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BUILDING ON NHS REFORMS

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SUMMARY

The Health and Social Care (Community Health and Standards) Bill – which has its second Commons reading on Wednesday 7 May – is the first step towards the denationalisation of UK healthcare provision.

This Bill introduces legislation for the creation of Foundation Trust status for (eventually) all UK hospitals.

Charges of 'two-tier service' are misplaced: the Foundation Trusts initiative will help deprived communities the most.

Foundation Trusts will stimulate the development of integrated healthcare – probably the most beneficial development for 21st century medicine.

However, the value of the proposal is largely in its implications: the current Bill does not go nearly far enough.

As an immediate next step the Government should extend Foundation status to Primary Care Trusts.

CHAPTER ONE
THE LONG VIEW

The Government introduced the Foundation Trust (FT) initiative with the suggestion that only a handful of "Three Star" NHS Trusts would qualify for FT status. But it has now been announced that by 2008 all NHS hospitals will operate as FT hospitals.

The FT concept amounts to the complete separation of the provision from the purchasing of healthcare. Indeed, rather than the 'internal market' of the 1990s – summarily abolished in 1997 but now in practical terms reinstated – we are moving towards an 'external market'. For under these proposals, by 2008 Britain will be the only country in Europe to have all its hospitals operating, at least notionally, in the independent sector.

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In time, this policy could lead to a complete overhaul of British healthcare. For not only does FT status amount to the State abandoning the ownership of hospitals: it will help create a climate in which various forms of private funding can thrive. This could be the first step towards the denationalisation of UK healthcare provision.

CHAPTER TWO
THE NEED FOR CHANGE

The need for change in the NHS is starkly apparent. The current system is a corporatist monopoly which suffers all the ills which industry suffered before the salutary reforms of the 1980s: over-employment, low productivity and diminishing returns. Most of all it is the victim of pernicious 'stagflation', by which periodic bouts of Treasury largesse are followed by wage inflation and continued low productivity. The last two years have shown very clearly that the system as it stands cannot deliver the kind of increases in treatment for patients which we have a right to expect – such as the three months maximum waiting times for hospital treatment common in Europe. The unlimited demand placed on the NHS acts as a constant upward pressure on prices, a pressure compounded by the legitimate claims of NHS staff for pay increases. Additional Treasury funding is merely swallowed up in pay and price rises with negligible impact on real output. Since 2000 expenditure has risen 18%, but 'medical activity' has only increased 2%.

Without Foundation Trusts, the government will soon be spending more than the European average, but getting far less in terms of medical service standards.

CHAPTER THREE
A 'TWO-TIER SERVICE'?

The case against change is usually expressed in the phrase 'two-tier service'. The argument begs the question. There already exist unacceptably wide disparities in standards of service, which current policy – centralised public-sector management – has caused and will not address. Funding increases have not helped reduce structural inequalities in healthcare provision: recent data from the Dr Foster medical comparison website shows that existing disparities have shown very little change in the past two years.

The initial list of trusts applying for Foundation status shows that much of the interest comes from deprived areas.

The 'two-tier' charge may have had more validity when the Government was only offering FT status to a handful of high-performing hospitals: it could legitimately be said that FT hospitals would poach resources and staff from neighbouring hospitals which lack their flexibility and freedoms. However, all acute hospitals are now to be helped to achieve FT status within three to four years. They will have to achieve "Three Star" status to qualify: the suggestion that some Trusts might find this difficult is an argument for change, not for maintaining the *status quo*. Allowing all Trusts to achieve FT status will act as a stimulus to improvement; the reform will have a positive impact even in its preparatory stages.

It is also often asserted that only hospitals in affluent areas will achieve FT status, leaving Trusts in deprived areas as a sort of rump NHS. But the development of the policy since it was first announced should have done a great deal to reduce anxieties. The initial list of Trusts shows that much of the interest comes from

deprived areas. There is a striking absence of hospitals from more affluent areas in the South East. Trusts applying include those in Liverpool Aintree, Basildon and Thurrock, Bradford, Sunderland, Hackney, Rotherham, Sheffield and Walsall. Of large London hospitals only three have applied.

The concern that the limitation to "Three Star" Trusts might narrow the field, so that only large acute hospitals in the big cities would apply, has turned out to be misplaced. Indeed the reform could help break down the dominance of such Trusts (largely the result of the exercise of covert professional pressure to concentrate high-tech medicine in a few large cities) and allow a much wider range of acute hospitals to play a leading role in acute healthcare provision.

CHAPTER FOUR
INTEGRATED CARE: THE CHALLENGE

The Foundation Trust programme must be understood in the context of the changing nature of healthcare. The largely intervention-based understanding of medicine, focusing on acute services and the expertise of consultants, is being replaced by one based on preventative, holistic and patient-owned treatment. Features of the developing system include:

- A more nuanced and qualitative assessment of health. Aims for care will be defined in terms of improved quality of life and social functioning. Expected outcomes will be predicted in advance and there will be care programmes over a period of years.
- Increased investment in prevention and early intervention in order to reduce ill-health and cut costs.
- New kinds of partnership between patients and professionals so as to increase motivation and give patients more information about options.
- New settings for care with more ambulatory care and shared care. Secondary care will be less about intervention and more about investing for information and skill development.
- More innovative approaches to chronic disease management, involving more support at home, acceptance of the expertise of patients and increasing effectiveness of drug therapies.
- Further development of the role of primary care in managing treatment programmes and reaching local populations.

The emerging principle of 21st century medicine is integrated healthcare – with the most important treatment often taking place outside hospital. The Foundation Trust concept fits directly into this emerging picture. Currently, Britain has a revolving door hospital system with 1000 acute bed days per year per 1000 population compared to 270 with Kaiser Permanente, a non-profit private health insurer and provider in the US. Foundation Trusts will have the incentive and the flexibility to develop new kinds of service outside hospitals. In Bradford, Sunderland and Walsall local managers have already expressed strong support for Foundation Trust concept in terms of creating new opportunities for more flexible working.

The emerging principle of 21st century medicine is integrated healthcare – with the most important treatment often taking place outside hospital.

The impetus to integrated care will come from the new set of economic incentives that Foundation Trust hospitals will be operating by. Under the present system any gains from greater efficiency disappear into the general stream of public expenditure. In the case of FT hospitals, however, local stakeholders – the local community – will own these gains. Moreover, unlike current Trusts, FT hospitals will have to earn their own revenue through local contracts. If they can deliver a given quality at lower cost, they will be able to keep the surplus for further NHS development. They will have much greater incentives to rethink how services are delivered: and the flexibility to develop new kinds of skills and staff teams. The gains from innovation will stay in local communities and benefit patients in local communities – including some of the most deprived.

Foundation Trusts will be able to escape from the NHS trap of low aspirations. There is no reason why a Trust, if it had real freedom to manage its resources effectively, could not achieve European levels of healthcare within three years from now. For the hospital – not the bureaucracy above it – will have the ownership of problems, most particularly the problem of waiting times. One obvious advantage of FT status is the freedom to develop more flexible ways of working. A hospital might introduce a fee-for-service system to reward teams for reducing waiting times.

More generally FT hospitals will have the freedom to develop joint projects with local companies and voluntary organisations. They will be able to play a much larger part than currently in local efforts for community regeneration.

CHAPTER FIVE
THIS IS NOT NEARLY ENOUGH

The value of the Foundation Trust proposal is almost all in the rhetoric. The reality falls sadly short.

While the new arrangements will prompt some basic incentives to integrated care and the setting up of joint ventures, Foundation Trust hospitals as envisaged in the Bill and supporting literature will remain hobbled by Department of Health oversight and intervention. Unless serious extensions are made to the freedoms offered to Foundation Trusts the initiative will be a redundant one. The Government will have gone through political purgatory and still have failed to create effective new services.

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Most immediately, clarifications are required as to the nature of the freedoms already being offered. It has been stated that Foundation Trusts will be able to develop joint projects with 'local companies'. Does that include the freedom to develop new kinds of joint enterprise with private companies in diagnostics, IT and care programmes? And will they be allowed to contract with PCTs on joint programmes? Trusts are to be allowed to retain their 'surpluses' from year to year. Will they be allowed to retain any savings they can make from reduced in-patient care, and invest them in new kinds of programme, including staff support?

Even if these freedoms are granted there remain far more serious restrictions on the operational autonomy of Foundation Trusts as currently envisaged.

Firstly, FT hospitals will remain subject to the same performance and rating regime as the rest of the NHS, with the possibility that if they lose their "Three Star" rating, they will lose their FT status. This will act as an inhibitor of innovation and development and keep the hospitals in thrall to the DoH.

Secondly, FT hospitals are prevented from altering the range of services they supply: they will not have autonomy over the product they offer. A system of integrated care must involve flexibility and diversity on the supply-side of medicine: this is specifically forbidden in the current plans. To change services, hospitals will be required to undergo a bureaucratic process of consultation with local government, through the mechanism of "Oversight and Scrutiny Committees"; they will also be subject to the dictat of the DoH-appointed Independent Regulator.

Thirdly, perhaps the most important freedom of all – the freedom to alter pay rates – is by no means guaranteed. While FT hospitals are supposedly allowed to vary the NHS rates in order to recruit and retain staff, this freedom is subject to the proviso that such action does not "undermine" other NHS providers; this clause would allow the Independent Regulator to impose the national pay scales on a FT hospital.

Fourthly, Information Technology, a vital element for flexibility, patient-empowerment and integrated care, will remain under the control of the DoH. FT hospitals must conform to the NHS Strategy for Information Management and Technology.

Fifthly, FT hospitals are denied the essential freedom to raise money on the capital markets. They will only be allowed to borrow with the approval of the Independent Regulator, on terms laid down by the Treasury, and their borrowing will remain in the government accounts. For while FT hospitals are being granted notional independence – including ownership and control of their assets – they remain to all intents and purposes within the public sector.

While the Treasury continues to disburse all the money in the system, FT hospitals will still have regard more for the Government than for the patient and the local community.

The denial of the right to raise private finance illustrates the curious irony of the FT initiative. While the rhetoric, and the long-term implication of the proposal is to knock down the artificial wall separating the public from the private sector, current conditions specifically maintain it.

Ultimately it is only changes to the financing of the health service that will deliver improvements. While FT status offers a far more plural supply side, autonomy of provision will avail the NHS little unless there is a corresponding autonomy of funding on the demand side. While the Treasury continues to disburse all the money in the system, FT hospitals will still have regard more for the Government than for the patient and the local community.

MORE FREEDOM

FT hospitals are already allowed to keep their 'surpluses' – a.k.a. profits – and this right should be extended. They or their subsidiaries should also be allowed to develop their own "local community health insurance products" too. Indeed, it is likely that many Foundation Trusts would want to explore possible arrangements with health cash plans, commercial Private Medical Insurers and even trade unions, as well as a host of professional bodies.

Further diversification could take place on the supply side, too. At present, ministers like to distinguish acute NHS Trusts from other NHS operations such as Diagnostic and Treatment Centres (DTCs) and the NHS franchising arrangements, both of which are developing in a more liberal direction. Is it not the case that if a for-profit company such as General Healthcare can design, build and operate a DTC, then in time, Foundation Hospitals may well be encouraged to travel down the same 'for-profit' route?

Indeed, just as all NHS hospitals and units should have Foundation Status, so they surely should have the freedom to choose their ownership philosophy? If the not-for-profit model is so effective and robust it should not need to be artificially protected by the government.

The FT initiative opens the door to far more profound reform than is actually envisaged in the proposed legislation. But there is one immediate step forward which the Government could commit to without altering the terms of the current Bill.

CHAPTER SIX
NEXT STEPS: FOUNDATION PCTS

The paradox of the Foundation hospitals initiative is that it will enable reform of the most important area of healthcare of all: primary care.

The importance of primary care is widely acknowledged. However, all the momentum in the health service runs counter to this imperative. Acute hospital services continue to attract the bulk of funding and political attention:

- According to the Audit Commission, spending on hospital services rose 60% over the period 1992-99 while spending on General Medical Services rose 20%.
- Primary Care Trusts, the commissioning bodies, have had to give an absolute priority to waiting time targets. They have had to put funding of hospital activity before investment in community care.
- Expansion of staff numbers has been much more rapid in the hospitals than in primary care. Over the last five years the number of hospital consultants has risen 25% while the number of GPs has fallen. The number of practice nurses rose 5% while the number of nurses employed in hospitals has risen 15%.
- The number of consultants is set for further expansion at a far faster rate than the number of GPs.
- The costs of PFI (acute hospital) schemes will also have to be a first priority for extra spending. Thus the momentum of current waiting time targets and of spending commitments will tend to pull more spending towards the acute sector.

- The NHS has a concealed problem in the low level of funding and staffing of primary care services in deprived areas. In the past the number of practice nurses and other key team members depended on the numbers of GPs. The new practice-based contract will help to change this but it will take at least five years to make a real difference. At present in areas of highest morbidity, the primary care teams for National Service Frameworks are half the size of those in more affluent areas.

It is at the level of primary care, rather than in the big hospitals, that the 'two-tier service' is a reality. The freedoms planned for acute hospitals under the FT scheme will help relieve this problem. The governance system of the Trusts will contribute to closer working with primary care. PCTs will be represented on FT Boards and they will have much greater role than they have at present. Governance and economic incentives will both stimulate much more joint working with primary care.

It is at the level of primary care, rather than in the big hospitals, that the 'two-tier service' is a reality.

However, PCTs are largely subject to DoH management. As we have suggested, while the funding and commissioning of care remains with the Government, liberalisation of the provision arrangements will have little impact on service standards.

Primary Care Trusts are the vehicle for commissioning services in the NHS. They have control over roughly three-quarters of the NHS' budget in England. They, too, should be given Foundation Status, and freed from some of the restrictions on their decisions – such as the requirement to focus on acute waiting times – which hamper their ability to provide holistic and integrated care. They should be able to access alternative sources of finance and to develop community services on their own initiative as well as to enter partnerships with secondary care providers – NHS, voluntary and commercial.

Foundation PCTs would mean that two sides of the NHS (the provision and commissioning of services) would be placed under independent local management. The Government has already intimated that this is the direction it would like to travel in (it has also expressed its intention of extending the FT concept to Mental Health Trusts). The present Bill should be just the beginning.

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