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NHS funding and reform: the Wanless Report

On 17 April 2002, the "Wanless Report" was published, setting out projections of how much it would cost over the next 20 years to deliver high quality services throughout the NHS. In his Budget statement a few hours later, the Chancellor announced real terms increases in funding of 7.4% annually over the next five years for the NHS, but emphasised that this funding must be accompanied by further reforms to make the NHS more responsive to the needs of patients. On 18 April, the Secretary of State for Health published an outline of these reforms in England in the document *Delivering the NHS Plan*. This Paper attempts to summarise the Wanless Report and the reform proposals, and then discusses the responses they have received. While the funding projections set out by Wanless and the funding commitments made by the Chancellor apply UK-wide, the reform programme applies to England only.

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Summary of main points

- In the March 2000 Budget, the Chancellor announced that he would be commissioning a long-term assessment of the trends affecting expenditure on health services. This review was subsequently carried out by Derek Wanless, who produced an interim report in November 2001 and a final report in April 2002. As was widely predicted, Mr Wanless concluded that the UK would need in future to devote a "substantially larger share of national income to health care".

- In the April 2002 Budget, the Chancellor accepted Wanless's projections for the five years beginning 2003/04, and committed the Government to an annual funding increase for the UK of 7.4% in real terms for the five-year period. This would be funded by increases in National Insurance contributions for both employers and employees. The Chancellor also made clear that further reform would be expected of the NHS in return.

- On 18th April, the Secretary of State for Health, Alan Milburn, published the document *Delivering the NHS Plan: next steps on investment, next steps on reform*, which set out the reform agenda for England. This included:

    - major expansions in NHS capacity (that is, in buildings, beds and staff) with the aim of dramatically reducing waiting times for treatment;

    - structural changes, with further power being devolved to the front-line of the NHS, the creation of "foundation" hospitals enjoying greater independence, and the introduction of a financial system which aims to ensure that money will follow the patient;

    - the introduction of financial incentives to penalise local authorities whose delays in securing social care provision for patients leads to delayed discharge;

    - the creation of a new health inspectorate, the Commission for Healthcare Audit and Inspection (CHAI), taking in the role of the Commission for Health Improvement, the private healthcare responsibilities of the National Care Standards Commission and the NHS value-for-money work of the Audit Commission. In addition to taking over existing roles, CHAI will also be responsible for auditing how the new money for the NHS is spent;

    - further co-operation with the private sector, including making good use of spare private sector capacity, enabling Primary Care Trusts and NHS trusts to enter into joint ventures with the private and voluntary sectors, and bringing overseas clinical teams to the UK to provide additional services while the NHS seeks to build up its own capacity.

- The increases in funding have, unsurprisingly, been welcomed with enthusiasm by the NHS. The details of the reform programme have received a more muted response.

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I Background

In the March 2000 Budget, the Chancellor announced significant increases to NHS funding, with annual real terms increases of 6.1% over the following four years, in comparison with an average annual real terms increase since the creation of the NHS of 3.3%.[1] At the same time, he made clear that "alongside the extra resources must come more reform and modernisation" and stated that he would be commissioning "a long-term assessment of the technological, demographic and medical trends over the next two decades that will affect the health service to report to him in time for the start of the next spending review in 2002".[2] It was announced in the following Budget, in March 2001, that this review would be led by Derek Wanless, former Group Chief Executive of Nat West Bank.[3]

On 22 March 2000, the day after the 2000 Budget, the Prime Minister made a statement to the House on the future of the NHS, setting out the Government's view that "a step change in resources must mean a step change in reform".[4] Highlighting wide variations in the quality, availability and cost of care in different parts of the health service, the Prime Minister promised a "detailed four-year action plan" for the NHS to be published in July, covering five "challenges" to be tackled: partnership, performance, the professions, patient care and prevention.

The *NHS Plan*, now described as a ten-year plan, was published on 27 July 2000 and set out the Government's vision of how the NHS should develop:

- major increases in NHS staffing and hospital capacity to improve access and reduce waiting times for treatment, accompanied by greater flexibility in the deployment of staff, new contracts for GPs and hospital consultants and a new pay system for other hospital staff;
- improvements in the environment in which care is delivered, with a particular focus on the cleanliness of hospitals and the quality of hospital food;
- modernisation of the NHS estate with investment in new and upgraded NHS buildings, equipment and IT;
- a much greater focus on the needs and entitlements of individual patients, both in terms of their involvement in their own care and in patient/public involvement in how the NHS is run;

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1 HC Deb 21 March 2000 cc871-872

2 *Prudent for a purpose: working for a stronger and fairer Britain*, HC 346 1999-2000, 21 March 2000, para 5.69

3 *Investing for the long term: building opportunity and prosperity for all*, HC 279 2000-2001, 7 March 2001, para 5.76

4 HC Deb 22 March 2000 c981

- publication of annual performance data on NHS trusts, with these data being used to reward high-performing trusts with greater autonomy, while poor performance would trigger action from a new Modernisation Agency responsible for spreading best practice;
- reductions in health inequalities, through ensuring that the NHS funding formula better reflects varying health needs, monitoring action taken at local level to address health inequalities, and placing greater emphasis on health promotion work, such as improving child nutrition and helping people give up smoking.[5]

An *NHS Plan implementation programme*[6] was published by the Department of Health in December 2000, setting out provisional milestones and key targets for 2001/2002, and the *Health and Social Care Act 2001* was passed in May 2001 by Parliament to make provision for those aspects of the Plan which required legislation. In April 2001, the Secretary of State for Health, Alan Milburn, announced that structural change in the roles of NHS institutions would be necessary to achieve the aims set out in the Plan and a document *Shifting the balance of power within the NHS: securing delivery* was published in July 2001, setting out plans to strengthen the role of Primary Care Trusts, abolish Health Authorities, and create new "Strategic Health Authorities" to take over many of the performance management functions currently carried out by the Department of Health.[7] The *NHS Reform and Health Care Professions Bill*, currently before the House of Lords, seeks to make provision both for these "devolutionary" changes in structure and for the aspects of the *NHS Plan* relating to patient and public involvement in the NHS, which were dropped from the *Health and Social Care Bill* before the June 2001 election. The Appendix lists a number of Library Research Papers and Standard Notes covering these issues in more detail.[8]

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5 *The NHS Plan: a plan for investment, a plan for reform*, Cm 4818-I, July 2000
6 Department of Health, *NHS Plan implementation programme*, December 2000
7 Department of Health, *Shifting the balance of power within the NHS: securing delivery*, July 2001
8 *The NHS Plan: a summary* (SN/SP/531); Library Research Papers 01/01 & 01/95

II The Wanless Report

The terms of reference of the "Wanless review" were:

> 1. To examine the technological, demographic and medical trends over the next two decades that may affect the health service in the UK as a whole.
>
> 2. In the light of (1), to identify the key factors which will determine the financial and other resources required to ensure that the NHS can provide a publicly funded, comprehensive, high quality service available on the basis of clinical need and not ability to pay.
>
> 3. To report to the Chancellor by April 2002, to allow him to consider the possible implications of this analysis for the Government's wider fiscal and economic strategies in the medium term; and to inform decisions in the next spending Review in 2002.
>
> The report will take account of the devolved nature of health spending in the UK and the Devolved Administrations will be invited to participate in the Review.[9]

Derek Wanless initially produced an interim report which was published on 27 November 2001, the day of the pre-budget report statement.[10] Following consultation on this interim report, his final report was published on the day of the 2002 Budget, 17 April 2002.[11] As was widely expected, he recommended that "over the next 20 years, the UK will need to devote a substantially larger share of national income to health care", with the percentage of total health spending rising from 7.7% of GDP in 2002-03[12] to between 9.4% and 9.5% in 2007-08, between 10.3% and 11% in 2012-13, between 10.6% and 11.9% in 2017-18 and between 10.6% and 12.5% in 2022-23.[13] The range in Wanless' projections for each of these years derives from the fact that he developed three different scenarios, "solid progress", "slow uptake" and "fully engaged", to reflect the very different ways NHS services and demand for healthcare might develop, depending both on the responsiveness of the service to change and on the extent to which the public changed in their demand for healthcare and in taking responsibility for their own health. Wanless' methodology was based on defining what a high quality health service in 2022 should look like, and then determining what additional resources would be required to deliver it, given a range of potential variables both in the demand for healthcare and in the cost of supplying it. Although the remit of the review covered the whole of the UK, and the projected resources were given on a UK-wide basis, Wanless emphasised that in the main he was

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9 reproduced in Derek Wanless, *Securing our future health: taking a long-term view: final report*, April 2002, p2

10 Derek Wanless, *Securing our future health: taking a long-term view: interim report*, November 2001

11 Derek Wanless, *Securing our future health: taking a long-term view: final report*, April 2002

12 all Wanless' projections as percentages of GDP include the current 1.2 percentage points spent privately by individuals

13 Derek Wanless, *Securing our future health: taking a long-term view: final report*, April 2002, p75

able to use only English data, extrapolating this on a population basis across the devolved administrations.[14] He acknowledged that this methodology did not reflect the variations in provision and health status across the UK.[15]

A. Wanless's vision of the NHS in 2022

The main elements identified in the Interim Report as key in a high quality service were:

- safe, high quality treatment
- fast access
- an integrated, joined-up system
- comfortable accommodation services; and
- a patient-centred service.[16]

The Final Report expanded further what these principles would mean in practice in a future NHS:

- patients fully involved in decisions about the prevention, treatment and management of illness, with the principle of "informed consent" to treatment being replaced by a concept of "informed choice";
- individuals taking more responsibility for their own health, with information and interactive advice available via the internet and digital TV;
- the NHS able to recruit and retain well-motivated staff, able and willing to develop their skills and take on new, more challenging roles;
- use of modern and integrated ICT (information and communication technology), permitting access to electronic health records, use of electronic prescribing and booking of appointments at patients' convenience;
- consistently high quality care, in appropriate settings, with smooth integration between different types and settings of care;
- ready access to health professionals in both primary and secondary care;
- services provided increasingly in primary care, with hospitals focusing on specialist treatments; a wide range of direct-access services, such as NHS Direct, walk-in centres and telemedicine available as an alternative to GP surgeries;
- hospital treatment provided in clean, modern surroundings, with fewer than four patients to a room and access to high quality food at a time to suit patients;
- no bottlenecks between health and social care, with patients moving from hospital as soon as they are medically fit to do so, and a choice of residential or nursing home placement for patients who cannot be cared for appropriately at home.[17]

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14 *ibid*, p3
15 *ibid*, p71
16 *ibid*, p14
17 *ibid*, pp15-16

Ways of closing the gap between the current services provided by the NHS and the ideal service described in the Report included:

- extending the development of "National Service Frameworks" (currently available for cancer, coronary heart disease, mental health, older people and diabetes and in development for children, long-term conditions and renal disease) to all disease areas, so that all services would be covered by clear service standards;
- ensuring that all NHS staff are able to spend 10% of their time in "clinical governance" activities, so that they are able to monitor and develop the quality of the services they provide;
- reducing waiting times for hospital treatment, firstly (in line with the *NHS Plan*) to three months for out-patient appointments and six months for in-patient care by 2005-06, and to three months for both in-patient and out-patient services by 2008-09, and then to two weeks for both in-patient and out-patient services by 2022-23;
- replacing one third of the hospital and community health service estate over the next 20 years; upgrading or replacing the entire primary care estate over the next 10 years; replacing equipment every eight years; and doubling current expenditure on ICT; and
- almost doubling the amount spent on hospital food per patient.[18]

B. Trends and factors affecting resources required

Wanless identified a number of factors, both in demand and supply, which would affect how much it would cost for the services described above to become a reality. On the demand side, he identified:

- changes in age structure within the population, while noting that demographic change is not the main factor driving up healthcare costs;[19]
- changes in the health status of the population, both in terms of its general health and in terms of the extent to which increased life expectancy results in extra years of good or ill health;
- changes in the likelihood of people seeking healthcare for a given level of need: the extent to which higher expectations and greater equality of access will lead to increased use of services even if actual health needs remain constant.[20]

On the supply side, he identified:

- the rate of spending on technology, both in terms of medical advances and use of ICT;

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18 *ibid*, pp26-34
19 *ibid*, p6
20 *ibid*, p36

- changes in pay and productivity of NHS staff, in particular the better use of skill mix (that is, ensuring that tasks are appropriately allocated among the various staff groups, regardless of historic professional demarcations);
- wider productivity gains through the more efficient use of NHS resources, including qualitative, as well as quantitative, changes within the measure of productivity.[21]

In order to explore how these variables might combine to place very different demands on healthcare resources, he then created three scenarios. The "solid progress" scenario is based on people living longer than at present, with their extra years evenly split between good health and ill health; a more appropriate skill mix in the NHS, with good take-up of modern technology; general improvements in public health and self-care, and higher expectations leading to higher demands on healthcare services than at present. The "slow uptake" scenario, on the other hand, is based on increased life expectancy being matched with longer periods of ill health at the end of life; little improvements in public health or narrowing of health inequalities; and good quality services being provided with only limited help from the productivity gains to be achieved through better deployment of staff or use of technology. Finally, the "fully engaged" scenario envisages people living longer and in better health than in the "solid progress" scenario; major improvements in public engagement with health, with people both taking much better care of their own health and making higher demands on services; and a responsive NHS making good use of technology and deploying its staff efficiently.[22]

Wanless then used these three scenarios (which he acknowledges are by no means the only possible ones[23]) to estimate how the demand and supply variables might impact on the resources needed to deliver the high quality service he described in Chapter 2. His methodology is set out detail in Chapters 3 and 4 of his report but some examples are set out below:

- use of medical technology contributes 3 percentage points a year to growth in health spending in solid progress and fully engaged scenarios, but only 2 percentage points in slow progress;
- spending doubles on ICT in solid progress and fully engaged scenarios by 2003-04 and in the slow uptake scenario by 2007-08;
- improved self-care switches 1% of GP activity to pharmacists in solid progress and slow uptake scenarios but 2% in fully engaged;
- greater demand for services leads to one additional GP visit per year by 2022 in solid progress and fully engaged scenarios but no change in slow uptake;
- productivity growth increases from 2-2.5% a year in the first decade to 3% in the second decade in the solid progress and fully engaged scenarios, while under the slow

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21 *ibid*, pp36-37 & pp62-64
22 *ibid*, pp37-40
23 ibid, p65

uptake scenario it increases from 1.5% a year in the first decade to 1.75% a year in the second.[24]

Similarly, estimates were derived for achieving the specific service improvements described above, such as the increases in activity necessary to deliver the waiting time targets (estimated at increases in activity of 5-6% a year for the next five years and 3-4% thereafter[25]) and the cost of extending the "National Service Framework" approach to all disease areas. This involved the publication, for the first time, of estimates of how much the existing disease-based NSFs covering cancer, coronary heart disease, renal services, mental health and diabetes, will cost to implement.[26]

C. Estimated resources required

On the basis of a financial model developed using the service development and trend data described above, Wanless produced the following estimates of the resources needed to deliver his "vision" of the NHS:

UK health spending summary

		Projections			
	2002-03[(a)]	2007-08	2012-13	2017-18	2022-23
Total health spending (per cent of money GDP)[(b)]					
Solid progress	7.7	9.4	10.5	10.9	11.1
Slow uptake	7.7	9.5	11.0	11.9	12.5
Fully engaged	7.7	9.4	10.3	10.6	10.6
Total NHS spending (£ billion, 2002-03 prices)					
Solid progress	68	96	121	141	161
Slow uptake	68	97	127	155	184
Fully engaged	68	96	119	137	154
Average annual real growth in NHS spending (per cent)[(c)]					
Solid progress	6.8	7.1	4.7	3.1	2.7
Slow uptake	6.8	7.3	5.6	4.0	3.5
Fully engaged	6.8	7.1	4.4	2.8	2.4

(a) Estimates

(b) All figures include 1.2 percent for private sector health spending

(c) Growth figures are annual averages for the five years up to the date shown (four years for 2002/03)

Source: Derek Wanless, *Securing our future health: taking a long-term view: final report,* p75

He suggested that, "roughly speaking", the resources projected for the first decade covered by the review aimed to enable the NHS to "catch-up" with the expectations

[24] *ibid*, p41
[25] *ibid*, p30
[26] *ibid*, p26

placed on a high quality service, while the projections for the second decade should enable the NHS to "keep up" these standards.[27]

Although his terms of reference had not explicitly included social care, Wanless had concluded that the review would be incomplete without considering the link between health and social care; indeed he noted that the consultation responses he received on his Interim Report led to a much greater focus on the role of social care in the Final Report.[28] While emphasising that the review had not had the necessary information to build up projections for social care funding in the same level of detail as for health care, Wanless made the following projections for adult social care expenditure based on the same three scenarios as for health care.

Personal social services (PSS) spending in England
Annual real growth, per cent

		Projections			
	1999-00 to 2002-03	2003-04 to 2007-08	2008-09 to 2012-13	2013-14 to 2017-18	2018-19 to 2022-23
Solid progress	1.2	2.0	1.8	2.4	2.9
Slow uptake	1.2	2.5	2.3	2.9	3.4
Fully engaged	1.2	2.1	2.0	2.5	2.7

Source: Derek Wanless, *Securing our future health: taking a long-term view: final report,* p94

He emphasised, however, that these projections covered only changes in population and in levels of ill-health; they did not cover any necessary improvements in quality, the need to stabilise the residential and nursing home markets, the impact which technology may have on the balance between home and institutional care, and children's and family services. They therefore underestimated the resources required.[29]

D. Other observations and recommendations

In making his projections of the resources necessary to deliver high quality healthcare, Mr Wanless also highlighted a number of factors he believed would affect delivery:

- Capacity issues, that is availability of appropriate staff, equipment and buildings, will be crucial in both the short-term and long-term. Given current constraints on capacity, the "early growth" in the projections "is at the upper end of what could sensibly be spent".[30]

27 *ibid*, p77
28 *ibid*, p7
29 *ibid*, pp93-95
30 *ibid*, p75

- Demand for the increase in number of healthcare professionals will vary between the three scenarios; using the "solid progress" scenario, there will be an increased demand in 20 years time for 62,000 doctors, 108,000 nurses, 45,000 therapists and scientists and 74,000 healthcare assistants.[31] While the increase in nurse numbers projected as a result of commitments in the *NHS Plan* would be almost sufficient to match this demand, "the planned increase in doctors is well short of needs", by around 25,000 after 20 years.[32]

- Skill mix changes could make a major contribution to more efficient staff deployment, with up to 20% of GP and junior doctor work being shifted to nurse practitioners. Similarly, some work currently carried out by nurses could be taken on by healthcare assistants. Even with such changes, however, there would still need to be an increase in the number of doctors and nurses over current plans.[33]

- There is "significant scope" to give more discretion to those providing services on a local level, although they should be required to deliver care to nationally set standards. This "facilitates the development of innovative approaches and the sharing of best practice". However, clear accountability both to Government and to the public is essential.[34]

- Scope for greater co-operation between the NHS and the private sector should be explored.[35]

- The current balance between health and social care is wrong, with care being focused far too strongly in the acute hospital sector and "bed-blocking" still far too prevalent. The Government should consider using financial incentives to improve co-operation between the NHS and social care, such as those in place in Sweden, where local authorities must pay hospital authorities for a patient's care in hospital, if that patient is medically fit to leave but unable to do so because of delays in making social care arrangements.[36]

- Similarly, there should be a shift in balance between primary and secondary (hospital) care, with diagnosis and treatment being increasingly provided in the primary sector.[37]

- The remit of the review did not include recommending the most appropriate financing method for the NHS. However, Wanless argued that it *was* necessary to examine

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31 *ibid*, p88
32 *ibid*, p90
33 *ibid*, p91 & letter to Chancellor, reproduced at the beginning of the Wanless Report
34 *ibid*, pp105-106
35 *ibid*, p105
36 *ibid*, pp106-108
37 *ibid*, p109

whether the current method of financing might in itself be a driver of the total funding required. Wanless concluded that "the Review still does not believe that there is an alternative funding method to that currently in place in the UK which would deliver a given level and quality of health care either at lower cost to the economy or in a more equitable way".[38] He describes the possibility of extending existing payments for clinical services as "inappropriate" and recommends that the current system of exemptions from NHS charges should be reviewed at some point in the future as its structure is "not logical, nor rooted in the principles of the NHS".[39] He does, however, leave open the possibility that out-of-pocket payments could be introduced for non-clinical services, such as IT facilities in patients' rooms.[40]

- There should be a clearer understanding between health professionals and the public as to their respective responsibilities, for example through a "contract" at local level between Primary Care Trusts and their populations, setting out what local NHS funding will deliver. In return, patients should be encouraged to use the NHS responsibly: for example charging for missed appointments should be considered. Better public and patient involvement in NHS boards would also assist accountability.[41]

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38 *ibid*, p113
39 *ibid*, p114
40 *ibid*, p115
41 *ibid*, pp116-117

III The Budget statement

In his Budget statement on 17 April 2002, the Chancellor announced real-terms increases in NHS expenditure of 7.4% per year for the next five years. The projected figures for the UK are given below:

Net NHS Expenditure
UK £bn

	Stage 1	Stage 2
2002/03	65.4	68.1
2003/04	72.1	74.8
2004/05	79.3	82.2
2005/06	87.2	90.5
2006/07	95.9	99.4
2007/08	105.6	109.4

"Stage 1" refers to "near cash" resource budgeting
"Stage 2" refers to full resource budgeting
Source: Department of Health

The table below details similar projections for England only:

Net NHS Expenditure
England £bn

	Cash	Stage 1	Stage 2
1996/97	33.0	…	…
1997/98	34.7	…	…
1998/99	36.6	…	…
1999/00	39.9	40.2	…
2000/01	…	44.1	…
2001/02	…	49.4	…
2002/03	…	53.5	…
2002/03	…	53.5	55.8
2003/04	…	59.0	61.3
2004/05	…	65.0	67.4
2005/06	…	71.6	74.4
2006/07	…	78.9	81.8
2007/08	…	87.1	90.2

Expenditure pre 1999-00 is on a cash basis.
"Stage 1" refers to "near cash" resource budgeting
"Stage 2" refers to full resource budgeting
Source: Department of Health

It should be noted that the figures cited by Wanless were given in resource terms, while those cited in the Chancellor's speech were given in "near cash" terms. The Red Book comments that resource budgets are generally higher than those expressed in cash terms, as they reflect costs associated with holding and using capital assets and changes in provisions to cover liabilities. The 7.4% real terms increase in cash is equivalent to the

7.3% increase in resource terms which was the highest increase recommended by Wanless for the first five years of his review period, based on his "slow uptake" scenario.[42]

In his Budget speech, the Chancellor argued that "the fundamental long-term choice our generation must make is whether the national consensus that existed for the last half century for an NHS freely accessible to all is to be renewed for the years ahead".[43] Dismissing alternative forms of financing, private insurance, social insurance and self-pay, as more expensive and more inequitable than provision through general taxation, he asserted that:

> It is the Government's view that the NHS system of funding is not just the most equitable but that a reformed NHS, by offering the most comprehensive insurance policy to meet the rising costs of medical advance, can give British people the greater security they need.[44]

This description of the NHS as an "insurance policy", with its implication of a clear link between individual contributions and entitlements, was reiterated at the end of the Chancellor's speech, when he described the Budget as "a Budget to make our NHS the best insurance policy in the world".[45] However, despite the strong links made throughout the Budget speech between the increases in NI contributions and the additional funding being made available to the NHS, the Chancellor made clear that he had considered, and rejected, explicit "hypothecation" of revenues to the NHS, on the basis that such hypothecation would make NHS financing subject to the ups and downs of the economic cycle.[46] It should also be noted that, although part of NHS financing has always derived from the National Insurance Fund (12% of NHS funding in England in 2000-01 came from this source[47]), entitlement to NHS services is based on "ordinary residence" in the UK, and not on individuals' contribution records.

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42 *The strength to make long-term decisions: investing in an enterprising, fairer Britain*, HC 592 2001-2002, 17 April 2002, p121
43 HC Deb 17 April 2002 c589
44 HC Deb 17 April 2002 c590
45 HC Deb 17 April 2002 c592
46 HC Deb 17 April 2002 c589
47 Department of Health, *Departmental Report*, May 2001, p30

IV Alan Milburn's statement: *Delivering the NHS Plan*

The Chancellor made very clear that the NHS would be expected to deliver significant reforms in return for the high increases, and long-term financial commitments, promised in his Budget statement. This approach mirrored that taken in the March 2000 Budget, which triggered the production of the *NHS Plan*. The proposals for further reforms, hinted at by the Chancellor, were announced to the House the following day by the Secretary of State for Health, Alan Milburn, and published in the document *Delivering the NHS Plan: next steps on investment; next steps on reform.*[48] They include the following:

- A new system of "payment by results" for NHS trusts will be developed.[49] While the current system of allocating resources to Health Authorities/Primary Care Trusts to "commission" care from NHS trusts and other providers will remain unchanged, the aim is to change the way money moves around the system between commissioners and providers, in order to reward those hospitals which treat more patients. *Delivering the NHS Plan* argues that this approach is fundamentally different from the internal market introduced in the 1990s, in that competition between providers will be based on volume and quality, rather than price, and will only apply to elective (ie non-emergency) treatment. In order to avoid price competition, reimbursement will be based on regional tariffs, not unlike the reimbursement systems used in social insurance schemes. Hospitals which are able to treat patients for a lower unit cost than the regional tariff will be able to keep the "savings" in order to invest in further capacity, while less efficient providers will be encouraged to improve through the intervention of the Modernisation Agency and if necessary the imposition of new management. The document acknowledges that "there are a number of issues that we need to explore in more depth with the NHS"[50] and states that a number of different ways of moving resources around the system will be tested in the current financial year. In 2003-04, hospitals will be contracted to provide a minimum volume of cases to achieve waiting time reductions, with additional payments on a cost-per-case basis for those able to treat more and financial penalties for those who fail to deliver. In the "medium term", the aim is to move to a system where all activity is commissioned using a standard tariff.

- The scheme announced in December 2001,[51] enabling patients who have waited for more than six months for heart surgery to choose their own hospital (whether in the NHS, in the private sector or abroad, assuming the hospital has the capacity to accept them), will be extended. The heart surgery scheme is due to start in July 2002;

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48 *Delivering the NHS Plan: next steps on investment; next steps on reform*, Cm 5503, 18 April 2002
49 *ibid*, paras 4.4ff
50 *ibid*, para 4.11
51 Department of Health press notice 2001/602, 6 December 2001

Delivering the NHS Plan promises that "we will roll out this new approach for other clinical conditions beginning in London later this year".[52]

- There will be further co-operation between the NHS and private sector in order to make up for the "historic deficits" in NHS capacity. Measures outlined include permitting Primary Care Trusts and NHS trusts to enter into joint ventures with the private and voluntary sectors (for example to provide supported housing for vulnerable older people or NHS-supported nursing home accommodation); the development of new public/private partnerships to create more "diagnostic and treatment centres"; maximising use of private hospital capacity based on a national framework of prices; and bringing clinical teams to the UK from overseas to provide services for the NHS (either in freestanding facilities, or making use of NHS facilities which cannot be used at present because of staff shortages).[53]

- There will be greater devolution of responsibility from Whitehall to the NHS, with the development of "Foundation" status for NHS trusts and PCTs which are deemed to be performing well.[54] Foundation trusts will have greater autonomy than existing trusts, for example in terms of full control over their own assets, easier access to capital, a lighter monitoring regime and freedom to develop their governance structures. While reference is made to "freedom and flexibility" as regards staff pay, it is made clear that this flexibility will be operated "within the new NHS pay systems".[55]

- Consideration will be given to the idea of an "NHS bank", to replace the current informal brokerage arrangements, under which NHS bodies with a surplus of cash "lend" to those in deficit via Department of Health officials.[56] Such a bank could provide risk reserves for PCTs and overdraft finance for NHS trusts.

- The Swedish system of "fining" local authorities which fail to make social care arrangements in time for patients to be discharged when they are medically fit to do so will be introduced.[57] This will involve local authorities meeting the costs of care of patients who remain unnecessarily in hospital. No timescale is given for introducing this system is given, but the document promises consultation with local government on implementation.

- A new Commission for Healthcare Audit and Inspection (CHAI) will be created, bringing together the work of the Commission for Health Improvement, the health value-for-money work of the Audit Commission and the National Care Standards

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52 *Delivering the NHS Plan: next steps on investment; next steps on reform*, Cm 5503, 18 April 2002, para 5.5
53 *ibid*, paras 6.4-6.8
54 *ibid*, para 7.7
55 *ibid*, para 7.10
56 *ibid*, para 7.12
57 *ibid*, para 8.10

Commission's responsibilities for regulating the private health sector.[58] In addition to taking on the existing responsibilities of these bodies, CHAI will be responsible for providing independent scrutiny of patient complaints, and will required to publish an annual report to Parliament on "national progress on health care and how resources have been used". This latter requirement would appear to go further than the provision in clause 14 of the *NHS Reform and Health Care Professions Bill*[59] (currently before the House of Lords) that the Commission for Health Improvement should report annually to the Secretary of State "on what it has found in relation to NHS bodies and service providers in the course of exercising its functions during the year". Similarly, a new Commission for Social Care Inspection will draw together the work of the Social Services Inspectorate and the National Care Standards Commission's social care responsibilities.

- The *NHS Plan* set out plans for "patients' prospectuses" which would provide information on a local basis on services, performance and patients' views.[60] *Delivering the NHS Plan* states that from autumn 2002, patients' prospectuses will include a much wider range of information, including an account of how local health resources were spent in the last year and will be spent in the following year, details of CHAI inspection reports on local health care providers and an analysis of how local providers have performed, both against their own plans and compared with other providers.[61]

- Action will also be taken to ensure responsible use of the NHS by patients: by providing extra resources to PCTs to deal with violent patients; by backing prosecutions against individuals who persistently make hoax calls to ambulance services; and by requiring all PCTs to consult their local populations on a "contract of rights and responsibilities". It is envisaged that such a contract could be used when patients register with a GP, forming the basis for a mature doctor-patient relationship.[62]

As a result of the new funding made available through the Budget settlement, and the reforms summarised above, *Delivering the NHS Plan* envisages the following expansion in NHS capacity and modernisation in the way services are delivered by 2008:

- staff numbers to have increased by 15,000 consultants and GPs, 35,000 nurses, midwives and health visitors and 30,000 therapists and scientists, compared with headcount numbers in September 2001;[63]

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58 *ibid*, para 10.7
59 HL Bill 78 of 2001-02
60 *The NHS Plan: a plan for investment; a plan for reform*, Cm 4818-I, July 2000, para 10.23
61 *Delivering the NHS Plan: next steps on investment; next steps on reform*, Cm 5503, 18 April 2002, para 10.15
62 *ibid*, paras 10.20-10.22
63 *ibid*, para 3.4

- 8,000 more nurses a year completing training and 1,900 more medical school graduates;[64]

- 42 additional major hospital schemes delivered through PFI, with a further 13 under construction;[65]

- the number of operations carried out as same day cases to be increased to 75% of all operations (the equivalent of providing 1,700 general and acute beds in hospitals);[66]

- the establishment of around 750 primary care "one-stop centres" to offer a broader range of services than is usually found in primary care;[67]

- a shift to more service provision in the community with, for example, "millions more" outpatient appointments taking place in community settings rather than in hospital;[68]

- the creation of electronic patient records in all PCTs and NHS trusts.[69]

Legislation will be required to introduce a number of the reforms set out in *Delivering the NHS Plan*: in particular to create the new "cross-charging" regime for delayed discharges, to establish the Commission for Healthcare Audit and Inspection and to establish the new Commission for Social Care Inspection. According to a Parliamentary Answer on 23 April, "the details of the legislative changes required to implement these and the reform package as a whole are now being considered".[70]

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64 *ibid*, para 3.5
65 *ibid*, para 3.7
66 *ibid*, para 3.7
67 *ibid*, para 3.8
68 *ibid*, para 3.8
69 *ibid*, para 3.8
70 HC Deb 23 April 2002 c240W

V Responses to the Budget and the linked reforms

A. Funding

The immediate response to the Chancellor's announcement of 7.4% per year real terms increases over the next five years was, unsurprisingly, positive among those representing the NHS and healthcare professionals. The BMA called the Budget statement "a historic watershed for the NHS"; [71] the King's Fund described the allocations as "welcome news";[72] and the *Health Service Journal* claimed that the Chancellor had "exceeded the expectations of all but the most widely optimistic".[73] According to a poll carried out by the *Daily Telegraph*, the Budget, despite the increase in National Insurance contributions, was also generally acceptable among the wider public: 77% of those questioned supported the increases in NHS funding, with 11% against; and 63% felt that the increase in "direct taxation" was justified, while 30% did not.[74]

Despite this enthusiasm, however, questions as to the adequacy of the settlement have been raised, with one *BMJ* columnist suggesting that "one problem might be that even a 50% increase will not be enough. The United States spends much more but still has many failures."[75] John Appleby of the King's Fund drew the attention of the Treasury Select Committee to the fact that NHS pay and prices have historically led to NHS inflation exceeding general inflation, with the result that the planned 43% "real-terms" increases to the NHS budget would represent only 35% once NHS-specific inflation had been taken into account.[76] The Royal College of Nursing did indeed mix its welcome of the Budget settlement with a strongly-worded claim for a "significant year-on-year increase in nurses' pay".[77] Moreover, the extent to which projections looking as far into the future as those produced by Wanless can be accurate has been cast into doubt: John Appleby comments that Wanless himself pointed out that "the range of uncertainty is large and grows rapidly the further ahead one looks", while the Conservative health spokesperson, Liam Fox, was quoted as saying:

> The report itself concludes that it needs to be repeated in five years' time because of a lack of quality information…. The projections it makes are therefore ridiculous.[78]

The choice of National Insurance contributions as a means of financing the increase generated rather more criticism than the NHS funding settlement itself: the *Sunday*

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71 BMA press notice 18 April 2002
72 King's Fund press notice 17 April 2002
73 "Riches beyond compare", *Health Service Journal*, 25 April 2002, Budget special, p1
74 "Reward system 'will expand NHS Plan'", *Daily Telegraph*, 19 April 2002, p4
75 "A bonanza for the NHS", *BMJ*, 27 April 2002 (editor's choice)
76 Treasury Select Committee, *Budget 2002*, 29 April 2002, HC 780 2001-02, para 46
77 RCN press notice, 18 April 2002
78 "Increase of 7%'would cost about £12bn in extra taxes'", *Financial Times*, 18 April 2002, p4

Telegraph called it "a scandalous breach of the spirit of Labour's election promise not to raise income tax",[79] a sentiment echoed by the Conservative Party.[80] The Chancellor justified the choice of National Insurance over income tax as a way of raising additional funding for the NHS on the grounds that:

> It did not seem to me right that pensioners should pay more when they were older towards the National Health Service if we could avoid it, and therefore the National Insurance route seemed the right route to take.[81]

The Conservative Party's health spokesperson, Dr Liam Fox, made clear that "we agree on the need to spend more on health care in the United Kingdom", but strongly regretted that greater consideration had not been given to alternative financing methods.[82] A comparison of international healthcare systems, published earlier in April by the Conservative Policy Unit, had concluded that "the UK is characterised by a healthcare system that is unresponsive to people's needs and not outstandingly fair in the distribution of the financial burden" and its foreword by Iain Duncan Smith argued that the NHS had much to learn from other countries.[83] Wanless, on the other hand, concluded on the basis of a comparative survey of a number of other healthcare systems commissioned from the European Observatory on Health Care Systems as part of his review[84] that there was no evidence to suggest that other funding systems would increase the quality or equity of UK services.[85] The view that the publication of the Wanless report had been used to "shut-down" debate on alternative methods of funding the NHS before they had properly begun was shared by a number of commentators,[86] while others suggested that if, in five years time, the NHS had *not* shown major signs of improvement, then radical changes in funding methods would ironically become far more likely.[87]

The Liberal Democrats welcomed what they regarded as the equivalent of a penny on income tax while criticising the Government both for failing to act sooner[88] and for failing to alert the electorate of their intentions in advance through their election manifesto.[89]

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79 "Worse than income tax", *Sunday Telegraph*, 21 April 2002, p18

80 HC Deb 17 April 2002 c595

81 Treasury Select Committee, *Budget 2002*, 29 April 2002, HC 780 2001-02, para 52

82 HC Deb 23 April 2002 cc 162ff

83 Conservative Policy Unit, *Alternative Prescriptions*, 2002, p3 & p55

84 European Observatory on Health Care Systems, *Health care systems in eight countries: trends and challenges*, April 2002

85 Derek Wanless, *Securing our future health: taking a long-term view: final report*, April 2002, p113

86 eg "This is why it never pays to fall ill in Britain", *Times*, 16 April 2002, p18 & "How to build a health service that works", *Observer*, 7 April 2002, p29

87 "Morning-after pall", *Health Service Journal*, 25 April 2002, p 15 & "A bonanza for the NHS", *BMJ*, 27 April 2002 (editor's choice)

88 HC Deb 23 April 2002 c173

89 HC Deb 18 April 2002 c721

Business leaders were reported to be "dismayed" by the increase in NI contributions,[90] with claims that employers do not benefit from the NHS and hence should not be asked to pay for its improvements.[91] In response, the Prime Minister's spokesman was quoted as pointing out that days lost through sickness were a heavy burden on industry and hence "business, like everyone else, will benefit from good quality health care".[92] Similarly, arguments that the increase in NI contributions would constitute an "own goal", in that both NHS employers and NHS staff would be liable to pay them, were countered by Downing Street officials arguing that the cost to the NHS must be "kept in perspective" and that there would have been "outrage" if the public sector had been exempt from the increases.[93] In an echo of those expressing concerns about the impact of increased NI contributions on the NHS as an employer, BUPA has argued that the additional cost on care-home owners would cost the business £4 million and could lead to the closure of care homes across the country.[94]

Doubt has been cast in some quarters as to whether the NI and other increases set out in the Budget will be sufficient to meet the rises in funding envisaged by Wanless and promised, for the next five years, by the Chancellor, with reports of a £7 billion "black hole". [95] The Treasury Select Committee summarised the evidence it heard on this issue as follows:

> The Chancellor's announcement of a five-year plan for health spending to 2007-08 means that the final year of the spending plan, namely 2007-08, is not covered by the Treasury's medium-term projections of the public finances. The IFS [Institute of Fiscal Studies] estimate that the extra health spending in 2007-08 will cost "an additional 0.7% of GDP, which in current terms is approximately £7bn", although cautions that this may not necessarily lead to financing difficulties at that time. The Chancellor told the Committee that "by tradition we will publish the 2007-08 borrowing requirement at the time of the November pre-Budget Report". Nevertheless, we note that the Chancellor in his evidence did not to say whether health spending in 2007-08 was covered by existing tax plans or whether new tax, borrowing or expenditure changes in the future might be necessary. Mr Balls highlighted that the figures for the year beyond the 2002 Spending Review included in the Government's projections, namely 2006-07, take into account the extra planned health spending, adding that "obviously that trend and that number continues to 2007-08 too", although these figures are not stated in the Red Book. Mr Balls also highlighted that Annex A of the Red Book

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90 eg "Business says the extra £4bn NI cost for employers may hit jobs", *Financial Times*, 18 April 2002, p1

91 "Brown's biggest gamble: will voters accept tax rises of £8.5bn to fund NHS?", *Independent*, 18 April 2002, p1

92 "National insurance bill for NHS to go up £200m", *Independent*, 19 April 2002, p7

93 *ibid*

94 "Bupa warns of closures as NI increase bites", *Daily Telegraph*, 23 April 2002, p25

95 "Think-tank unearths £7bn black hole in the Chancellor's NHS spending plans", *Independent*, 19 April 2002, p 21 & "Increase of 7% 'would cost about £12bn in extra taxes'", *Financial Times*, 18 April 2002, p4

> shows the illustrative long-term fiscal projections, where the Red Book states that the Treasury's "long-term fiscal projections ... show that the UK's public finances are broadly sustainable over the long term". However, specific figures for 2007-08 are not available for Parliament to scrutinise, even though the Treasury's Code for Fiscal Stability imposes no restriction on the maximum number of years for the Treasury's projections of the public finances. If specific spending figures are to be committed on a five year basis, we want to see that complete period covered by the Treasury's published medium-term fiscal projections. Given the significance of the additional spending on the NHS, the Chancellor should have published, at the time of the Budget, the borrowing requirement for the final year 2007-08.[96]

The position of other spending departments, who are yet to find out the results of the 2002 Spending Review, was taken up by William Rees-Mogg in the *Times* who described the Budget as giving "an extraordinary priority to the health service – and therefore discriminat[ing] against the claims of all the other departments";[97] similarly, Professor Ray Robinson of the LSE commented in the *BMJ*: "Moreover, the emphasis on health spending at the expense of other areas of public expenditure is bound to produce political tensions. How will ministers oriented to focus groups respond to these?"[98]

B. Reform

Responses to the reforms outlined by Alan Milburn in *Delivering the NHS Plan* have reflected a wide range of views as to the extent to which the NHS can be changed to deliver the sort of service envisaged by Wanless, the speed with which reform can be achieved, and the effectiveness of the particular approaches set out in the document. Some scepticism among the general public was shown in the *Daily Telegraph* poll cited above which suggested that while 20% of the public believe that the additional funding for the NHS will lead to "substantial improvements" in three to four years time, 58% believe that it will bring "some improvement but not a great deal" and 20% believe that it will not bring about any improvement at all.[99] These apparently muted expectations may be a relief to NHS managers charged with implementing the reforms: the NHS Confederation (which represents NHS trusts, Health Authorities and Primary Care Trusts) responded to Alan Milburn's statement with a call for "a realistic debate with the public about the realistic timescales of change and the things that are already happening to improve the NHS".[100] Similarly, Derek Wanless himself stated in an interview with the *Times* that many of the hoped-for benefits of reform and investment would not be felt by patients by the time of the next election.[101] Stephen Thornton of PPP Foundation (and

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96 Treasury Select Committee, *Budget 2002*, 29 April 2002, HC 780 2001-02, para 28
97 "Everyone pays the price of Brown's NHS Budget", *Times*, 22 April 2002, p22
98 "Gold for the NHS", *BMJ*, 27 April 2002, pp987-988
99 "Reward system 'will expand the NHS Plan'", *Daily Telegraph*, 19 April 2002, p4
100 NHS Confederation press notice 18 April 2002
101 "Architect of NHS revolution fears it will fail", *Times*, 19 April 2002, p1

formerly chief executive of the NHS Confederation) has urged Ministers to "hold their nerve" and recognise that it will take time to deliver improvements, arguing:

> This investment for the long-term must continue. Much of what they are doing is sound and is beginning to make up for decades of neglect. They have already learnt the lesson of over selling the impact of new money. Now they must use their well-oiled communications machine to convince the public that just as the Channel tunnel rail link is a massive 10-year project, so it takes even longer to train an extra cancer specialist.[102]

While initially-muted expectations may be welcomed by those responsible for delivering improvements in NHS care, clearly it is crucial for the success of the Government's plans that the extra finance is seen to be effective over the medium and long-term. The *Health Service Journal* comment column warns that "if the cash does not achieve what they want, no sensible politician will ever assume such a stance [for a tax-funded NHS] again"[103] while, according to the *Financial Times*, the Conservative Party has decided to delay major health policy announcements for a year on the premise that the general public will need time to come to the view that the new money and reforms will not work. A spokesperson was quoted as saying:

> We believe the extra spending on the NHS will not work because the necessary reforms have not taken place, but we need more time for the public to see that.[104]

The overall reform package outlined in *Delivering the NHS Plan* has received a mixed response. The *Health Service Journal* cast doubt on the whole idea of further fundamental reform, suggesting that:

> HSJ readers who have spent the last two years involved in one of the most wide-ranging and significant restructurings of the NHS in a generation will have raised a hollow laugh [at the call for root-and-branch reform]. Most newspapers' leader writers called for less cash and faster, bigger reform. The opposite is more likely to deliver results, especially in the short term.[105]

The NHS Confederation welcomed in general terms "the increase in positive incentives and freedoms" included in the proposed reforms, while expressing doubts about particular aspects (see below);[106] similarly the Long-Term Medical Conditions Alliance expressed a "number of concerns" despite their general welcome for Alan Milburn's

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[102] "There are no quick fixes, so ministers must hold their nerve", *Financial Times*, 18 April 2002, p4
[103] "Morning-after pall", *Health Service Journal*, 25 April 2002, p15
[104] "Tories delay policy update on health", *Financial Times*, 30 April 2002, p3
[105] "Morning-after pall", *Health Service Journal*, 25 April 2002, p15
[106] NHS Confederation press notice, 18 April 2002

announcement.[107] The *BMJ* suggested that "initial euphoria in the NHS over the dramatic funding boost has been tinged with concern at some of the detail in the reforms".[108]

Comments on some of the more specific aspects of *Delivering the NHS Plan* and its ability to transform the NHS in the way set out in the Wanless Report are given below.

1. Capacity of NHS to deliver

There appears to be general consensus that the "capacity" of the NHS, in terms of the availability of the staff, buildings and equipment needed to provide care, will be crucial in determining whether or not major improvements are made in waiting times, in the patient environment, and in providing more "patient-centred" care. In particular this will be central in determining the extent to which patients will genuinely have "choice" as to where in the NHS they are treated; the *Times*, for example, comments that "choice will be an abstract concept if there is not a credible range of options inside the NHS and beyond it" and argues that "as this does not exist today, Mr Milburn's task is to encourage its development".[109]

On staff capacity, bodies representing NHS staff have been quick to argue that improvements will be needed in pay and working conditions to ensure both the initial recruitment and then the retention of more staff. The President of the Royal College of Nursing called for both better pay and more flexible working conditions at the RCN conference shortly after the Budget;[110] the head of UNISON has been reported as demanding "fair terms and conditions" for NHS staff following the Budget settlement;[111] and the BMA press release responding to Alan Milburn's statement commented:

> The NHS needs more doctors and more nurses. That simple fact is universally accepted. Attracting and retaining them is more complex. Both GPs and consultants have an element of incentive in their pay systems already and that will continue, but their new contracts cannot simply be inducements to do more. They must enable them to control their workloads to receive the better rewards promised in today's statement.[112]

Negotiations have been proceeding for some time on new approaches to NHS staff pay: the BMA are currently consulting with their members on the outlines of a new GP contract;[113] talks are continuing with the medical profession over a new consultant contract, although the requirement included within the Government's proposals that for

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[107] Long-Term Medical Conditions Alliance, *Delivering the NHS Plan: LMCA's response*, April 2002
[108] "NHS to receive an extra £40bn over next five years", *BMJ*, 27 April 2002, p993
[109] "Theory and practice: Milburn's challenge is to implement flexibility and choice", *Times*, 19 April 2002, p23
[110] "Nurses expect a big pay rise for playing their part", *Times*, 22 April 2002, p15
[111] "Health Union pushes for big wage rises", *Guardian*, 30 April 2002, p11
[112] BMA press notice 18 April 2002
[113] BMA press notice 19 April 2002

an "initial period" consultants would work exclusively for the NHS has not been well received;[114] and the *Agenda for Change* talks, which aim to produce new core conditions of service for all staff, a national job evaluation framework and three national pay spines, first started back in 1999.[115] Speaking to the RCN conference on 24 April, Alan Milburn promised that negotiations over the *Agenda for Change* pay structure would be completed by the end of this year, but attempted to damp down high pay claims by making clear that higher salaries would have to be accompanied by higher productivity and increased responsibility.[116] In response, the RCN argued that "it is crucial that nurses are fairly paid and that their value is recognised throughout the health service. What is good for nurses is good for patient care."[117]

Wanless' estimates of the numbers of extra health professionals needed, and the possibility of training and recruiting them, have also been the subject of some comment. The *BMJ* highlighted the inevitable time lags in recruiting new doctors, given the long time-scale involved first in qualifying and then in reaching GP or consultant status,[118] while other commentators argued for more attention to be paid to the teaching implications of increasing the number of medical students. Stephen Thornton of the PPP Foundation, writing in the *Financial Times*, urged that more attention be paid to academic medicine with "the number of unfilled professorial posts stand[ing] at a record high",[119] and the *BMA News Review* expressed concern about the higher number of medical students being assigned to a single "firm" (ie consultant-led team) which ran the risk of reducing the effectiveness of their training.[120] Perhaps unsurprisingly, Wanless' premise that productivity could be much enhanced by better skill mix (nurses doing some jobs traditionally done by doctors; healthcare assistants doing some jobs traditionally done by nurses) has been challenged, with the *BMJ* reporting concerns that Wanless was "too optimistic" over the impact of skill-mix changes on future medical staffing requirements.[121] The *Times* editorial took a more assertive stance, arguing:

> The first [issue] concerns the ongoing bargaining over the contracts of GPs and consultants. These have to reallocate responsibilities in a more rational fashion and allow nurses to take on a wider role within the service. The second is working practices in the NHS as a whole which the Government acknowledges have "learned too little from other employers" and have let to an inadequate

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[114] Department of Health, *The NHS Plan – proposal for a new approach to the consultant contract*, February 2001 & BMA press notice, *BMA consultant leaders reject muddled Government thinking on private practice*, 16 August 2000

[115] Department of Health, *Agenda for change: modernising the NHS pay system*, February 1999

[116] "Health secretary warns nurses on pay: you must do something extra to earn it", *Financial Times*, 25 April 2002, p6

[117] RCN press notice 24 April 2002

[118] "Gold for the NHS", *BMJ*, 27 April 2002, pp987-988

[119] "There are no quick fixes, so ministers must hold their nerve", *Financial Times*, 18 April 2002, p4

[120] "Firms too big for good teaching, students say", *BMA News Review*, 20 April 2002

[121] "Wanless report outlines 'Rolls-Royce' health service for 2022", *BMJ*, 27 April 2002, p998

> productivity performance. This will not be achieved without conflict with the trade unions.[122]

A few days later, the *Guardian* reported the creation of new hybrid healthcare worker roles, being piloted in Kingston upon Thames: "healthcare practitioners" responsible for taking full patient histories, initiating and interpreting diagnostic tests, providing chest physiotherapy and able to prescribe from a limited list of drugs; and "healthcare practitioner assistants", described as "elevated healthcare assistants", with responsibility for routine observations and taking blood as well as general support work.[123] The roles have reportedly been developed on the basis of patient feedback, with the aim of reducing the number of health professionals patients need to see and the amount of time spent waiting around; the trust's chief executive was quoted as saying that "we expect [the posts] to attract some people who don't want to be doctors, feel that nurses' roles are too restrictive or don't want to specialise to the extent of, say, a physiotherapist or radiographer".[124]

The level of productivity gains, above and beyond those achieved through skill-mix changes, will clearly be key in determining the extent to which the NHS is able to meet the greatly improved standards for access to treatment, outlined in the *NHS Plan* and extended in the Wanless report and *Delivering the NHS Plan.* The Wanless report itself recognises that productivity assumptions "are subject to significant uncertainty".[125] John Appleby of the King's Fund was cited in the *Health Service Journal* as believing that Wanless' assumptions on productivity are "realistic", but raising concerns about demand management, arguing that if capacity is increased, demand often rises to use up that extra capacity:

> By increasing spending, you increase the demand to go with it. Doctors start changing their thresholds for treatment. For example, in London the winter before last, there was no flu but all the emergency beds were used up.[126]

Nick Bosanquet, Professor of Health Policy at Imperial College, London has argued that the NHS is facing a "productivity crisis", with big increases in funding in recent years leading to only very limited numbers of extra patients being treated. He therefore concludes that the NHS is unlikely to meet the target reductions in waiting times set out in the *NHS Plan* and the Wanless report.[127] The NHS Confederation, on the other hand, argues for a "much cleverer approach" to measuring productivity, with a recognition that improving the quality of healthcare is also an increase in productivity, even if it doesn't increase the number of patients treated. Similarly, improvements in services may lead to

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122 "Milburn's challenge is to implement flexibility and choice", *Times*, 19 April 2002, p23
123 "Blueprint for the future", *Guardian* Society, 234 April 2002, p4
124 *ibid*
125 Derek Wanless, *Securing our future health: taking a long-term view: final report*, April 2002, p64
126 "The three degrees", *Health Service Journal*, 25 April 2002, pp12-13
127 "NHS 'will miss time target' despite spending", *Financial Times* 25, April 2002, p6

more patients being treated in primary care, with an apparent "loss" of activity in hospital because of the reduced number of referrals.[128] The Wanless report does in fact recommend just such an approach (see above p12).

2. NHS structures and responsibilities

The promise of greater devolution of responsibility from the centre to local NHS organisations has been welcomed in principle, but subject to a degree of cynicism. The question of the extent to which Primary Care Trusts (PCTs) and NHS Trusts will genuinely have the freedom to act autonomously, given the Secretary of State's powers to issue legally binding Directions as to how they carry out their functions, has already been a matter of considerable debate during the proceedings of the *National Health Service Reform and Health Care Professions Bill.*[129] The NHS Alliance, for example, which represents Primary Care Trusts, issued a press notice welcoming the focus on devolution in Alan Milburn's speech,[130] but had warned two days earlier in response to the Budget speech that it was time for the centre to let go:

> "Having put in place health service reforms, creating the new primary care trusts and devolving power to the NHS frontline, government itself must now reform" [Dr Michael Dixon, NHS Alliance chairman] said.
>
> "Its policies can only deliver if PCTs have the freedom to make decisions that meet the health needs of their local communities. That means less micro-management, fewer targets, and central planners taking into account advice from the frontline," Dr Dixon said. "We must have more input from those who understand the impact national decisions will have on local services for patients and the public."[131]

In a similar vein, the Long Term Medical Conditions Alliance noted that "the decentralisation of the NHS is welcome but needs to be backed up with more explanation on how the tension between national standards (NSFs) and local priority setting is to be managed.[132]

Ten days after the publication of *Delivering the NHS Plan*, on 30 April 2002, the Department of Health issued a circular, *Securing service delivery: commissioning freedoms of Primary Care Trusts,*[133] as part of its attempt to "shift the centre of gravity to

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[128] NHS Confederation press notice 17 April 2002

[129] HL Bill 78 of 2001-2002, currently awaiting Third Reading in the House of Lords; for debates on the "decentralisation" agenda see for example HL Deb 14 March cc974-983 & HL Deb 21 March 2002 cc1226-1228

[130] Primary Care Alliance press notice 19 April 2002

[131] Primary Care Alliance press notice 17 April 2002

[132] Long Term Medical Conditions Alliance, *Delivering the NHS Plan: LMCA's response*, April 2002

[133] HSC 2002/7, available on the internet at www.doh.gov.uk/pricare/hsc2002007.htm

the NHS frontline".[134] The circular reminds PCTs that they should "use the full range of flexibilities and freedoms available, now and in the future, to ensure they effectively secure the services required to meet the needs of their local populations". In particular, the circular emphasises that PCTs should feel free to commission services from wherever they can obtain the best care for patients, whether in hospital or in the community and whether in the public or private sector. With immediate effect, PCTs will also have the discretion to determine for themselves how much they spend on their clinical management infrastructure. However, while urging PCTs to use their freedoms to improve their local services, the circular is clearly directive over what they should be seeking to achieve:

> PCTs will want to use their local commissioning discretion to reshape how local health care services are delivered to reduce waiting times, increase responsiveness and improve clinical outcomes. They will want to ensure a focus on prevention services as well as treatment, to forge local partnerships to more effectively address health inequalities and ensure an appropriate balance between investment in primary and community services as well as acute services.

The announcement of new ways of NHS funding flowing around the system, with "payment by results", has led to comments that the Government intends to return to the "internal market" created by the *National Health Service and Community Care Act 1990* in 1991 and abolished by the Labour Government in 1997. While *Delivering the NHS Plan* makes clear the Government's view that the proposed payment mechanisms (see above, p19) would differ from the 1990s internal market, under which NHS Trusts "competed" for business on the basis of both service levels and price, the Conservative Party is unconvinced, with their health spokesman Liam Fox commenting;

> When the Government came to power, they said no internal market, no money following the patient and no GP fundholding. Having broken their promises on taxes, they have now gone back to many of the reforms that they said in opposition they would never tolerate. They are admitting that they wasted five years for all those who use and work in the health service. They were wrong and we were right. The one word missing from today's statement was "Sorry".[135]

Similarly, press comment on the reforms has referred to the "reinvention [of] the Tory internal market"[136] and the "language of the 1990s market place";[137] indeed the American professor Alain Enthoven, who was widely credited as being the architect of the 1991 reforms, has been quoted as describing Alan Milburn's proposals as constituting a "bold wide-open market" by contrast with the "comparatively timid Thatcher-Enthoven

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134 Department of Health press notice 2002/204, 30 April 2002
135 HC Deb 18 April 2002 c719
136 "New Labour reinvents the Tories' internal market", *Independent*, 19 April 2002, p6
137 "New incentives raise ghost of internal market", *Health Service Journal*, 25 April 2002, p3

model".[138] However, a number of differences appear to exist between the system in place in the 1990s and that being proposed in *Delivering the NHS Plan* (the precise details of which, in any case, are still to be worked out): most notably that NHS trusts will not be allowed to compete on price, as reimbursement will be fixed through regional tariffs. The focus will therefore presumably be on issues such as the quality of the care provided and on the extent to which services are organised around the convenience of patients. However, the Long Term Medical Conditions Alliance warned of the danger of the creation of "sink hospitals" in less affluent areas and expressed concern that "in practice [standard tariffs] may result in choice being increased for the purchaser rather than the consumer".[139]

Initial responses in the health press and from professional organisations regarding the creation of "foundation hospitals" have been limited, perhaps because little detail is yet available as to what these will involve. The BMA commented:

> We have an open mind on the question of foundation hospitals. It must be right for patients to have more choice and for the most successful hospitals to expand the services they can offer. However we must avoid the danger of any hospital cherry-picking patients who can be treated quickly and simply to the disadvantage of patients with complex, chronic or intractable health problems.[140]

3. Commission for Healthcare Audit and Inspection

The proposal of creating a new independent Commission for Healthcare Audit and Inspection (CHAI), responsible for inspecting both the NHS and the private sector, and with a remit covering both quality standards and financial management, has on the whole been warmly welcomed. The BMA singled it out for praise, commenting:

> We support the decision to create the Commission for Healthcare Audit and Inspection which we hope will strike the right balance between accountability and hyper-regulation. Currently we have a confusing patchwork of 17 or more regulatory and inspection bodies. We want to see a much more streamlined system which sets common standards for both NHS and private care and which does not pull doctors away from the central task of treating their patients.[141]

The Commission for Health Improvement issued a press release welcoming the Secretary of State's statement and stating:

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[138] "'Payment by results' leaves Thatcher in the shade", *Health Service Journal*, 2 May 2002, pp6-7
[139] Long Term Medical Conditions Alliance, *Delivering the NHS Plan: LMCA's response*, April 2002
[140] BMA press notice 18 April 2002
[141] BMA press notice 18 April 2002

> The bringing together of inspection of the NHS and independent healthcare is eminently sensible and is something we have called for for some time. This announcement is a vote of confidence in what CHI has achieved.[142]

The *Health Service Journal*, on the other hand, reported speculation that the recent resignation of the Chair of CHI, Dame Deirdre Hine, was directly linked with the increasing shift towards a more "Ofsted-like" approach to healthcare inspection. This suggestion has, however, been rejected "outright" by a spokesperson for Dame Deirdre who made the following statement on her behalf:

> I am delighted the government recognises explicit independence is so important for the new organisation. I am also pleased CHAI will encompass the private sector. It is important that, although the new commission will have additional responsibility for reviewing the financial elements of the NHS, emphasis on quality of patient care and the patient experience should still be central to the work it does.[143]

The *Health Service Journal* also cited Andrew Foster, director of the Audit Commission, as welcoming the establishment of CHAI, while expressing "slight disappointment" that the Audit Commission would therefore lose its NHS value-for-money work.[144] However, Mr Foster highlighted the fact that the Audit Commission would still retain its responsibility for appointing external auditors to NHS bodies and noted that, since it would probably take nearly two years before CHAI could be up and running, the Audit Commission might well play a role in developing the audit of how the new NHS funding was being spent.[145]

As noted above, the fact that the new body will be responsible for regulating both the public and private healthcare sectors has received a general welcome, even though the National Care Standards Commission only took over its responsibilities for regulating the care home sector and private health facilities on 1 April 2002. Amendments to the *National Health Service Reform and Health Care Professions Bill*, tabled in March 2002 during the Lords Committee stage, had in fact sought to bring the private health sector within CHI's remit,[146] with similar proposals being made during the passage of the Health Bill in 1999 when CHI was first created.[147] In response to the most recent attempt to extend CHI's role, the Health Minister Lord Hunt expressed "great sympathy" with the principle, but felt it was premature.[148] Ray Robinson, professor of health policy at the LSE, commented somewhat acidly on the apparent change in policy, saying:

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142 CHI press notice 18 April 2002
143 "Hine quits as scrutiny takes an Ofsted-style approach", *Health Service Journal*, 25 April 2002, p4
144 "Audit chief warns on regulation 'risk'", *Health Service Journal*, 25 April 2002, p4
145 *ibid* & "Separate checks", *Guardian Society*, 24 April 2002, p6
146 HL Deb 21 March 2002 cc1562-1566
147 eg Standing Committee A, 13 May 1999, cc711-724 & 18 May 1999 cc727-734
148 HL Deb 21 March 2002 c1564

> The fact that these bodies will subsume the only recently created commission for health improvement and the national care standards commission (the latter only set up about a month ago) does not inspire confidence in the depth or maturity of official thinking on this subject.[149]

Some concern has also been expressed that separate Commissions are being established for health and social care, given the increasing importance of providing "seamless" care across the health and social care divide.[150]

While many of CHAI's functions will be taken over from existing bodies, the role of scrutinising precisely how additional NHS funds are being spent will be new, and has provoked both support and criticism. The *Guardian* suggested that such monitoring would provide "the best safeguard" against the "abuse" of local NHS organisations failing to follow national priorities in their spending plans,[151] while the thinktank Reform was reported in the *Sunday Times* as arguing that "regulation and audit is no substitute for real reform."[152] Ray Robinson, writing in the *BMJ*, set out the position of those opposed to such an audit regime: "But to those people with doubts about the wisdom of yet more top-down performance monitoring and management, these new bodies carry the risk of added bureaucracy, diversion of managerial effort, perverse incentives and gaming".[153]

A number of issues about CHAI's role are not yet clear: in particular whether a single inspection body will lead in time to a single inspection regime (given that at present the registration and inspection regime established through the *Care Standards Act 2002* is very different from CHI's inspection role in the NHS);[154] and whether it will cover Wales.[155]

4. "Cross-charging" between health and social care

The principle that local authorities will become responsible for the costs of NHS patients if they are responsible for delays in discharge from hospital has proved one of the more contentious aspects of *Delivering the NHS Plan*. The BMA accepted that it was a "good idea to provide incentives to local councils to speed up the discharge of patients who are well enough to leave hospital" but expressed concern that "relationships between doctors and social workers, hospitals and councils [might] become fraught due to the threat of financial penalties".[156] The King's Fund commented that "investment in care services still lags behind the NHS" and argued that "a sustained rise in social care spending will need to follow from today's announcement if care services are to keep pace with rising NHS

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149 "Gold for the NHS", *BMJ*, 27 April 2002, pp987-988
150 "Separate checks", *Guardian* Society, 24 April 2002, p6
151 "Can the NHS deliver?" *Guardian*, 19 April 2002, p23
152 "So much for prudence", *Sunday Times*, 21 April 2002, p15
153 "Gold for the NHS", *BMJ*, 27 April 2002, pp987-988
154 "The power of one", *Health Service Journal*, 25 April 2002, p14
155 "Welsh NHS needs a new broom", *Western Mail*, 25 April 2002, p2
156 BMA press notice 18 April 2002

activity".[157] Rabbi Julia Neuberger, the King's Fund chief executive, was also reported to be concerned that penalties for delayed discharge might lead to a reduction in user-choice over care packages, and could result in patients being discharged too early.[158] Gill Morgan of the NHS Confederation urged caution,[159] while the Local Government Association expressed concern that a system which penalised local councils "unable to ensure care for the elderly due to circumstances beyond their control" would undermine partnership working between the NHS and social care.[160]

Delivering the NHS Plan does not include a detailed description of how the proposed system would work; according to the journal *Community Care*, the Department of Health intends to consult councils over the next few months, with the new system not expected to be in force before summer 2003.[161] The architect of the Swedish system on which these proposals are modelled has reportedly "urged the British government to act fast to avoid prolonged wrangling by the organisations the new policy would affect".[162]

5. The role of the private sector

The intention set out in *Delivering the NHS Plan* to enhance the private sector's role in the NHS appears to have produced remarkably little comment, perhaps because it builds very much on existing known policies. Private sector healthcare providers in both the UK and abroad were reportedly "very encouraged" by Alan Milburn's announcement that full use should be made of the private sector to make up for historic lack of capacity in the NHS,[163] while John Edmonds of the GMB union was quoted as saying:

> We have been hopeful of a fresh approach … but it seems that once again he is simply reaching out to the usual privatisation suspects.[164]

6. Patient involvement in the NHS

The proposals in *Delivering the NHS Plan* to increase the extent to which patients and the public feel involved in the NHS prompted little comment, although the Long Term Medical Conditions Alliance expressed "extreme concern" that *Delivering the NHS Plan* did not once mention the proposed Commission for Patient and Public Involvement in Health, due to be established through the *National Health Service Reform and Health Care Professions Bill*:

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157 King's Fund press notice 17 April 2002

158 "Concern grows over penalties for delayed discharges from hospital", *Community Care*, 25 April – 1 May 2002, p6

159 "Realism needed on timescales", *Health Service Journal*, 25 April 2002, p7

160 LGA, *Budget debate on health: briefing*, 24 April 2002

161 "Penalties for delayed discharge may cancel out increases in funding", *Community Care*, 25 April – 1 May 2002, pp18-19

162 "Bed-block pioneer urges UK to act fast", *Health Service Journal*, 2 May 2002, p4

163 "Private health operators cheered by pledge", *Financial Times*, 23 April 2002, p4

164 "Milburn in union clash", *Times*, 20 April 2002, p1

> Plainly the Commission has an important part to play in developing the accountability agenda and its absence from the document is worrying.[165]

The Alliance welcomed the idea of a contract of rights and responsibilities between the NHS and its users but went on to argue that:

> Just as the government emphasises the responsibilities of patients and the need for the NHS to become more responsive, so we want to emphasise the government's responsibilities to be responsive to priorities identified by patients and the public.[166]

In addition to recommending that local contracts should establish the respective rights and responsibilities of both patients and the NHS, Derek Wanless also suggested that consideration should be given to fining patients who miss appointments (see above p16). While no mention was made of this possibility in *Delivering the NHS Plan*, the *Guardian* has reported that Ministers are seriously considering the idea, once the system of booked admissions (that is, patients choosing their appointment times when referred for treatment, rather than receiving an appointment at a later date) is in place.[167]

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[165] Long Term Medical Conditions Alliance, *Delivering the NHS Plan: LMCA response*, April 2002
[166] *ibid*
[167] "Tardy patients could face fines", *Guardian*, 2 May 2002, p7

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