When politics and markets collide: reforming the English National Health Service

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Executive Summary

Reforms to the English national health service (NHS) are using patient choice and provider competition to drive improvements in performance. In completing the design of the reforms, the government faces the challenge of ensuring that commissioners can negotiate on equal terms with providers, and that appropriate arrangements are put in place for market management and regulation. Politicians also face the challenge of dealing with NHS providers that get into difficulty. The experience of implementing changes to the role of Kidderminster Hospital demonstrates the political risks involved in promoting reforms that affect the public’s access to valued services. With an increasing number of contested major service reconfigurations emerging, much hinges on the ability of the Independent Reconfiguration Panel to develop into a credible and respected source of advice to the government. If this challenge can be met, then the Panel may offer a way of reconciling the logic of a system driven by competition but overseen by politicians.

Introduction

The English national health service (NHS) has been on a roller coaster ride of reform in the last decade(1,2,3). On its election in 1997, the Labour government turned its back on the internal market in health care introduced by the Conservative government and relied on national targets for service improvement and performance management as the main instruments of reform. Four years later the government published Shifting the Balance of Power(4) in which it set out a commitment to devolve responsibility for budgets and services to NHS organisations at a local level, within the framework of national targets and standards that had been established. The wheel turned full circle in 2002 when Delivering the NHS Plan(5) announced plans to expand patient choice and introduce greater plurality among providers, foreshadowing the reintroduction of provider competition into health care in England.

The re-election of the Labour government in May 2005 for a third term (without precedent in the history of the Labour party) led to a reappraisal of the programme of NHS reform, the results of which were published in Health Reform in England: update and next steps in December 2005(6). This document summarised the many improvements achieved by the reforms, including increases in staff, reductions in waiting times for treatment, and better outcomes in major disease areas such as cancer and heart disease. It emphasised that ‘Improvements have been made through a combination of centrally driven targets and a huge amount of hard work on the part of NHS staff(7), adding that a different approach was needed to ensure change in future. Specifically, Health Reform in England: update and next steps argued that the NHS had to become ‘self improving’, driven by patients rather than politicians. This meant finding the right balance of incentives, patient choice, plurality and transparency in the system(8).

Further detail on the direction of health reform was provided in Health Reform in England: update and commissioning framework, published in July 2006(9). This document described the organising framework for the health reforms as being based on four elements. These were:

- more choice and a much stronger voice for patients, connected to strong commissioning by primary care trusts and practices
- more diverse providers with more freedom to innovate and improve services
- money following the patients, rewarding the best and most efficient providers, giving others the incentive to improve, and
- a framework of system management, regulation and decision making which guarantees safety and quality, equity and value for money

A programme of further work was described in the document, designed to provide more detail on each of these elements and how they related to each other.
The implication of the post election reappraisal is that provider competition will become an even more important driver of reform in future, and national targets and performance management will become less significant. Competition will be stimulated by the policy of extending the range of choices available to patients, and introducing greater plurality among providers. Choice and plurality will be facilitated by new financial incentives in the form of the so called ‘payment by results’ policy under which money will follow patients to the providers of their choice. The theory behind the reforms is that empowering patients and encouraging new providers into the market will create a dynamic for improvement from within the NHS, thereby enabling politicians to be less involved in micro managing change. The challenge in implementing this theory is to ensure that the design of the emerging market is appropriate and to reconcile the logic of a system driven by competition but overseen by politicians.

The design of the market

The supply side

On the supply side, the NHS market in England comprises public and private providers. The public providers are NHS trusts that own and manage hospital, community, mental health and ambulance services. The aim of the reforms is to turn these organisations into NHS Foundation Trusts, a new kind of public benefit corporation operating in a much more business like way than NHS trusts. By the beginning of 2007 there were 58 NHS Foundation Trusts in existence and their performance is overseen by a new regulator, Monitor. The role of Monitor is to assess applications for NHS Foundation Trust status, monitor their performance and intervene if there is a danger of the Foundation Trust authorisation being breached. The expectation is that most NHS trusts will become NHS Foundation Trusts by 2008. The governance of NHS Foundation Trusts is designed to ensure closer involvement of staff, patients, the public and other stakeholders than is the case in NHS trusts, as part of the policy of devolving responsibility for budgets and services to organisations at a local level.

If NHS Foundation Trusts represent a significant departure that was strongly contested by some elements in the Labour party, then even more radical is the policy of procuring additional treatment capacity from the private sector. Under this policy, the government has negotiated contracts with private sector providers to establish new treatment centres to deliver care to NHS patients. Treatment centres carry out elective surgical and diagnostic work that is simple and repetitive and does not require the full facilities of an acute hospital. The government has also made use of spare capacity in existing private hospitals to treat NHS patients in order to hit the targets that have been set for reducing the time patients have to wait for treatment. The stated aim is that around 10% of elective surgical work will be carried out in private hospitals and treatment centres, paid for by the NHS, by 2008. The willingness to use the private sector is one of the factors that has contributed to waiting time improvements.

The demand side

On the demand side, the NHS market comprises primary care trusts that have responsibility for managing budgets allocated by the Department of Health and commissioning services for the populations they serve. Budgets are calculated using a needs-based formula that reflects the size of the population and its age and disease profile. Primary care trusts use their budgets to directly provide some services and to commission others. The services commissioned by primary care trusts include those provided by GPs and the teams with which they work, and hospital and other services provided by NHS trusts and the independent sector.

The demand side has undergone significant change in recognition of the need to strengthen the commissioning of services. This has involved a reduction in the number of primary care trusts from around 300 to 152, and the devolution of budgets from primary care trusts to primary care practices. The expectation is that in many cases this will entail networks of practices in the same area working together to control a budget. To avoid an increase in transaction costs, the negotiation of contracts is undertaken by primary care trusts on behalf of practices. More specialised services are commissioned by primary care trusts either individually or working in collaboration with other trusts. The aim of devolving responsibility for budgets to practices is to secure greater clinical engagement in commissioning and to create incentives for primary care teams to use resources more efficiently.

Financial flows and incentives

The supply side and the demand side are linked by the new system of financial flows known as payment by results. Under this system, government determines the prices of treatments through a national tariff based on the current average cost of providing these treatments. The tariff is being introduced in stages and in 2007 covers around 30% of NHS spending. The importance of payment by results, which is more accurately described as payment for activity, is that providers are paid for each patient treated instead of working under the terms of block contracts. Money therefore follows patients to the providers of their choice and providers compete on the basis of their accessibility and quality rather than price. Providers whose costs are above tariff will find themselves under pressure to increase efficiency. As in other countries that have implemented this form of funding, it is expected that lengths of stay in hospital will fall and there will be a move to substitute ambulatory surgery and outpatient care for inpatient treatment.

Market management and regulation

Market management and regulation are under review to ensure that appropriate
and proportionate safeguards are in place as the NHS moves away from national targets and performance management to choice and provider competition as drivers of reform. Under proposals published in November 2006(10) responsibility for regulating standards and quality will transfer to a new organisation bringing together the work currently done by the Healthcare Commission and the Commission for Social Care Inspection. Alongside the new regulator, Monitor will continue to hold NHS Foundation Trusts to account for their performance, and primary care trusts and strategic health authorities will be responsible for system management within their areas. The system management role includes promoting choice and competition.

One of the challenges facing the bodies responsible for market management and regulation is how to deal with providers that get into difficulty. If patient choice and provider competition result in some hospitals losing market share and having to scale back their activities, who will be responsible for handling the consequences? If providers that get into difficulty are merged with other providers or are taken over, who will judge whether the new organisations occupy such a dominant position in the market that they will work against choice and competition? In a health care market in which the population has access to comprehensive services in every area is a key aim, who will have responsibility for ensuring that essential services are available and are not withdrawn as a result of competition?

Some answers to these questions were outlined in the government’s proposals on the future of regulation which identified roles for primary care trusts, strategic health authorities, Monitor and the regulator in dealing with providers in difficulty. At the same time, the proposals acknowledged the need for more work to develop what it described as ‘clear competition rules’ to ensure a level playing field between providers and to avoid anti-competitive behaviour. The government also announced plans to establish an insolvency regime for NHS Foundation Trusts through secondary legislation, with the aim of creating ‘a transparent regime for creditors but where essential NHS services can continue undisturbed'(11). These comments indicate the scale of the work still to be done to ensure that the design of the market is appropriate. The outcome of this work will have an important bearing on the ability of the NHS to become a self improving organisation.

The logic of competition and of politics

Equally important will be the way in which politicians respond to the logic of provider competition. Put simply, the theory behind the reforms is that long term and sustainable improvement in the NHS cannot be brought about by continued reliance on national targets and performance management. Instead, the aim is to achieve improvement by empowering patients and stimulating competition between providers.

Policy makers expect that patient choice and the incentives contained within payment by results will galvanize providers to respond to the demands of patients. If providers do not respond, then they face the threat, as in other markets, of losing income and having to scale back on their services, in extremis leading to merger or closure. On the assumption that those leading health care organisations harbour a strong survival instinct, the expectation is that providers will act to avoid this happening. In a system in which the choices exercised by patients and those advising them play an increasing part in influencing the allocation of resources, ensuring survival will depend on understanding what patients want and delivering services in a way that meets patients’ requirements.

Provider failure

On the second point, the consequences for providers of failure, much will depend on the regime for market management and regulation that is put in place. Notwithstanding the uncertainty surrounding this aspect of market design, it is already clear that NHS Foundation Trusts face a much more stringent regime than NHS trusts. Monitor, the regulator of NHS Foundation Trusts, has sent out a clear signal in this regard in its handling of financial difficulties at Bradford Teaching Hospitals NHS Foundation Trust, one of the first organisations to achieve NHS Foundation Trust status. Faced with evidence of a projected deficit at Bradford, Monitor exercised its powers of intervention by requiring the appointment of external professional
advisors, Alvarez and Marsal, to analyse the challenges facing the organisation. Subsequently, Monitor exercised its powers of intervention a second time to remove the Trust’s chairman and install an interim chairman of its choice. The Trust then decided to appoint a new chief executive and finance director and a financial recovery plan was agreed with Monitor. The explicit rules based intervention regime adopted by Monitor, which will be applied to all NHS trusts in due course, makes it clear to providers that financial failure will not be tolerated and that the jobs of senior managers are at risk if business plans are not realised.

The establishment of NHS Foundation Trusts as public benefit corporations subject to scrutiny by an independent regulator enables politicians to distance themselves from the consequences of failure. The difficulty for the government is how to handle failure in organisations that have yet to become NHS Foundation Trusts, especially where there are large financial deficits. Currently, these organisations face intervention by external turnaround teams drawn from the private sector, brought in by the government to address the problems faced by NHS trusts with the biggest challenges. The expectation is that the work of these turnaround teams will lead the NHS towards net financial balance by the end of the 2006/07 accounting year. In some parts of the country, NHS deficits affect not just individual organisations but ‘health economies’ in which commissioners and providers operating in the same local market areas face a significant shortfall in their budgets. In these areas, it is likely that reducing hospital capacity either by closing one or more hospitals or limiting the range of services they provide, will be needed to achieve financial balance.

The next stage of health reform

The expansion of patient choice, the introduction of additional private sector capacity and the implementation of payment by results will create further instability in a system that is already finding it difficult to balance its budgets.

Stimulating ‘constructive discomfort’ is in fact an explicit aim of government policy in order to unlock a system that may not change rapidly enough to satisfy patients and the taxpayers who fund the NHS. The effects of discomfort are likely to be felt most strongly in district general hospitals that have formed the backbone of the NHS for much of its history. These hospitals face the prospect of increased competition for patients and income from other NHS providers and the private sector.

They also face a threat from practice based commissioners who will have an incentive to provide some services directly rather than to refer patients to hospitals. As some of those services are delivered by other providers or outside the hospital, district general hospitals may be unable to continue to provide a comprehensive range of acute hospital services to their communities. The economics of providing care could also be affected if district general hospitals are less able to subsidise the costs of complex treatments by providing high volumes of elective and diagnostic care, should more of this care migrate to the private sector.

The future funding of the NHS will affect the way in which these issues are resolved, and the pace of change. At the time of writing, the NHS is coming towards the end of the biggest sustained increase in its funding since its establishment in 1948. Budgets have increased by around 7% annually since 2000 and will continue to do so until 2008. Thereafter, it is expected that expenditure increases will revert to the historic trend of around 3% each year. With budgets continuing to grow but at a much slower rate, competition for patients and resources will become more intense, especially with new private sector providers seeking to secure their position in the market.

In this context, NHS trusts whose hospitals have been rebuilt under the private finance initiative (PFI) face a bigger challenge than other providers in having to bear the additional costs of their new facilities. These costs, which typically extend over a period of 30-35 years, are not fully compensated under the payment by results tariff, and require providers to seek efficiency gains to enable them to repay the resources they have borrowed to fund their facilities. Already there are signs that some hospitals built under PFI are experiencing difficulty in fulfilling their commitments and the combined effects of prices being fixed under the tariff and resources to
fund services growing more slowly after 2008 suggests that PFI is storing up even greater problems in the future.

The next stage of health reform in England therefore creates a huge challenge for politicians in explaining to the public why NHS hospitals may have to change their role and in some cases close.

The Politics of Health Reform in England

It was, of course, exactly this challenge that led the Conservative government in the 1990s to have second thoughts on the implementation of the internal market reforms designed by the Thatcher administration. When the internal market created difficulties for hospitals that lost income, the government set up a review of the future of hospital services in London, where the effects were felt most strongly, and it instructed the commissioners of care not to destabilise providers in the run up to the 1992 general election. Subsequently, Conservative politicians placed much less emphasis on competition as a driver of policy, emphasising instead the need for change to be planned and for 'management reforms' rather than market reforms to be the engine of service improvement. As the politicians at the heart of the reforms later explained, their aim had never been to embrace a market in health care. Rather, they had wanted to introduce private sector disciplines into the reform of public services.

Even allowing for a degree of retrospective rationalisation, it was clear that the Conservative government in the 1990s faced the dilemma of how to reconcile a system based on competition, albeit the diluted form of competition represented by the internal market, with the inevitably in a tax funded health service of politicians steering the development of the system and being held accountable for its performance. The dilemma was resolved at that time in favour of politics rather than markets with the government changing both the reality and the rhetoric of the reforms and deciding to manage their implementation in a way that severely weakened the incentives to improve performance. In 2007, the question is whether the Labour government will similarly lose the courage of its convictions and bow to political logic, or whether it will see the reforms through to their conclusion even if this means risking unpopularity with the public over changes to the role of hospitals.

The early indications from the new Secretary of State for Health, Patricia Hewitt, suggested that the government was willing to accept that some NHS providers might fail as a result of the operation of the reforms, and that this was a necessary consequence of longer term improvements in care for patients. As she told the Financial Times in June 2005, 'there is a real risk of a unit closing because it simply can't deliver the quality of care and the value for money that all of us as patients and taxpayers want'. Shortly afterwards, the Secretary of State seemed to backtrack on this statement, arguing that 'where you have a hospital that is delivering A&E services, there is no question at all of putting that hospital service in jeopardy, because the A&E service is absolutely central'.

More recently, the Secretary of State and the Prime Minister have both reiterated the need to change the organisation of services, including closing departments within hospitals and reconfiguring hospitals. They have argued that in part this is driven by the need to eliminate deficits in the NHS, and in part by changes in medical practice. As far as the latter is concerned, a series of reports from national clinical directors published by the Department of Health have set out the reasons why some services, such as those for people suffering from heart attacks and strokes, may need to be concentrated in fewer specialist centres in the future.

Changes to the organisation of maternity services are likely to prove particularly controversial, as the experience of Halifax and Huddersfield has demonstrated. In this case, Ministers backed the decision of the Independent Reconfiguration Panel that Halifax should become the specialist centre for maternity services, with Huddersfield providing midwife led services for low risk births. Political support for this change lent credence to the Prime Minister's argument that the government would back managers in implementing necessary but unpopular service reconfigurations.

On the other hand, the opposition of a number of Ministers to proposed changes to maternity services and other forms of specialist care in several areas illustrated the difficulties facing the government in persuading its own members as well as the public that service reconfigurations would result in improvements in services.

The nature and extent of opposition to changes in service provision suggests that the Independent Reconfiguration Panel may finally be finding a role. Established in 2003, the Panel reviews contested major service reconfigurations referred to it by the Secretary of State. In practice, most of its activity involved offering informal advice and guidance to the NHS until 2006 when it received three referrals, including the case of Halifax and Huddersfield discussed above. The prospect of referrals increasing in line with opposition to proposed service changes is likely to put pressure on the limited resources available to the Panel. It will also subject the Panel’s own processes to closer scrutiny, especially among stakeholders who may disagree with its assessments. This suggests that the Panel may need to review the way in which it operates to ensure that it can demonstrate accountability for reasonableness in undertaking reviews in order to become a credible and respected source of advice to the Secretary of State. If these challenges can be met, then the Independent Reconfiguration Panel may offer a way of reconciling the logic of a system driven by competition but overseen by politicians.
To enable the Panel to perform this role, politicians must be willing to accept the advice they are offered on contested reconfigurations, not least to lend credibility to its work. In this regard, the experience of the independent external panel set up to advise on the reconfiguration of primary care trusts serves as a cautionary tale. The panel’s advice was rejected by the Secretary of State in a number of cases, with the effect that ‘politics may well creep in by the back-door even if expelled by the front-door’[23]. The issue at stake here is the willingness of politicians to make use of devices like the Independent Reconfiguration Panel that offer the potential to insulate them from politically contentious issues. The question that arises out of experience to date is whether the Panel is a sufficiently robust institutional solution, or whether more radical options, involving a much larger measure of independence for the NHS, as advocated by leading Labour and Conservative politicians, will be needed.

Conclusions

The story of health care reform in the English NHS since 1997 is a tale of learning in government and the quest for an approach that secures sustainable improvements in performance. Evidence of learning is apparent in the initial emphasis on national targets and performance management, followed by the move to devolve control over budgets and services to a local level, and the reintroduction of competition into health care. The quest for sustainable improvements in performance is evident in recognition that national targets and performance management are unlikely to deliver continuing change over time and in the aspiration to develop a system based on self improvement rather than externally imposed change.

The challenge facing the government is to design the market to create a system that is strong enough to promote self improvement, and to live with the consequences of changes driven by competition but overseen by politicians. Work on market design that has been commissioned will progressively fill gaps in the policy framework, producing greater clarity in the development of commissioning, the operation of payment by results, and the arrangements for market management and regulation. On the bold assumption that the market generates incentives that do indeed stimulate self improvement, health ministers then have to decide how to respond when providers get into difficulty. Will they accept the short term costs involved in changing the role of failing hospitals, or will they bow to political logic and intervene in the market to avoid unpopularity? And will the Independent Reconfiguration Panel offer a sufficiently robust institutional solution to this question, or will more radical options be needed?

References

7. Ibid.
8. Ibid.
9. Ibid.
11. Ibid.
13. S. Stevens op.cit.