has often intervened pre-emptively, effectively avoiding the need for governors to use their own powers to remove non-executive directors as FTs have entered troubled waters.

In Monitor's new role, as an economic regulator of both private and public NHS providers, regulation is likely to become more 'light touch' and distant, leading to intervention only in extremis. For instance, Monitor is likely to have its powers to remove FT directors withdrawn; this would make the role of governors increasingly demanding as they hold their board of directors to account for the performance and sustainability of their trusts. In such circumstances non-regulatory organisations, which support governors in their increasingly challenging role, will be very important.

“The only real similarity between the new Monitor and the old Monitor is the name.”

David Nicholson

Quasi-Regulation

The removal of the secondary tier of control of NHS trusts – the quangos – might also present a challenge to providers. For example, a key role of the NPSA is to alert providers to safety incidents that have occurred but that can be avoided by changes in practice. This sharing of information allows trusts to operate in a safer environment and gives assurance to both directors and governors about the safety of their trusts. Although it is intended that some NPSA functions transfer to the new NHS Commissioning Board, governors may wish to understand from their board of directors how it intends to get the same level of safety and other assurance in the changed regulatory environment.

Final Reflections

This Essential Brief sets out to provide governors with an overview of health policy, and of how the Coalition Strategy fits with previous policy themes, so that governors can constructively challenge their boards of directors on the strategy and business plans of their FTs. Very successful organisations develop strategies that establish a ‘difference they can preserve’¹³ in the market place. As the health care market becomes increasingly competitive, governors have the potential to add real value to their trusts by contributing to the development of strategies which give their FTs that ‘difference’.

As the Coalition Strategy is implemented, governors might wish to ensure that they develop an understanding of the priorities of the NHS Commissioning Board and local GP consortia and how that might be impacting on their FT’s long-term strategy. Governors should be aware of the potential volatility of commissioning as GP consortia are established, leading to a more unpredictable financial environment. Among all this change, regulation will be in transition and governors

would be wise to reflect on how effective their processes are for holding their board of directors to account in these interesting times.

Although not the focus of this Essential Brief governors must of course not lose sight of the key role they have in ensuring the accountability of hospitals to the communities to which they provide services. Sir David Nicholson (Chief Executive of the NHS) pointed out in the recent FTGA Development Day that as strategic health authorities and primary care trusts are abolished and make way for the NHS Commissioning Board, GP consortia and health and wellbeing boards (the latter providing local authority influence over commissioning by GP consortia) *“governors will be the only point of continuity in a system of local democratic legitimacy that will be rapidly changing”*. In these conditions of change it will be increasingly important that governors maintain effective contact and communication with the community to ensure local accountability.

The final word on the implementation of the Coalition Strategy is left for T S Eliot in 'The Hollow Men':

**Between the idea
And the reality
Between the motion
And the act
Falls the Shadow**

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