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Franchising Healthcare?

Presenting past NHS reforms and discussing the proposed changes in the White Paper *Equity and Excellence: Liberating the NHS*

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1. Introduction

The National Health Service (NHS) is the publicly funded healthcare system in England[1]. The NHS provides healthcare to anyone legally resident in England, and in any other part of the United Kingdom, with almost all services "free at the point of use". "Free at the point of use" is the famous wording employed when the NHS was originally set up. Considered a cornerstone of the NHS, the frase has been much debated and re-interpreted in recent years.

The NHS organisation was established in 1948 after a century's discussion of the provision of health services to meet a long-recognised need. It emerged at a time when Britain saw healthcare as a crucial aid to fighting the "five giants" (want, disease, squalor, ignorance, and idleness) that William Beveridge[2] declared should be defeated during post-war reconstruction. The cataclysm of war provided an opportunity that might not have been taken in quieter times. Many other social reforms were also introduced during the post-war period.

Today's NHS is a very large organisation. In fact it is one of the largest employers in the world, and the biggest in Europe, with over 1.3 million staff[3]. The NHS has been subjected to various reforms and changes during its history. The current discussion about the cost of good-quality healthcare provision has been sparked by the demographic trend of people living longer and thus needing care for a longer period of time, and by the economic crisis that started in 2008. Healthcare has for long been the most costly public service, competing with pensions as the single largest item of expenditure in the UK government's spending[4]. Over recent decades the cost of the NHS has skyrocketed, which can be partly explained by inflation, but a large part of the rise in costs is due to demographic developments and partly due to technological advances. Even though there have been large-scale ICT reforms promising

[1] The term is also commonly used to refer to any other or all of the national health services in the UK, but only the English system is referred to without a national qualifier; the rest are, for example, NHS Wales and NHS Scotland.

[2] William Beveridge, the eldest son of a judge in the Indian Civil Service, was born in Bengal, India, on 5th March 1879. After studying at Charterhouse and Balliol College, Oxford, he became a lawyer. Beveridge became interested in the social services and wrote about the subject for *The Morning Post*. In 1909 Beveridge, now considered the country's leading authority on unemployment insurance, joined the Board of Trade and helped organize the implementation of the national system of labour exchanges.

[3] http://www.jobs.nhs.uk/about_nhs.html. Accessed 5 July 2011.

4 http://www.ukpublicspending.co.uk/. Accessed 5 July 2011.

efficiencies, programmes such as The National Programme for IT in the NHS have cost more than originally planned[5].

However, today the NHS is not financially secure and that it will face a £20 billion shortfall in the next five years if the situation does not change dramatically[6]. Over the period from 1997 to 2008 expenditure on healthcare in the UK rose at a faster rate than spending in the wider economy. In 2008 expenditure on healthcare was equivalent to 8.7 per cent of GDP compared to 6.6 per cent in 1997. In 1997 expenditure on healthcare was £54.8 billion, and by 2009 it had gone up to £136.4 billion[7]. The volume of drugs prescribed by GPs more than tripled over the period 1995–2009, with growth averaging 8.6 per cent per year[8].

The current coalition government under Conservative Party leader David Cameron has been applying harsh measures to reform public services. At the heart of the discussion has been Cameron's idea of the *Big Society*. The Big Society is a vision of a society in which individuals and communities have more power and responsibility, and use it to create better neighbourhoods and local services. The Prime Minister has stated that 'the people are the boss' and that four tools - competition, choice, payment by results, and transparency - are essential to achieving a radical shift of power away from the centre[9]. The Big Society concept in the context of public services means that a multitude of actors are invited into the field of service provision. Localism and decentralisation are core principles of the Big Society. The main criticism towards the political concept has been that the Big Society is 'a con', or trick. Critics say that it is merely an excuse for austerity cuts and it seems evident that the Big Society agenda will result in public services being produced more cheaply by expanding the role of charities, social enterprises and private companies in the provision of public services.

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5 The National Programme for IT in the NHS (NPfIT – now Connecting for Health) aims to implement an integrated ICT infrastructure in all NHS organisations in England by 2014. The total cost of NPfIT is estimated at £12.4 billion (at 2005/6 prices) over the 10 years to 2013/4 (NAO 2006) www.kingsfund.org.uk/document.rm?id=7132. Accessed 3 July 2011.

6 Knight, Sam. Prospect (December 2010), *This Might Hurt*, 28–33.

7 In 1997, £44.1 billion was from the public (NHS) healthcare, respectively £10.8 billion from the private sector. In 2009 the same figures were £113.8 billion and £21.6 billion. National Statistics, Expenditure on healthcare in the UK - 1997%u20132009 – published May 2011 (pdf) http://www.statistics.gov.uk/articles/nojournal/healthcare-expenditure-may2011.pdf

8 Expenditure in real terms is projected to have increased by nearly 7 per cent each year between 2000/01 and 2010/11, compared to average increases of 4 per cent over the lifetime of the NHS. This represents the highest sustained increase in funding since the NHS was established. Ibid.www.kingsfund.org.uk/document.rm?id=7132. Accessed 3 July 2011.

9 http://www.communities.gov.uk/communities/bigsociety/. Accessed 11 July 2011.

This paper discusses the current reform of NHS England and the possible new outcomes. The idea of studying the NHS came as a response to the extensive discussions of the healthcare reform, which raised general questions about the organisation of the NHS and about previous reforms. The NHS is clearly an institution of significant value to British people and the proposed changes affect millions of people. The NHS represents values that derive from the post-war era of welfare-state building and it is interesting to study the reforms that challenge the traditional interpretation of these values. At the time of writing, the Health and Social Care Bill 2011 is still being assessed by the House of Commons.

The first part of the paper concentrates on the birth of the NHS and gives a quick overview of past reforms. The last chapters of the first part concentrate on the way the current NHS is organised. The second part presents the reforms imposed by the Health Secretary Andrew Lansley and discusses the White Paper *Equity and Excellence: Liberating the NHS*. The third part analyses and discusses the imposed changes presenting the most important changes to the current NHS. The fourth part places the reforms in the context of the wider political discussion of the Big Society and the new division of responsibilities between public and private service providers.

2. The original NHS and past reforms

The NHS was officially born on July 5th 1948 when *Park Hospital* in Manchester was opened by health secretary Aneurin Bevan. This was the climax of a hugely ambitious plan to bring good healthcare to all. For the first time hospitals, doctors, nurses, pharmacists, opticians and dentists were brought together under a single umbrella organisation to provide services that were free for all at the point of delivery[10].

The central principles of the healthcare system were clear: the health service would be available to all and financed entirely through taxation, which means that people paid into it according to their means. From 1948 onwards the NHS provided comprehensive medical care[11]. Hospital doctors became salaried employees. General Practitioners (GPs) remained formally self-employed, but were contracted to work for the NHS based on a mixture of tax-funded capitation payments[12]. In this way neither hospital doctors nor GPs had an incentive to over-treat (as in fee-for-service systems[13]). Costs were also controlled by the fact that, apart from accidents and emergencies, specialists would only see patients referred to them by a GP, which meant that GPs were gatekeepers for access to expensive specialist care[14].

2.1 The NHS as an organisation 1948–1980

In spite of some organisational changes the main features of the NHS remained basically constant from 1948 to 1980. The structures of the NHS related to the kinds of service it provided – preventive, primary, secondary and tertiary care. The Department of Health and the NHS Executive were responsible for developing strategy and implementing policy, and for the performance of the nationwide functions, including workforce planning, managing the NHS estates, data collection and IT.[15] Many of these actions were performed in conjunction with the regions and districts.

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[10] The previous system was a mixed system of social insurance and private voluntary insurance created by Lloyd George in 1911. The insurance system had proven to be expensive and generated too much unfairness, leaving 50 per cent of the population, mainly women, older people and children, without coverage and providing care of very uneven quality for those who were covered by it, Talbot-Smith & Pollock 2006, 2.

[11] Including dental and eye care.

[12] Capitation payment refers to a fixed sum for every registered patient. Leys 2003, 166.

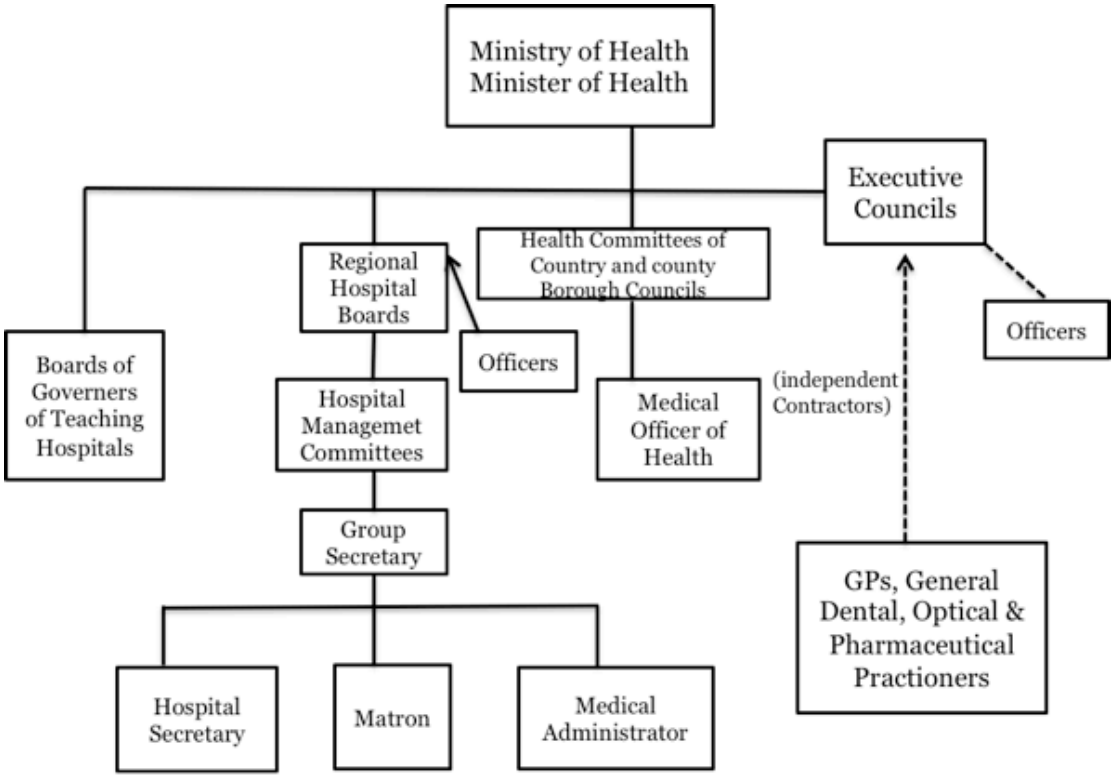
[13] Fee-for-service (FFS) is a payment model in which services are unbundled and paid for separately. In health care, an FFS model provides an incentive for physicians to use more treatments (including unnecessary ones) since payment is dependent on the quantity of care. FFS is the dominant physician payment method in the US.

[14] Leys, Colin (2001) *Market-driven Politics – Neoliberal Democracy and the Public Interest*. London. Verso.166.

[15] Talbot-Smith, Alison and Pollock, Allyson (2006) *The New NHS: A Guide*. Oxon. Routledge.3.

Regional health authorities or boards were responsible for planning and overseeing the provision of tertiary care in their own regions and for blood transfusion, cancer strategy, intensive care beds, IT, workforce strategy, ambulance services, training and education. District health authorities were responsible for planning and providing hospital care services for local residents, and for overseeing the provision of primary care[16].

Regional and district authorities[17] acted as agents for the Department of Health, channelling funds (or commissioning) to over 2000 hospitals and to Family Practitioner Committees through which GPs were paid[18].



NHS England organisational structure 1948

The NHS had a strong system of political accountability. All NHS organisations were directly accountable to the Secretary for Health through the Department for Health (DH). There was also patient and public representation through the inclusion of local

[16] Talbot-Smith & Pollock 2007, 4-5.

[17] From 1974 to 1996 the NHS in England was administered by Regional Health Authorities. The regions closely followed the areas of the previous Regional Hospital Boards established in 1947, but in many cases they were renamed. Each Region was subdivided into District Health Authorities, which were organised geographically, there being eight of them from 1994 onwards: Northern and Yorkshire; Trent; Anglia and Oxford; North Thames; South Thames; South and West; West Midlands; North West.

[18] Leys 2003, 166.

councillors and other members of the public on health authorities and boards. Even though this first period of the NHS (1948-1970) was relatively calm with regard to reforms, concern had been growing about the costs of the NHS, which had consistently exceeded estimates.

From 1974 onwards Community Health Councils (CHC) were set up to work as independent bodies with some paid staff, but mostly consisting of volunteers. NHS bodies had to consult CHCs every time major changes were proposed[19]. A local government representative also sat on the board of each District Health Authority[20]. Some still argued that there was a weak sense of local democracy in the decision-making, since district-level CHCs consisted of appointed, not elected, lay members. It was also argued that the real policy-making and influencing power of the CHCs was very weak[21].

Moreover, the period after 1974 was a difficult one for the NHS for many reasons. It was a time of relative economic restraint; in 1976 the Treasury introduced a new system of financial allocation, known as cash limits, to the public sector. This meant that NHS hospital and community health services also faced changes. A system of central control of management costs was also introduced.

At the same time the number of people with private medical insurances (PMI) provided mainly through corporate plans trebled from 4 per cent in the mid-1970s to 11.6 per cent in 1990. Simultaneously NHS bed numbers fell by 21 per cent, while private hospital bed capacity expanded[22].

2.2 Thatcher and the introduction of general managers

To make the NHS more efficient Margaret Thatcher[23] wanted to reform the way in which it was managed. During her third year as Prime Minister, 1981, the Cabinet began to consider various options for opening up healthcare to private companies

[19] Talbot-Smith & Pollock, 2007, 4

[20] Leys 2003, 166-167.

[21] Leys 2003, 166-167.

[22] Leys 2003, 170-171.

[23] Margaret Thatcher (13.10.1925) was elected Leader of the Conservative Party in 1975, and in 1979 became the UK's Prime Minister. Her political philosophy and economic policies emphasised deregulation, particularly of the financial sector, flexible labour markets, the sale or closure of state-owned companies, and the withdrawal of subsidies to others. She resigned as Prime Minister and party leader in November 1990 after 11 years in power.

which included a plan to introduce private health insurance. In the middle of the planning process an internal document from the government's Central Policy Review staff describing proposed changes to the NHS was leaked to the press and caused a huge public outcry. This resulted in Margaret Thatcher issuing "a public promise" that the NHS was safe with the Conservatives.

In the 1980s modern management processes, referred to as *General Management*, were introduced in the NHS, replacing the previous system of consensus management. The most important organisational change was implemented in 1984, when a new hierarchy of general managers was installed, backed up by businessmen appointed to hospital management boards. They replaced senior doctors (consultants), who had previously managed the hospitals. Overall spending was also cut to below growth, forcing the NHS to cut back on services and their quality[24].

The change meant that health authorities no longer ran hospitals, instead they *purchased* care from their own or other authorities' hospitals. Certain GPs also became "fund holders" and were able to purchase care for their patients. Healthcare providers in the NHS became independent trusts. This change encouraged competition, but it also increased local differences, making the quality of care less consistent throughout the country. *Contracting-out* (or outsourcing) of services, such as pathology tests, cleaning, catering and laundry, was introduced.

One result of the above-mentioned changes was that more general managers were employed on short-term contracts and *performance-related pay*. The main criticism of this arrangement was that they had little knowledge of healthcare. Cleaners, cooks and other support staff were contracted from firms outside the NHS and they no longer worked directly for the NHS. In practice this meant that they did the same work for less money, and were non-unionised. Some of these firms went on to be profitable businesses and some were even listed on the stock market[25]. Due to the organisational changes the number of people employed by the NHS decreased by 40 per cent between 1981 and 1991[26].

[24] Leys 2003, 169.
[25] Talbot-Smith & Pollock 2007, 5.
[26] Leys 2003, 170.

Universal access to dental care was withdrawn in the late 1980s by capping the dental budget, which led to dentists refusing to treat NHS patients. Children were still covered by NHS dental care. The NHS no longer provided regular eye examinations, and glasses were no longer free of charge to children. The effects of these reforms on patient care were also evident. Waiting lists to see specialists grew longer, comprehensiveness and equality of access were reduced[27]. Radical funding cuts led to a crisis both in the NHS and in the all-party parliamentary Select Committee on Health[28]. Tensions culminated in a joint open letter from the three senior Royal Colleges of medicine, declaring that the NHS was in a serious crisis and that the situation needed instant action. In response, Thatcher set up a committee. This committee decided that the NHS was to be divided into two sections: *purchasers* and *providers*, creating an internal market, which was introduced later in 1991[29].

When Labour was in opposition they harshly criticized the changes made to the NHS during the Thatcher era. According to Labour, the new "fund holder" system was part of the Conservative plan to privatise the NHS, which became a major feature of Labour's election campaigns.

In 1991 the government radically restructured the NHS, creating a so-called *internal market*. The idea was that it would make the NHS more cost-effective and make hospitals more responsive to customer demands, while the government still controlled total spending. The 1990 *NHS and Community Care Act* turned NHS hospitals and other bodies, such as ambulance and community health services, into semi-independent *trusts*, and required them to act like independent businesses in a marketplace. The health authorities became *commissioners* or *purchasers* and the trusts became *sellers*[30].

The new system changed the way in which the NHS resources and funding were accounted for. Since NHS hospitals and other services could no longer rely on an annual block budget, they were no longer required to give priority to medical needs. They had to break even by generating their own income and cutting costs, and

[27] By 1994, for example, the average wait to see an ear, nose and throat surgeon was three months, and an orthopaedic surgeon six months. Prescription charges trebled in the 1980s. NHS income from "user fees" for dentistry rose from £65 million in 1979 to £340 million by 1990. By 1998 it was £475 million. (Leys 2003, 169)

[28] The Health Committee is appointed by the House of Commons to examine the policy, administration and expenditure, of the Department of Health and its associated bodies.

[29] Leys 2003, 170.

[30] Talbot-Smith & Pollock 2007, 6.

competed with each other for business. The priority is claimed to have been balancing the books[31]. Within a short time more than a third of the new trusts faced serious financial difficulties and many were forced into mergers and service closures.[32]

2.3 New Labour: Primary Care Trusts and the re-organising of commissioning

Labour came to power in 1997 with a promise to abolish the "internal market" and fundholding. What happened instead was that it decided to further reorganise the NHS in the direction of market-based healthcare. The main organisational change proposed in the government's 1997 White Paper[33] *The New NHS* was to make the NHS primary care led and to increase the power of GPs.

Organisations commissioning or purchasing healthcare services on behalf of patients hold a central role within the NHS. Since April 2002 organisations known as primary care trusts (PCTs) have had the main purchasing power and responsibility for commissioning primary, secondary, and community healthcare services for their local populations. This power was taken away from the district health authorities. Around 80 per cent of the NHS budget in England is today distributed by 152 PCTs, whose work is overseen by eight regional strategic health authorities. The PCTs receive funding from the Department of Health relating to population and specific local needs. They should break even, that is, they must not show a deficit on their budgets at the end of the financial year, although in recent years cost and demand pressures have made this goal practically impossible for some Trusts.

PCTs vary considerably in size from under 100,000 patients to over one million patients, with an average of 330,000, and they each have hundreds of administrative staff and a typical budget of around 500 million pounds a year. The entire population of England is now covered by 152 PCTs.

The NHS was given a boost when New Labour announced in 2000 that it would increase the NHS budget by an average of 6.1 per cent per annum in real terms for the

[31] Talbot-Smith & Pollock 2007, 6.

[32] Between 1990 and 1994 245 hospitals were shut down in England and Wales.

[33] A white paper is an authoritative report or guide that helps solve a problem. White papers are used to educate readers and help people make decisions, and are often requested and used in politics, policy, business, and technical fields.

following four years[34]. In return the government expected dramatic changes in the running of the NHS. It organised a task force of healthcare experts and professionals to draw up the *NHS Plan* published in July 2000. Its main thrust was reform in every sector of the NHS, ambitious targets to make it more accountable to patients and the public, increasing staff numbers and pay, breaking down inter-professional barriers, reducing waiting times, and improving hospital food and facilities.

One important reform was that clinical services were opened up to the market in order to provide additional capacity. It soon became evident that private doctors could not provide services in significant volumes as was hoped, and the change ended up being more about giving patients a wider choice of service providers[35].

After multiple reforms of its financial arrangements the NHS gradually emerged as a sort of a holding company, franchising health services out to various providers, public and private. Today the NHS is a government-funded player, but less and less the direct provider of health services. A clear shift can be seen from the old NHS, which was politically accountable and based on public trust in the service ethos of the NHS workforce, to one that is more based on competition in the marketplace and legally binding contracts[36].

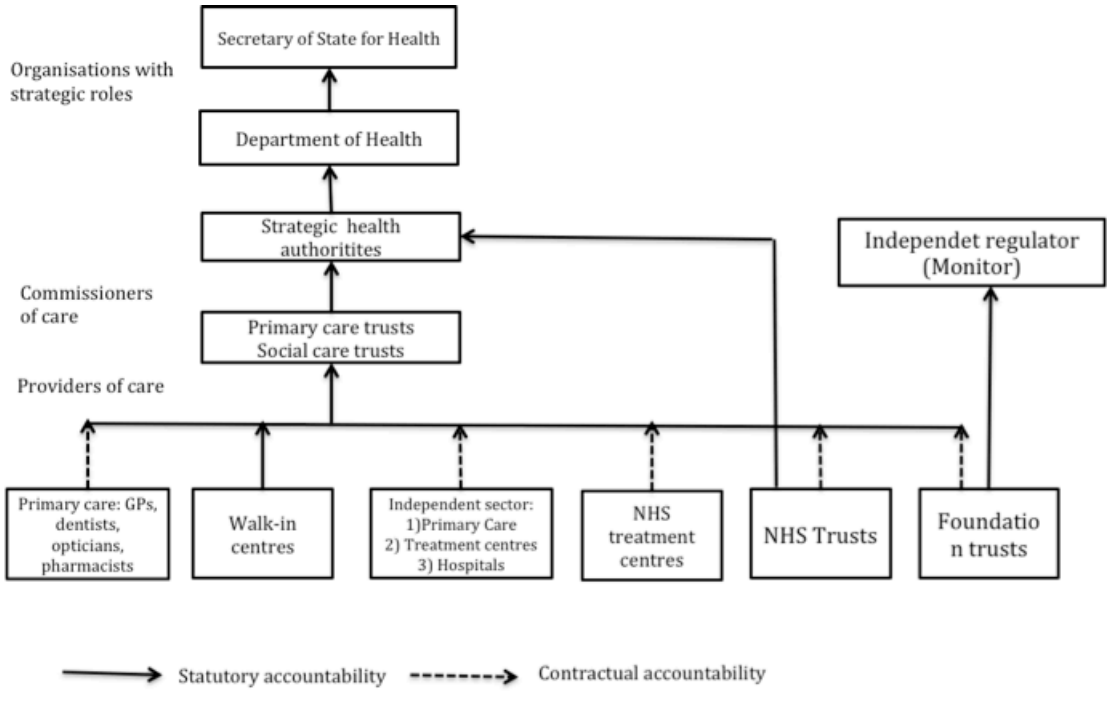
2.4 Strategic roles and decision-making in the current NHS

The current NHS has what are known as strategic bodies. Their job is to define the direction of the NHS, overseeing and organising the work of the various bodies within the NHS. The ultimate responsibility for the work of the NHS lies with Parliament, through the Secretary of State for Health, and the Department of Health (DH) is supported by several organisations, which provide specific national functions on its behalf. There are five junior ministers, each responsible for a specific aspect of the NHS. Strategic Health Authorities (SHAs) are responsible for implementing NHS strategy on the regional level[37].

34 Leys 2003, 202-203.
35 Talbot-Smith & Pollock 2007, 7.
36 Talbot-Smith & Pollock 2007, 7.
37 Talbot-Smith & Pollock 2007, 12–13.

The Department of Health is responsible for health and social services. It advises government ministers on health and healthcare issues and implements the national policy decided by them. It is responsible for the health services that the NHS delivers. This does not mean that the DH runs the day-to-day activities of the NHS – PCTs are responsible for that – but that it sets national policy, provides guidance, and oversees the performance of the NHS.

Responsibility for managing, inspecting and regulating services has been largely left to the Strategic Health Authorities. In 2002 twenty-eight SHAs were set up. Each covers a population of 1.5 million. SHAs function as a link between the strategically-focused DH and the frontline organisations, such as PCTs. SHAs have three main responsibilities. The first is to create a coherent, strategic framework for the local development of services. The second is to build the capacity of local services. In practise this means developing strategies for capital investment, overseeing investments, allocating funds for strategic capital developments and approving business plans. The third responsibility of SHAs is performance management of the NHS organisations in their area: the PCTs, NHS hospital trusts and other trusts[38].



The structure of the NHS in England

[38] Talbot-Smith & Pollock, 2007. 18-19.

3. The White Paper *Equity and Excellence: Liberating the NHS*

The White Paper *Equity and Excellence: Liberating the NHS* represents one of the biggest shake-ups of the British health system since the NHS was established. Its grand aims are to devolve power from Whitehall to patients and professionals, and to shift the focus of healthcare management to quality of care.

3.1 The Rhetoric of the common good

Launching the White Paper, Health Secretary Andrew Lansley said: "People voted for change and the Coalition Agreement set out a bold and exciting vision for the future of the NHS — a vision based on the principles of freedom, fairness and responsibility"[39]. Lansley indirectly refers to the challenges the NHS confronts in order to justify the required changes. As part of this justification, reference is made to the common good shared by all.

> The NHS is our priority. That is why the Coalition Government has committed to increases in NHS resources in real terms each year of this Parliament. The sick must not pay for the debt crisis left by the previous administration. But the NHS is a priority for reform too. Investment has not been matched by reform. So we will reform the NHS to use those resources far more effectively for the benefit of patients.

However, Lansley also mentions that the NHS is something to be proud of:

> The Government's ambition is for health outcomes and quality services that are among the best in the world. We have in our sights a unique combination of equity and excellence.

The reader is invited to share the sense of the high stakes involved. Together with this, a 'contract of confidence' is established based on the notions of empowerment associated with improving results:

> With patients empowered to share in decisions about their care, with professionals free to tailor services around their patients and with a relentless focus on continuously improving results, I am *confident* that together we can deliver the efficiency and the improvement in quality that is required to make the NHS a truly world class service.

[39] Department of Health, Secretary of Health Andrew Lansley's speech on 12 July 2010. http://www.dh.gov.uk/en/MediaCentre/Speeches/DH_117366. Accessed 3 July 2011.

There is a strong sense of a common project in Lansley's speech. Patients should play a bigger role in the healthcare system. A specific body, HealthWatch, is being set up to gather feedback from users, and to play a part in the development of the NHS. While the rhetoric is convincing as such, it has been questioned whether this reform will eventually be able to redeem its promises. Next we will take a close look at the practical changes in the White Paper.

The White Paper outlines major changes in both the funding and structure of the NHS. The government wants to reduce NHS management costs by 45% over four years. These cuts will be made in NHS funding and regulation bodies, not GP practices and acute trusts, mainly by dismantling primary care trusts and strategic health authorities, and reducing layers of bureaucracy[40]. Currently the purchasing side of the NHS accounts for 13 per cent of the annual budget.

These changes have been discussed for several years, and some of the actions have already been carried out, or are being trialled or were planned by the previous government. For example, PCTs had already started separating their provider services from their commissioning functions. The White Paper does acknowledge some of the work done by the previous government, but also makes many new initiatives.

3.2 Establishing commissioning consortia

Funding of the services to which GPs refer patients will now be undertaken by GP *commissioning consortia* in partnership with local authorities. Every GP practice will have to join a consortium. Each consortium will "have to have a sufficient geographic focus to be able to take responsibility for agreeing and monitoring contracts for locality-based services". The consortia will also need to be of sufficient size to manage financial risk and allow for accurate allocations. These GP consortia were originally planned to take full financial responsibility by April 2013, however, following the listening-exercise period an exact transition time has been abolished.

[40] The entire purchasing side of the NHS will be scrapped. This currently handles around 80 per cent of the NHS budget and accounts for 13 per cent of the total NHS budget.

There have been vehement arguments against changing the role of GPs, not least from GPs themselves[41]. The main argument is that GPs who become involved in managing commissioning will have less time to spend in patient care, and that more GPs will then be needed to take over some of their patient-care work. GPs have also opposed the Health and Social Care Bill 2011, because it will subject their profession to rule by the Government, as well as leading to a mixing of GP and managerial tasks, which used to be separated, especially after the Thatcher government.

The consortia will also have to acquire the various skill sets necessary for commissioning the care services that the PCTs have acquired during their evolution of the last few years, and which GPs do not yet have. It is possible, therefore, that there will be mass migration of PCT staff into consortia management, or that the private sector will be drafted in to provide the necessary skills, also employing former PCT staff.

A new NHS Commissioning Board will be set up to fund and oversee the GP consortia. This will be a "lean and expert organisation, free from day-to-day political interference, with a commissioning model that draws from best international practice". The NSH Commissioning Board will still be funded by and be responsible to the Department of Health.

3.3 All NHS hospitals to become foundation trusts

The health-improvement functions[42] of PCTs will be transferred to local authorities under "health and wellbeing boards" or within existing partnerships, joining social care, health improvement and commissioning of NHS services. This is part of the government's plan to decentralise the NHS and give Whitehall less say in health-provision.

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[41] The Guardian, http://www.guardian.co.uk/society/2011/feb/01/nhs-reforms. Accessed 15 June 2011.

[42] Health improvement specialists will be key in driving this forward, particularly in tackling the wider determinants of health and health inequalities by enabling the delivery of health improvement. This will be achieved through positively promoting healthy lifestyles and prevention of ill health through commissioning of lifestyle interventions across all ages, including stop smoking services, healthy weight initiatives, mental health, reducing teenage pregnancy, and alcohol harm reduction projects.
http://www.iow.nhs.uk/index.asp?record=1564. Accessed 12 July 2011.

In secondary care, the foundation trust model[43] will be streamlined and become the model for all NHS hospitals. This will also apply to all providers of commissioned care. All NHS hospital trusts will have to become foundation trusts, which means regulation by Monitor and the Care Quality Commission (CQC). The duplicated functions of Monitor and the CQC are being removed, so that Monitor becomes solely a financial regulator. The government also says that it wants to simplify the submission of large numbers of data returns to the Department of Health, which, along with reporting to the CQC, PCTs and Monitor, is currently a huge administrative burden on NHS trusts and distorts the focus of management.

Along with the regulatory changes, the White Paper proposes giving NHS foundation trusts more freedom to innovate and adapt. The proposed freedoms include abolishing the cap on the income that trusts can earn from other sources, such as private healthcare or diagnostic services, so that they can generate more of their own funds to reinvest in services. This is a clear effort to open up the NHS to further market-based forms of management and management by results.

The White Paper also talks about an information revolution. It refers to information provided to patients and the public about healthcare quality to enable them to choose where to have treatment. Some have said that this seems to be simply a continuation of the plan for the NHS Choices website, which provides the public with simplified indicators of quality[44]. As part of the patient-empowerment strategy, HealthWatch will be set up. HealthWatch will gather information on performance and feedback from users of health services.

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[43] NHS foundation trusts are part of the NHS and subject to NHS standards, performance ratings and systems of inspection. Their primary purpose is to provide NHS care to NHS patients according to NHS quality standards and principles. They have a significant amount of managerial and financial freedom compared to NHS hospital trusts. The introduction of NHS foundation trusts represented a historical shift in the NHS Service, and in the way in which hospital services are managed and delivered. They are accountable to local people, who can become members and governors. Each NHS foundation trust has a duty to consult and involve a board of governors (comprising patients, staff, and members of the public and partner organisations) in the strategic planning of the organisation.

[44] British Journal of Healthcare Computing, http://www.bj-hc.co.uk/archive/news/2010/n1007001.htm. Accessed 15 June 2011.

3.4 The amended version of the bill

The launch of the White Paper also marked the start of an extensive consultation and discussion that took place over the subsequent months. The Health and Social Care Bill was introduced into Parliament on 19 January 2011.

On 6 April, the Government announced that it would take advantage of a natural break in the legislative timetable to "pause, listen and reflect" on its modernisation plans and make improvements to the Health and Social Care Bill where necessary. An eight-week NHS Listening Exercise was announced[45]. The objective was not to repeat the formal public consultations which had already taken place, but to reflect on the areas which had prompted the most heated discussion and debate, and to highlight potential improvements to the legislation where necessary. The four core themes of the NHS Listening Exercise were: choice and competition; clinical advice and leadership; patient involvement and public accountability; and education and training.

As a result some aspects of the health bill were changed. The transition deadline of 2013 for passing commissioning power to GPs has been withdrawn. "Commissioning consortia should only take on their full responsibilities when they can demonstrate they have the right skills, capacity and capability to do so"[46].

The review group also made recommendations for changes to the bill, stating that NSH should be free from day-to-day political interference, and with ultimate accountability remaining with the Secretary of State. It was also recommended that in the bill there should be stronger and clearer duties of involvement, so that the declaration "no decision about me, without me" would become a reality. In practise this would mean that patients and cares would be treated as equals with healthcare professionals in decision-making regarding the treatments, but also more citizen involvement in designing local health services.

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[45] The Government set up an independent group to review the Health and Social Care Bill. The group was known as the NHS Future Forum and consisted of 45 members. The group reported its findings and recommendations to the Government on Monday 13 June 2011. The Bill received its second reading on 31 March 2011 and completed its committee stage in the House of Commons on 31 March 2011.

[46] http://www.lampdirect.org.uk/news/2011/jun/changes-to-health-and-social-care-bill. Accessed 22 June 2011.

The key point of the Health and Social Care Bill is the establishment of an independent NHS Board to allocate resources and provide commissioning guidance. It increases the GPs' power and responsibility to commission services on behalf of their patients. The Care Quality Commission's role will be strengthened, and Monitor (the body that currently regulates NHS foundation trusts) will be developed into an economic regulator to oversee aspects of access and competition in the NHS. The number of different health bodies will be cut in line with the Government's decision to cut NHS administration costs by a third. Part of this decision involves abolishing PCTs and Strategic Health Authorities. Local authorities are taking on responsibility for public health for the first time since the 1970s.

4. Conclusions

The authorisation of GPs to buy services for their patients dates back to the late 1980s, when the Conservative party started building an internal market. The idea is that GPs, who are the closest link to patients, are best qualified to understand their needs and to buy diagnostic tests and minor surgery on their behalf. Some important advantages accrue from handing the commissioning over to GPs. GPs in Britain are independent contractors with small businesses of their own, and typical GPs surgeries have turnovers between £1m and £2m a year. GPs tend not to tolerate poor providers and drive inefficiency out of the system[47]. The latest NHS reform plan intends to increase to power of GPs to purchase services for their customers, replacing PCTs that currently handle around 80 per cent of the NHS budget and cost 13 per cent of the total NHS budget[48], with GP-led commissioning consortia.

The planned consortia could consist of different types of service producers, such as private companies, social enterprises, or simply old-fashioned GP practises that outsource everything to consulting firms. Many will look much like the old PCTs, and they may hire the same NHS managers who are now due to lose their jobs, to do that same job. There are some strong factors forcing the implementation of a stronger market-based system. Letting the size and composition of the consortia be decided by the consortia themselves is one clear way of granting them the independence to seek the form of organisation best suited to their specific needs. This could lead to wider financial disparities between consortia, and ultimately to bigger differences in the quality of healthcare provided to people living in England.

The other important aspect of the Bill is the aim to create a genuine market for both public and privately run organisations that will ideally compete for NHS work. From 2003 onwards private clinics have been allowed tender for smaller-scale surgical operations. The proportion of procedures carried out by private clinics is between 1 and 3 per cent[49]. To make the transition to a genuine market the NHS will have to be autonomous of government. The reform aims to organise the NHS in a way that will make it more like an umbrella under which services are produced with competition

47 Prospect, December 2010, Sam Knight, 28-33.
48 Talbot-Smith & Pollock 2007, 7.
49 Talbot-Smith & Pollock, 2007, 104.

and quality as the two main principles. To monitor this new system two new bodies will be set up, one to monitor commissioning, the other to monitor and evaluate quality.

The NHS is in transition from being a public system accountable to Parliament to being a market-based system of mixed public and private provision, accountable to an independent regulator. It is claimed that in the past efficiency was assured by direct management and supervision by authorities, and by the public service ethos of NHS employees, while standards were mainly the responsibility of the clinical professions, exercised through the Royal Colleges of medicine and other professional bodies[50].

The shift to a market-based system means that clinical standards and safety will be assured by external monitoring, audits and sanctions, since there is always a risk in a competition situation that organisations will be tempted to reduce costs by lowering standards. This could mean that, instead of achieving its aim of reducing bureaucracy, the Health and Social Care Bill 2011 could actually enhance the cost of bureaucracy by creating a set of new monitoring bodies.

There are some clear links between the rhetoric and the formulation of the Health and Social Bill and the concept of the Big Society launched by Prime Minister David Cameron. With the abolition of the PCTs the new consortia will have a much more vague form. Ideally they will consist of a multitude of health-service providers, such as social enterprises, and private companies. At the same time responsibility for healthcare provision is being split between public and private providers. The rising cost of healthcare provision has been a catalyst for change and, by aiming to make the NHS more efficient by increasing the role of private providers, the Health and Social Care Bill 2011 is changing the nature of public-service healthcare.

The Health and Social Care Bill 2011 does not discuss in any clear terms the underlying reasons for the rise in health expenditure such as the role of ageing in the growing need for healthcare provision, the developments in information technology or the increase in levels of drug prescriptions which have been pushing the costs of public healthcare upwards. The changes proposed in the White Paper seem to

[50] Talbot-Smith & Pollock, 2007, 104.

concentrate on downsizing bureaucracy, and on seeking efficiencies through organisational changes.

Cutting the administrative costs of running the NHS has been one of Health Secretary Andrew Lansley's main proposals, similarly to the previous healthcare reforms in England. These reforms have not proved very effective in redeeming their promises[51]. For example, the Blair government's administrative reform of the NHS based on the use of information technology resulted in one of the biggest IT projects in the world, which cost an astonishing £12.4 billion over 10 years instead of the estimated £2.3 billion[52]. From the economic and managerial point of view, the track record of previous NHS reforms and of other decentralising reforms in various European countries has not been particularly convincing.[53]

3.1 Repetitive reforms

The NHS has been the victim of repetitive reforms for the last few decades. The power of commissioning has been with different authorities depending on the reform. New bodies have been established and old ones abolished, and as a result the organisation's structure has changed almost constantly. No matter what the reforms have proposed, the endgame seems to be the same: healthcare expenditure rises. There is an evident trend towards the NHS being used as a political trophy by both Labour and Conservatives for their own benefit and popularity. This might partly explain the enthusiasm for reforming the organisation. In an organisation like the NHS there is always something to reform, and the on-going public discussion of the quality of care feeds the waves of reforms.

Past reforms have actually changed the NHS. They have gradually opened the NHS up to market-based modes of operation. The most important changes that Lansley's White Paper will bring are the establishment of new consortia and the form they will

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51 King's Fund, *Summary of NHS funding and performance since 2002*. www.kingsfund.org.uk/document.rm?id=7132. Accessed 3 July 2011.

52 The National Programme for IT in the NHS (NPfIT – now Connecting for Health) aims to implement an integrated ICT infrastructure in all NHS organisations in England by 2014. The total cost of NPfIT is estimated at £12.4 billion (at 2005/6 prices) over the 10 years to 2013/4 (NAO 2006) www.kingsfund.org.uk/document.rm?id=7132. Accessed 3 July 2011.

53 Axelsson, Runo et al., 2007, 'Effects of decentralization on managerial dimensions of health systems', and Kinnunen, Juha et al., 2007, 'Effects of decentralization on clinical dimensions of health systems. In Slatman, Richard, Vaida Bankauskaite & Karsten Vrangbæk (eds.) *Decentralization in Health Care. Strategies and outcomes*. Berkshire: Open University Press.

take. The role of GPs will change when they begin to handle commissioning, but the outcomes are unpredictable. As the healthcare system moves towards a more market-based form of service delivery with increased competition between providers, there will also be a need for monitoring and evaluating bodies to control the healthcare market and to guarantee a certain level of quality of the NHS services. HealthWatch and the NHS Board are being established for this purpose.

Cameron's four tools for creating the Big Society: competition, choice, payment by results, and transparency, are obviously important in the changes proposed in the White Paper. Competition and quality will be the main pillars of the reformed NHS. For the ordinary NHS customer, freedom of choice will increase, as consortia will be able to start generating their own income more freely as the NHS is "liberated". Payment by results is already part of the organisation of the NHS, and this aspect will be further strengthened. Transparency and accountability form an important part of the effort to empower customers, and to give them more say in the service they receive. HealthWatch is a new tool for empowering patients and an attempt to implement the slogan "no decision about me without me".

The Big Society project emphasises the role of social enterprises in the provision of public services, as they are driven not only by profitability, but by other values as well. One of the more or less intentional consequences of the reform is to open up space for various social enterprises. The composition of GP consortia is left unspecified in the Health and Social Care Bill, at least partly in order to allow various types of enterprise to be established to perform the functions of the abolished PCTs.

The NHS is moving towards being more of a system than an organisation. It will be more common for the NHS not to be the direct provider of services, but more like a holding company "franchising out" health services to various providers, both private and public[54].

To paraphrase Andrew Lansley, the NHS is an organisation in which everyone seems to have a stake: it is a massive employer and a service provider to millions of customers. It is an organisation with a proud history and people are genuinely interested in its future. The proposed changes challenge the core ethos of the NHS as

54 Talbot-Smith & Pollock 2007, 7.

a public service provider and this has naturally provoked reactions. Only time will tell whether the NHS will continue to belong to the public realm, proudly providing a common good to us all.

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