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The most recent reforms in the NHS, viewed from the eyes of the Strategic Health Authority

The state funded, tax-based national health service in England is in transition. Once again, the Government are seeking to improve NHS productivity, service quality and outcomes and demonstrate – in the run up to a general election – that the considerable additional investment they have made in the service has been spent wisely and effectively. To most managers in the NHS this feels remarkably familiar. The successful stewardship of the NHS has for many years been a major political battleground, leading to a series of major reforms, since Margaret Thatcher's introduction of an internal market to Tony Blair's drive to free acute hospitals from state control by establishing foundation trusts.

Why these reforms?

At the heart of this desire to reform lies a deep-seated frustration with inadequate NHS performance particularly when viewed through the eyes of the electorate, including NHS staff. Whether this frustration is justified is arguable. Over recent years the NHS has made dramatic improvements in performance, significantly reducing waiting times, improving mortality rates in major diseases such as CHD and cancer and in comparison with the international health systems, at considerably lower costs and with a smaller workforce.

Yet the general perception is that the service is sub-optimal, has variable quality and that any positive public response to using the service is a consequence of "luck" rather than "service redesign". Arguable too is that service reform has been the platform for any service improvements. For many analysts, the improvements in the NHS are simply a result of funding increases leading to a growth in the "supply side" capacity, rather than of the introduction of new ways of working such as the purchaser/provider split, the drive towards a system based on managed care, the establishment of new structures such as GP fundholding and their evolution to primary care groups, and most recently the introduction of primary care trusts (PCTs) and foundation trusts. So it may be worth standing back for a moment from the debate and considering what is happening in the NHS – what lies behind the most recent reforms? What benefits or risks might they bring? Which lessons are emerging from this experience?

Key elements of the most recent reforms

In summary, the most recent reforms are based on a number of key elements.

One: creating more contestability, initially in the acute sector through the introduction of overseas teams, independent sector provided treatment centres and enabling NHS trusts to leave state control and become independent foundation trusts. Increasingly this is spreading beyond acute care into community and primary provision.

Two: developing greater purchaser capability and strength, in part by organisational change through PCTs but primarily through the introduction of a payment by results system of financial flow to reward acute providers for the volume of work they attract and provide.

Three: raising public expectation and stimulating consumerism through the commitment to allow patients to exercise choice and determine their own route through the system via direct electronic booking and holding their own electronic patient records.

Four: shifting the focus to primary prevention and the management of chronic disease, largely as a means to maximise existing NHS primary and secondary capacity by managing demand rather than continuing to expand supply.

Benefits of these changes

In practice, the underlying rationale of these changes is that involving patients in their health and choice of health care provider coupled with enhancing the capability of those organisations that commit resources on their behalf and making potential providers compete for the right to provide their care, will ultimately improve the quality (effectiveness and efficiency) of care provided. The hope of policy makers is that this in itself will create a more customer-focused service which then becomes the platform for internally driven continuous quality improvement.

However it is possible, that this explicit change to create a market for health whilst trying to maintain the values and principles of the NHS where care is free at the point of delivery may be destined to create as many problems as it solves.

Taking the reforms in turn - increased contestability will create 'losers' and it is unclear yet as to how failing or the less successful providers will be handled. In the commercial world unsuccessful providers are allowed to fail and leave the market with a loss. Will this be possible in the political environment of the NHS? Would patients tolerate the closure of local services or the rapid and frequent transfer of their management? Would the differentiation of performance between providers lead to better staff being attracted to the better performers and a rapid spiral of decline for those seen to be performing less well?

The ability to create greater strength on the purchasing side is severely limited by the available skills in the current workforce. At present Primary Care Trusts are lacking the ability to differentiate the preferences of the populations they serve, and have a poor track record of service specification and procurement. Indeed a debate is still continuing about the appropriate levels in the system (practice, PCT, regional or national) for the procurement activity to take place. If wrong decisions are taken on this, the NHS faces the prospect of higher than necessary transaction costs and services bought that bear little relationship to local need or patterns of access.

It is also true that despite the desire to create patient choice as driver for higher quality, this is constrained by the ability of the system to provide the information upon which patients can base their choice and indeed by the menu of options generated by the purchasing decisions made on their behalf by Primary Care Trusts. Under payment by results, prices are fixed under a tariff arrangement set nationally and in theory there is no competition on price only on quality. In these circumstances the risk is that purchasers identify different service options and quality standards to those that their patients might choose for themselves.

Finally, the shifting of the focus on to prevention and better management of chronic long term conditions such as diabetes, coronary heart disease, depressive illness etc whilst laudable may fail as a consequence of an inability to deliver the necessary resource that this would require. Many NHS managers fear that to tackle the public health agenda and introduce effective case management requires a large slice of the resource (money and people) currently destined to be

committed within the acute hospital sector on achieving the new targets set by Government to reduce journey time from GP appointment, diagnostic, out patient and inpatient admission to a maximum of 18 weeks and an average of 9 weeks by 2008.

This may of course be pessimistic. My job in the highest performing acute sector area in the country is to bring in these reforms and deliver their positive intentions whilst avoiding the pitfalls. We believe that increased acute sector contestability via new market entrants (South Yorkshire PCTs have recently entered into a 5 year contract with an independent sector treatment provider of elective care) and the move to have all NHS Trusts as independent Foundation trusts by Jan 2005, will have positive benefits. Indeed we have already seen significant reductions in acute lengths of stay for primary hip and knee operations in response to the prospect of competition and the drive to provide care at less than the tariff rate. Under payment by results there is a new clarity in the financial flows between PCTs and Acute trusts and far more aggressive self imposed efficiency targets being set by acute providers. Patients and the public in the area are becoming much more involved in priority setting through internet polls, in service design, delivery, evaluation and, through local Foundation Trust membership arrangements, in governance. In turn these benefits have created new space and incentives for the NHS to focus, arguably for the first time, on some of the major morbidity, mortality and health inequalities problems the area faces.

But, what is yet to be seen is that all of these changes serve to improve the quality of service provided on a sustainable basis and in turn that they secure higher patient and public satisfaction, and fulfil the Government's desire to convince the electorate that their investment and reforms have finally delivered recognisable improvements in the NHS. Only time and the possible outcome of the next general election will tell.

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