

CIVITAS: Response to Conservative White Paper: NHS Autonomy & Accountability

9 July 2007

There are aspects of this White Paper to applaud, but they are pretty much restricted to the supply-side and even then no proper mechanisms are put in place to ensure an end to micromangement. That proposed for commissioning, however, is far from adequate.

Encouraging every NHS Trust to become a self-governing Foundation Trust (FT), lifting restrictions on FTs' borrowing arrangements and an unambiguous sounding commitment to allow any provider from the independent or private sector to offer services to NHS commissioners, should all help to 'liberate the supply of healthcare and bring about effective competition' as the document says. This is welcome.

As is the pledge to scrap top-down performance targets, which would free up providers to focus much more on responding to patient needs and demands, rather than artificially diverting their attention to one particular aspect of care and often seeking out ways to cheat it at that.

The Paper is also right to focus attention on the necessity of securing public access to high-quality information on health outcomes and standards of care. Patients need such data to make choices over providers, and commissioners need it to focus their purchasing of services on health outcomes and quality, thereby holding providers to account in contracts. NHS organisations should also come to view data collection as a vital tool for attracting patients and for piloting innovation.

And there are some useful ideas for payment by results (which would be greatly assisted by better quality information in any case), in particular that the tariff 'should increasingly be set on the basis of the costs delivered by the more efficient providers – and that providers should also be entitled to offer discounts to it'. This would allow some competition on price and help drive up efficiency. But the White Paper stops short of: a. scrapping any tariff and allowing true competition between providers on price rather than just information on comparative performance or b. (an idea that was given some attention in the Public Services Improvement Policy Group report, but for some reason not transferred here) linking the tariff to quality and outcomes. As is correctly observed in the PSIPG paper, payment by results is not really payment by results at all; it is payment by activity. It gives the example of how a hospital admitting a stroke patient aged over 59 will be paid £4,293 for care with further payment if the hospital exceeds 57 days – 'payment is linked to admission and length of stay, rather than to quality, efficiency or outcome'. This should have been carried through.

However the main criticism of this Paper should properly be aimed at the commissioning side of things where, in truth, the whole thing becomes a bit of a mess. For a start, the ideas that are presented seem to be hamstrung by prior commitments given by Cameron to 'rule out any more such pointless organisational upheavals which have done so much damage to the NHS', because it is precisely organisational change that it seems to want.

The masterstroke offered is the creation of an independent NHS Board to oversee the commissioning of NHS services and put an end to political interference in the NHS. It seems you can't go wrong here – the idea is very trendy amongst policy wonks, and, crucially, the BMA. But the fact is that it is unlikely to change much. It is surely right, for a start, that politicians should have a significant interest in what is being done with £92 billion of taxpayers' money. Moreover, with or without an NHS Board, politicians will

still set the budget for the NHS, so an independent NHS board will not necessarily solve the boom-bust patterns of funding the NHS has had to endure throughout its history. Moreover, the commissioning decisions that the NHS Board will take will not be purely technical, they will be inherently political so long as the NHS is funded by general taxation and, as such, the Board will almost certainly suffer from the same itch to micromanage as the government has done.

What is more, placing health professionals at the helm of such a board represents a serious threat to one of the few positives to come from Labour's hotch-potch of reform in the NHS, which is to place real emphasis – through extending the purchaser-provider split to include patient choice of provider – on the importance of the system being responsive, and ultimately accountable, to patient need. An NHS board, dominated by professionals, could well muddy these waters intractably, by reasserting the power of the producer over the consumer. The fact the White Paper also proposes that the Board be *appointed* by Ministers makes something of a mockery of the drive it presents towards greater accountability for the NHS. Yes, there should be more consultation with health professionals and clinicians about the direction of reform and over controversial decisions, but this could be in the form of a strong consultative body instead.

An independent board would also be yet another layer of bureaucracy that the NHS could well do without. This is particularly true given that the White Paper envisages the commissioning role to be done through 'Primary Care Commissioning', i.e. GP practices. So we have the NHS Board charged with the allocation of NHS resources, the promotion of patient choice, patient and public involvement in healthcare, safe and high-quality health services; i.e. significant performance management. Yet we also have a designated role of SHAs as 'the performance-management of PCTs', and a designated role of PCTs as 'the performance management of GPs and primary care commissioners'.

This begs the obvious question: how much performance management do you want? And it is not a matter to be joking with. Its consequences could be disastrous. You cannot have a market for healthcare if only the supply side (the hospitals) is allowed to play game. An insightful report released recently by the NHS Confederation comes out against the idea of an NHS Board for the simple reason: that independence and innovation are more about relationships than structures. The more hierarchy and layers you put in a system, the more communication is likely to be corrupted, the more likely it is that a dependency culture will evolve and the more likely it is that policy production will be for the worst performers. More particularly it means that commissioning will probably never really be performed in the interests of patients, rather in the interests of logistical, protectionist and cost containment objectives. In essence this means a continuation of the current dire situation the NHS finds itself in of 'falling productivity, excessive bureaucracy and lamentable leadership and management'; the very situation the White Paper seeks to tackle.

Neither is there an explicit statement in the Paper that what we have is a market for healthcare; again a highly dangerous situation according to a publication last month by the King's Fund (Windmill 2007). This report states unequivocally that without having the political expediency to admit we have a market, we will continue down the contradictory route of performance management and a half-hearted market, which will leave the NHS 'in the worst of both worlds: the costs of a more competitive market without the benefits'.

While happy to liberalise the supply side, the White Paper is a lot more guarded on strong, patient-led, commissioning. Yes, it advocates primary care commissioners, which

will at least in theory allow clinicians to act as the patient voice and hold real budgets (bringing commissioning much closer to the patient than through PCTs), but there are so many mentions of performance management one has to wonder what the real outcome will be. There is, for example, little discussion of how to encourage truly impartial commissioning (other than stopping PCTs from providing services to avoid conflicts of interest), or of any failure regimes for poorly performing providers. It is also questionable whether individual - or even groups of - GP practices will have the capacity and bargaining power to commission effectively.

An interesting suggestion that is made, however, is to allow 'those living with long-term conditions to exercise wider choice and voice in the care they receive [through] the widespread use of individual budgets'. The implication being that healthcare is optimised through actually giving the patient the money to spend, which can only really be done universally through an insurance-based system. A more radical suggestion for reform that should seriously be considered is to scrap funding through general taxation. Get the government to lay down the minimum healthcare package that has to be provided, make PCTs insurers, open them up to competition from the private health insurance market (which at the moment is something of a sleepy backwater), and allow patients to vote with their feet by choosing the health service they want. Only then will the 'NHS' really have the proper incentives to provide world-class healthcare for its patients.

This would not be committing political suicide. A 2006 ICM poll found that two thirds of voters believe that in its present form the NHS is unlikely to ever meet public demands, however much is spent on it; and almost half agreed that instead of paying taxes for the NHS, we should have a European-style system where everyone takes out health insurance and the government tops up the payments for people who can't afford the premium. This is unsurprising. General taxation is not the only way to have a universal and comprehensive health service. In European countries such as France, Germany, Holland and Switzerland, social/private insurance enjoys the support of parties of the Left, whose main concern is that the poor of their own countries should have the best health care money can buy.

Again, this is unsurprising, because their systems have consistently provided better health outcomes, for both the poor and the rich, than the NHS. The NHS, at least by international standards, really isn't a very good health system. Take the main killer diseases: cancer, coronary heart disease and stroke. The OECD measures deaths before the age of 70 that were potentially preventable by good medical care. The UK had the third worst death rate from cancer in nine developed nations in 2003. For ischaemic heart disease, the UK had the second worst death rate in 2000 and was still there in 2003. An OECD report on strokes found that in 1998 the UK was by far the worst performing country measured by deaths within 30 days. Fatality rates were often double those in 11 other countries. Despite recent reforms NHS patients still wait far longer for treatment. In 2005, 41 per cent of UK patients waited four months or longer for elective surgery, compared with 33 per cent in Canada, 19 per cent in Australia and less than 10 per cent in the US and Germany.

It's time for a more radical change.

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