‘Things can only get better?’ - the argument for NHS independence

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Part of the problem with the NHS is that health care is so important to the general public that politicians have no choice but to intervene. From Margaret Thatcher’s “the NHS is safe in our hands” to Tony Blair’s “one day to save the NHS”, politicians from all major political parties recognise that the NHS is an acid test of their performance in government. In many ways, of course, political involvement in the NHS is desirable and necessary – in a parliamentary democracy like the UK, it is entirely right that our elected representatives should have a key role to play in ensuring that the NHS delivers high quality services to those in need and that significant sums of taxpayers’ money are invested wisely for the collective good.

However, there are also situations where political involvement is neither necessary nor appropriate, and where over-involvement by national politicians can actively hinder service delivery. A good example here is the repeated reorganisation of NHS structures (which has been gathering pace in recent years) and an arguably hyper-active policy context, in which initiative after initiative is introduced before previous changes have bedded down (see Box 1). In recent years, the NHS has witnessed:

- A rapid turnover in Secretaries of State for Health and senior government advisors.
- Repeated reorganisation of NHS structures, with the introduction and then the subsequent merger of Primary Care Trusts, the advent of Foundation Trusts, the reorganisation of mental health services and several reorganisations of regional health bodies.
- As part of this process, an ongoing shift between structures based on local responsiveness and a system based on economies of scale.
- The introduction, abolition and subsequent merger of various health and social inspectorates (one of which only lasted 17 days before it was abolished).
- The creation and subsequent abolition or merger of various bodies designed to support service improvement (such as the NHS University and the Modernisation Agency).
- The abolition of GP fundholding followed by a later emphasis on (GP) practice-based commissioning.
- Ongoing shifts in the extent to which either competition or collaboration are the best way of improving services.

Of all the issues raised above, it is the repeated reorganisation of the NHS that has attracted some of the most criticisms in recent years. Whilst some of the other policies outlined above have their critics and their supporters, all the available evidence on reorganisation suggests that (see, for example, Peck and Freeman, 2005; SSI/Audit Commission, 2004):

- Structural change by itself rarely achieves stated objectives.
- Mergers typically do not save money – the economic benefits are often modest at best and are more than offset by unintended negative consequences such as a potential reduction in productivity and morale.
- Mergers are potentially very disruptive for managers, staff and service users, and can give a false impression of change.
- Mergers can stall positive service development for at least 18 months.

As a result, many NHS managers find themselves focusing less on making current systems work as on preparing for the next reorganisation. This quickly leads, as Kieran Walsh (2003, p.108) has argued, to a situation in which the NHS has increasingly become “an organizational shantytown in which structures and systems are cobbled together or thrown up hastily in the knowledge that they will be torn down in due course.”

Box 1: The impact of rapid reorganisation and hyperactive policy

The results of constant change are “large financial deficits, low productivity, and deep cynicism in clinicians, who see each innovation as having a half life of two to three years before it is either abolished or displaced by another.”

(Gwyn Bevan, Professor of Management Science, London School of Economics, 2006)

“The panoply of changes, the sudden policy corrections, and the impatience that makes plans end before gaining traction create confusion and cynicism for even a willing workforce. If the NHS was a publicly traded company, stockholders would flee because of its unsteadiness of course.”

(Don Berwick and Sheila Leahtereman, Institute for Healthcare Improvement, 2006)
While recent debate has centred on ongoing NHS reorganisations, there is also wider concern about a more general tendency for detailed targets and micro-management of NHS services to detract attention away from the NHS’s primary aim – providing high quality health services and improving the health of the population. As an example, Box 2 sets out some recent examples of what we see as inappropriate central intervention in the NHS. In most (if not all) of these cases, the role of the media has arguably been central – and it may well be that it is the pressure (real, perceived or self-perpetuating) to respond to bad news in the media that prompts such constant interventions. Also significant are the short timescales with which politicians have to work – with the next election fast approaching, it can be easy to become frustrated with the time that any new initiative takes to be successful (or not).

Behind all these quotes, examples and issues is a strong sense that the NHS is so politically important that being seen to do something is often more important than doing the right thing. This manifests itself in a myriad of ways throughout every level of the health service, and often leads to policy statements that central government will seek to ‘shift the balance of power’ closer to the front-line (Department of Health, 2001). In practice the government seems to have found it hard to let go – seemingly believing in the need to devolve decision making, but not quite trusting those at ground level to do it properly. This then results in a rhetorical commitment to devolution, coupled with ongoing micro-management of everyday NHS activities, which infuriates managers and clinicians alike. While Nye Bevan said that the sound of a dropped bedpan in Tredgar should reverberate around the Palace of Westminster, he surely would not have wanted to distribute bedpans, empty them and clean them out all by himself.

The irony of this situation is that it is damaging both to the NHS and to politicians. Every time they intervene in the NHS, politicians deepen an already widespread belief amongst the public and in the media that politicians are personally responsible for everything that happens in the health service. This then leaves the Secretary of State in an impossible situation – responsible for managing one of the largest organisations in Europe, and personally criticised whenever anything goes wrong (irrespective of whether the issue at stake is actually the fault of the Minister or not). A classic example is the now notorious incident in which Tony Blair was confronted by the partner of a cancer sufferer about conditions in the health service. In the build-up to a general election, this was a damaging incident for New Labour just hours after the launch of their manifesto. Tragic though this case was, it is clearly impossible for one politician to be held personally responsible for the care of every single patient, and we see this as evidence of a tendency in the media and amongst the public (albeit fuelled by politicians themselves) to over-estimate what can be reasonably expected of elected politicians when it comes to the day-to-day realities of the NHS.

In response to this situation, there have been two main developments. First, and for some time, the government has been taking steps to grant some areas of the NHS greater freedom from central control. Examples here include the advent of Foundation Trusts, the creation of independent regulators and the powers given to bodies such as NICE. This is particularly the case for provider organisations (hospital Trusts, mental health providers and, in future, possibly community health service providers too). In future, the relationship between the government and the NHS is likely to be with Primary Care Trusts and practice-based commissioners – those bodies tasked with commissioning services from an increasingly diverse and potentially more autonomous range of service providers.

Box 2: Examples of government intervention and micro-management

- Ongoing reorganisation of NHS structures (see above).
- Intervention by the Secretary of State to fast-track use of the cancer drug, Herceptin, in advance of decisions by NICE (the body tasked by government to investigate the effectiveness of new drugs).
- The inquiry that followed photographs in local and national newspapers about dead bodies on the floor of a chapel at Bedford Hospital (with the Secretary of State making a statement in the House of Commons).
- The imposition of Independent Sector Treatment Centres (ISTC) – particularly in areas such as Oxfordshire which felt that they did not need this extra capacity. They subsequently turned out to be right, leaving PCTs to pay for care that they did not want, did not need and did not use.
- The topslicing of PCT budgets to offset overspends elsewhere in the system.
- National guidance in the summer of 2005 which appeared to call for PCTs to divest themselves of their provider services. This came out of the blue with no consultation and was subsequently partially retracted. However, ongoing doubts remain about what is likely to happen (causing considerable unrest for staff).

“The NHS more and more resembles an organizational shantytown in which structures and systems are cobbled together or thrown up hastily in the knowledge that they will be torn down in due course.”

(Kieran Walshe, Professor of Health Policy and Management, University of Manchester, 2003, p.108)
Second, and potentially more radical still, there have been a series of recent calls for NHS ‘independence’. While politicians should have a key role to play in setting overall priorities and holding the NHS to account for its performance, it is argued, the design and delivery of services should be left to those who know best. The NHS, after all, is a massive institution with a substantial budget and significant numbers of staff, and the detail of how best to deliver desired outcomes is surely best left to those with the skills and experience to manage such a complex organisation. As Griffiths argued in 1983, “the NHS is one of the largest undertakings in Western Europe. It requires enormous resources; its role is very politically sensitive; it demands top class management” (p.11).

Indeed, the reference above to Griffiths’ 1983 review tells its own tale - despite what seems like an increase in the rate and pace of change, this is not a new issue, and creating some sort of NHS agency or arms-length body has been discussed in various previous reviews and discussion papers over many years (see, for example, Royal Commission on the National Health Service, 1979; Griffiths, 1983; Langlands, 2003; Dewar, 2003; see also Box 3).

Interestingly, however, recent calls have come from both New Labour and from David Cameron’s Conservatives (Burnham, 2006; Press Association, 2006; Cameron, 2006). At the very least, there seems to be an appetite for creating some sort of NHS constitution, setting out core principles on which future services will be based (Burnham, 2006; Department of Health, 2006). However, rumour is also rife that Gordon Brown could do for the NHS what he did for the Bank of England when he gave them the power to set interest rates, and the possibility of a Brown premiership makes the possibility of more genuine NHS ‘independence’ seem less remote than might previously have been the case.

Extending our earlier analysis, however, it is hard to know whether this is because independence is the right way forward for the NHS, or because each of the main two parties are trying ‘to be seen to be doing the right thing’ by outbidding each other over their ‘pro-independence’ stance. Against this background, this discussion paper explores the case for independence and suggests some possible ways forward should such a policy be enacted. Drawing on examples from other sectors (see Box 4), the paper considers what we mean by ‘independence’, why this might be desirable, the kind of freedoms that an ‘independent’ NHS might need, and some possible high level targets that should shape such an organisation.

Our starting point for this discussion is that the NHS is a key British institution that is crucial to patients and to the public alike – both in terms of the services it offers and in terms of the values it embodies. In a time of rapid change, indeed, the NHS may even be seen as central to our identity – if we asked the general public what made them proud to live in this country or what they saw as a key symbol of what being British is all about, then the NHS would be likely to emerge as a key national asset and symbol. As a result of this, it is entirely appropriate that the NHS should work to priorities and within parameters set by elected politicians, and that it should be accountable to our elected representatives for the quality of its services and its use of taxpayers’ money. Independence, in our use of the term, should not mean freedom from accountability.

However, we believe that the NHS needs to be at the “high independence” end of the continuum set out in Box 4 and Figure 1. As a result, we believe that the role of national politicians should be to:

- Negotiate the overall priorities of the NHS and the targets it should be striving to achieve.
- Draft appropriate legislation.
- Determine funding.
- Hold NHS commissioners to account for the performance of health services.
- Within these parameters, however, we agree with Dewar’s (2003) previous analysis that the NHS should be free to:
  - Allocate money to NHS organisations.
  - Manage performance in line with national targets.
  - Take a lead on improving NHS organisations.
  - Set clinical standards.
  - Co-ordinate national undertakings (for example, research and IT strategy).
  - Negotiate pay and conditions.

However, to this list, we would add an additional freedom - the right to decide the best organisational structure for the delivery of healthcare so as to best meet commonly agreed targets and performance indicators. In the past, we believe, government intervention has tended to focus on issues of process (what the NHS does and how it does it), not on outcomes (what this actually achieves for patients).

While further work will be required around the detail, we propose that the government and an ‘independent’ NHS might adopt the following process for agreeing targets, allocating resources and ensuring appropriate accountability (see Box 5).
Box 4: Examples from other sectors

Independence is not a singular concept – instead, there is more of a continuum with varying degrees of administrative independence and political control (see figure 1).

The BBC is often used as an example of one of the more advanced models along the continuum. The BBC is an independent public body, established under Royal Charter. Under the charter, the BBC is governed by the BBC Trust, which sets the strategic direction of the BBC and has a clear duty to represent the interests of licence fee payers. The Trust ensures the independence of the BBC, engages the public and holds the Executive Board to account for its performance in delivering services. Operational responsibility rests with the Executive Board whose 15 members ensure that the BBC’s services and running are in accordance with the overall strategy set by the BBC Trust.

The Bank of England is also frequently cited as an exemplar of independence, and one associated with the incumbent government (and the Chancellor in particular). The Bank of England is a public organisation and is accountable to Parliament – principally via the House of Commons Treasury Committee. The 1998 Bank of England Act altered the constitution and functions of the executive management committee – The Court of Directors – along with the transfer of the monetary policy objective. The Court consists of the Governor, two Deputy Governors and 16 Directors (all non-executive). The Court is responsible for managing the Bank’s affairs other than the formulation of monetary policy (which is the responsibility of the Monetary Policy Committee). The Court determines the Bank’s objectives and strategy with an aim to ensure the Bank makes the most efficient and effective use of its resources. Nedco is a sub-committee of Court made up of the non-executive Directors and a chairman appointed by the Chancellor of the Exchequer. NedCo reviews the Bank’s performance in relation to its objectives and strategy and monitors the extent to which the Bank’s financial management objectives are met. NedCo is also responsible for reviewing the procedures of the Monetary Policy Committee (MPC). The MPC is a committee of the Bank which sets a framework for its operations. The MPC is overseen by NedCo and has clear objectives laid out under the 1998 Act.

The Republic of Ireland has established a Health Service Executive (HSE), which replaced the previous Health Board structures and concurrently sought to centralise control of health and personal social services, and also create some degree of political independence for these services. In this way, the HSE operates as an executive agency, which is further down the continuum of independence from the examples outlined above. The HSE exists outside of the Department of Health and Children, with its own board. However, it is ultimately accountable to the Minister for Health and Children for the management of health and personal social services. The HSE has a Chairperson plus ten Board members (appointed by the Minister), and a Chief Executive Officer (appointed by the Board), plus a management team of eleven. The Health Act 2004 states the objective of the HSE is to use resources available to it in the most beneficial, effective and efficient manner to improve, promote and protect the health and welfare of the public. The HSE delivers services through four Regional Health Offices.

Further down the spectrum again, an example can be found from the Department for Work and Pensions (DWP). Like all government departments, the DWP has a series of objectives that are underpinned by a Public Service Agreement that sets out specific targets that must be met in return for resources from the Exchequer. However, the DWP does this by providing services by or through formally designated Executive Agencies (Jobcentre Plus, The Pension Service, Child Support Agency, Disability and Carers Service, the Appeals Service and The Rent Service). The Secretary of State has overall statutory authority and accountability to Parliament for all matters associated with the Department. The Secretary of State agrees the allocation of resources with the Department, drawing on advice from the Head of Department. Each Agency is headed by a Chief Executive who is responsible for delivering specified outcomes. The Chief Executives are responsible for meeting operational and performance targets within resource allocations as agreed with Ministers and the Head of Department.

Figure 1: Independence as a continuum

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<tr>
<th>Independent Public Body</th>
<th>Executive Agency</th>
<th>Current NHS</th>
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<td>(e.g. BBC)</td>
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High Levels of independence Low
The Secretary of State and a much-reduced Department of Health would be

In the build-up to each (three-year) Comprehensive Spending Review, the government
An ‘independent’ NHS could be overseen by an NHS Board (with an appropriate

- 1. Improving the health of population –
   As Britnell has already argued, an ‘independent’ NHS should be challenged to accelerate the improvement in average life expectancy. It should also be tasked with reducing health inequalities by at least 20 per cent for the most disadvantaged and deprived, so that an ‘independent’ NHS works hardest to help those who need it most.

- 2. Ensuring that patients are satisfied with services and that patient experience improves year on year –
   using current mechanisms for assessing public and patient experiences of the NHS, patient satisfaction should exceed 75 per cent for general approval of the NHS and for clinical services, with a year-on-year improvement. As Britnell also argues, an ‘independent’ NHS could also consider making such satisfaction ratings a part of staff pay so that clinicians are directly accountable to their patients for the quality of the service they provide.

- 3. Ensuring staff are satisfied and that staff experience improves year on year –
   in the same way as for patients, staff satisfaction should be measured to ensure appropriate levels of satisfaction and year-on-year improvements. While current reforms often emphasise the importance of valuing NHS staff, building this in to one of only five high level targets would send a powerful message that this was being taken seriously and was a core part of improving services more generally. In particular, this target has potential to link to the patient satisfaction target above, as the patient experience tends to be mediated by staff satisfaction.

- 4. Improving clinical quality and safety –
   with an independent inspectorate assessing standards, an ‘independent’ NHS should be tasked with achieving acceptable, good or excellent ratings under the new system. In addition to this target, NHS providers would be expected to demonstrate year-on-year improvements in clinical quality, building on the pioneering example of cardiac surgeons who now collect and publish data on risk adjusted death rates following surgery. The NHS as a whole would also be expected to achieve measurable improvements in patient safety, for example through adapting the 100,000 lives campaign led by the Institute for Healthcare Improvement in the US (see www.ihi.org/IHI).

- 5. Using resources efficiently –
   each NHS organisation should be tasked with achieving a surplus of one per cent a year, reinvesting this in public health and preventative services. In addition, the NHS would be expected to deliver year-on-year improvements in productivity, using a measure of productivity that reflects the full range of activity and an adjustment for improvements in the quality of care. Such a measure would build on the Atkinson Review (2005) and the analysis of the Office of National Statistics (2006).

Key targets

Box 5: Holding an ‘independent’ NHS to account

- The Secretary of State and a much-reduced Department of Health would be responsible for setting overall priorities and strategic aims.
- An ‘independent’ NHS could be overseen by an NHS Board (with an appropriate balance of NHS leaders, clinicians, patients and members of the general public).
- In the build-up to each (three-year) Comprehensive Spending Review, the government and the NHS could negotiate an agreed budget and agreed targets (see below for some more detailed suggestions). These could be set out in the form of an ‘NHS charter’ (much like the current BBC charter).
- An independent inspectorate (similar to current organisations such as Monitor or the Healthcare Commission) would assess standards and progress against agreed targets, reporting directly to the Secretary of State. Where standards were not being met, the inspectorate and/or the Secretary of State would have powers to intervene directly in the NHS (for example, to remove the NHS Chief Executive and/or Board, to agree and monitor detailed action plans in key areas of concern, or to require some sort of external support). The circumstances in which intervention may be justified would be clearly set out in the NHS charter, together with the types of intervention that were permitted.

Conclusion

In summary, this discussion paper argues that the current system allows (and indeed encourages) politicians to overstep their democratic mandate and to intervene directly in the NHS in a way that can be detrimental to the quality of service provision and to the credibility of the politicians themselves. According to our analysis, this has probably been the case for some time, but has now got so bad that it is time for a decisive change. As we have argued above, the time is right for an ‘independent’ NHS, working to priorities set by elected politicians and held to account for its performance, but with sufficient flexibility and discretion to do what NHS leaders feel would best achieve desired outcomes rather than what politicians dictate. As a contribution to the debate, we have built on the arguments of Britnell (2007) to set out five high level indicators that an ‘independent’ NHS could be tasked with achieving. Ultimately, it will only be with much greater levels of freedom and autonomy (but also with much more responsibility) than at present that the NHS can deliver the quality of service that people need and that has made the NHS a British institution.
In September 2006, HSMC’s Creating ‘NHS Local’ paper called for a fundamentally different relationship between the NHS and local government, recommending local authority-led health care commissioning. If adopted, such a proposal would help to take the (national) politics out of the NHS, albeit replacing this with local politics. As a result, both the previous and the current paper should be seen as attempts to grapple with the same underlying issues of accountability, governance and how best to deliver health care services (and hence as different contributions to and perspectives on the same overall debate).

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