



## Inside this Issue

Systems reform in the NHS.. Or reinventing the NZ wheel?	1
For richer, for poorer: Lifestyle gurus set to advise people on healthier behaviour	5

## Systems reform in the NHS.. Or reinventing the NZ wheel?

For our November seminar we were able to take advantage of Stephen Boardman's short sabbatical as a visiting consultant with Counties Manukau DHB. Stephen is a Director of Fynamore Management Consultants in the U.K. and his assignments have included a review of the national capital allocation system for the NHS Executive and three county-wide reviews of Trust configurations. His particular interests are in strategic planning, service development, investment appraisal and the Private Finance Initiative.

Stephen was Director of Business Planning with the former South and West Outpost, subsequently the NHS Executive where he had responsibility for developing strategic and business planning systems and for appraising and approving business case submissions. He was a member of the national project board responsible for development of the Capital Investment Manual and was seconded to the Private Finance Unit as a professional advisor. Prior to joining the NHSME Stephen was Director of Corporate Development with United Bristol Healthcare Trust, and Director of Planning and Estates with Bristol and Weston DHA.

With that background Stephen was well prepared for his seminar subject "Systems reform in the NHS ....or reinventing the NZ wheel?" While NHS reform has been covered by other speakers, Stephen's interactive flowing debate with his audience brought a fresh perspective to the subject, so interesting that we kept him at his task for 90 minutes. Throughout, Stephen offered his personal opinions, which are not necessarily those of Fynamore Management Consultants.

Stephen began by discussing the NHS reforms over the last 40 or so years. From 1948 to 1984 the NHS was administered in a classic public service way rather than managed, then in 1984 "General Management" was introduced in the Public Service reform we also picked up in New Zealand during the term of the 4<sup>th</sup> Labour government. In the tail end of the Thatcher years from 1989 to 1997 the NHS was introduced to the "Internal market", which was very similar to what we experienced in New Zealand. When Labour came to power in 1997 there were all sorts of system changes that boil down to a "command and control" approach. This might be called "Blair Mk 1". However, since 2002 there has been a shift back to an internal market approach (Blair Mk 2).

In the Thatcher internal market years the philosophy was that the money would follow the patients but this did not really happen because the government was worried about the consequences. This time the money is following the patients, so rather ironically Blair has been able to go far further than Thatcher.

The system reforms in health are part of a much wider government agenda. What is happening in health is also happening in other government departments. There are three elements to this reform: Funds flow - called payment by results but is actually about money following patients; Choice; and Foundation Hospitals. While funds flow and choice affect the whole of the NHS, Foundation hospitals have attracted the attention of the press although they are actually



Stephen Boardman

*(Continued on page 2)*

(Continued from page 1)

only a small sub set of the NHS.

So why is the government going about public sector reform? It is to do with the demographics of the country and a decentralisation from the centre. Currently, the power brokers admit that they do not know all the answers. People who get close to the Ministers hear them saying “stop asking us – we are giving you the freedom to do it. Many people in the NHS are a bit uncomfortable with this because they both prefer and are accustomed to being told what to do.

Stephen’s view is that the change is also about politics. The NHS has become an electoral liability for every government and this is a way of shifting liability away so, come the next election, they will be able to say “actually we are not responsible.” It is also about breaking the power of the medical consultants, the last of the strong trade unions.

Public Service principles call for more choice and diversity of service provision (the NHS is virtually a monopoly provider); the devolution of responsibility; more flexibility for front line workers; and, as opposed to New Zealand, very tight and clear national standards, guidelines and accountability. On senior management accountability, over the past 10 years there has become more and more an entrenched mentality of “if you don’t reach the benchmark you get sacked.”

For the NHS it is move from being a monopoly provider of health services accountable to Department of Health, to a greater diversity and plurality of services, more responsive to patients, inspected and regulated against transparent common standards by an independent body that reports nationally and locally

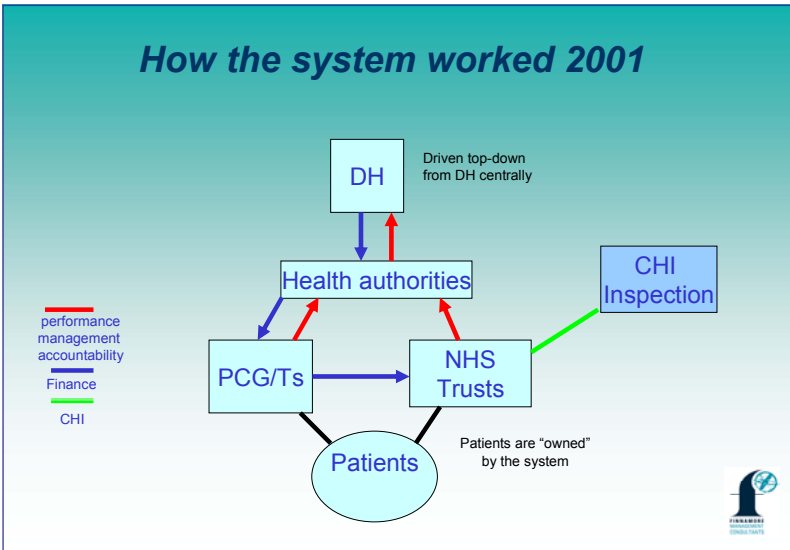
One of the things driving all this is a change in demographics and socio-economic changes. People have larger disposable incomes - 66% higher than in 1986 and this leads to greater desire for choice. There are longer working hours - Number of employees working >46 hours up from 14% in 1984 to 21% in 1998 and with this comes a greater need for convenience. Patients are becoming informed consumers. With 10,000 health information web sites, 62% of UK internet users have used the web for health information and there are >200 patient groups with websites in UK alone. The number of UK health publications has increased from 13 in 1992 to 46 in 1999.

Patient choice is becoming increasingly important. A MORI opinion poll found 28% of hospital patients were dissatisfied with the amount of choice over when and where they were treated and 73% of people think it is important for them to be able to choose which hospital they receive treatment. A BMA poll found that 68% of people would be willing to travel to exercise choice over treatment. So in developing change the government is not targeting their core supporters who will vote Labour come what may. They are targeting the middle class in the south east, because if they do not get their vote they are going to lose the next election.

The implementation of these changes requires greater diversity. The NHS will need to shift from a hierarchical, vertical organisation, to a horizontal organisation with a range of different providers. Such as, GPs with special in-

terests – where one GP can refer to another GP; NHS Walk in Centres to capture people who find it difficult to get on a GP’s register; Diagnostic and Treatment Centres (DTCs) – similar to the Manukau Super Clinic; sending work out to independent providers; and using NHS Foundation Trusts.

The financial system has been changed from bulk funding to payment by results. The objectives are to facilitate patient choice; incentivising good performance; rewarding efficiency; and supporting effective planning and delivery. This introduces a level playing field and is supposed to work for a diversity of providers. Not only will the NHS be paid under this system, other providers can be paid in the same way.



For most of the NHS there will be three phases to the payment by results process. Phase 1: 2003-2005, the tariff will be introduced in a limited way with an increasing use of cost and volume commissioning and use of 15 HRGs. Phase 2: 2005 – 2008, tariff + cost and volume commissioning will be applied to the majority of activity with a 3-year transition path to tariff prices for Foundation Trusts and Primary Care Trusts. For Phase 3 from 2008 onwards there will be a full roll out with national tariff prices for almost all activity.

The Foundation Trusts have the opportunity to be the early implementers. While they have an option, there are big incentives for them to do so. Although there is an election in 2005 there is no chance that this process will be changed. The Conservatives are even more in favour of it than Labour.

A key issue is the tariff structure and there and there are a lot of issues being kicked around on how to make it work. There is a shift to “Spells” from Finished Consultative Episode as the activity measure because a patient’s stay in hospital could be several FCEs. They could be admitted say to the emergency department then be transferred to another department and that would be another FCE. Therefore one patient could generate a number of FCE and cause inflationary accounting. When hospitals were asked how many patients they treated they always quoted their number of FCEs because it was a higher number. With ‘Spells’ each spell will account for the whole of a patient’s episode at hospital.

(Continued on page 3)

(Continued from page 2)

There is a query about elective and non-elective admission because at the moment the tariff is the same yet when patients are admitted in an emergency the costs tend to be higher so there is debate about whether there should be combined or separate tariffs. Outpatients is interesting because there is a move to only pay for the first and one follow up visit. This change is offered as a disincentive to having repeated follow up visits because if you get paid for every visit you will keep calling patients back.

There is an assumption that this whole process is a zero sum game. That is, across the country the average cost of a procedure will be the same and everybody will be paid that average cost. The problem with this approach is that many providers will not be able to get their costs down to the average because a lot of their costs are fixed costs and they can not shed those fixed costs easily. So there is a real anxiety that while in theory it is a zero sum game, in reality it is not.

your waiting lists down or get sacked.

Senior Civil Servants would ring up Trust CEOs and say “you have still got 3 people on your waiting list after xx months – get them off or get another job.” One consultant confided that in 10 years there have been 8 Chief Executives (including acting CEOs) at his Trust. The latest CEO walked in and said, “Either you are going to get the waiting lists down or I am going to get sacked.” Such motivation did not work for that consultant. The average life of a CEO in the NHS is 22 months. Management consultants, like Stephen’s firm, are often the holders of the corporate memory of an organisation. They have been working with one hospital for 6 years and in that time there have been 4 CEOs.

Focus groups and surveys show that patients want more choice and control over the services they receive from the NHS. In a London patient choice project, 70% of patients chose to move hospital. The availability of a choice of when and where to have treatment is seen as attractive and

the developing agenda on patient choice is starting with the choice of hospital for elective surgery. This northern summer patients waiting more than 6 months have had a choice of hospital for elective surgery. Then from December 2005 the choice of hospital will be available at GP referral.

Consultation on extending choice within the NHS will include primary care, chronic conditions, and maternity care. Patients can choose from four or five potential providers. This is, at the best, idealistic. For much of the country, even in large centres, there are only one or two hospitals. Patients will be supported in making their choices by the Primary Care Team/call centres and information to support choice will be made available through the Directory of Services, which will be linked with [www.nhs.uk](http://www.nhs.uk)

There is little spare capacity in the system for all this so the government is trying to create capacity by bringing in extra providers, some from abroad. There is also an untested belief that some providers will be able to do the procedures more quickly, efficiently and cheaper and this will create capacity.

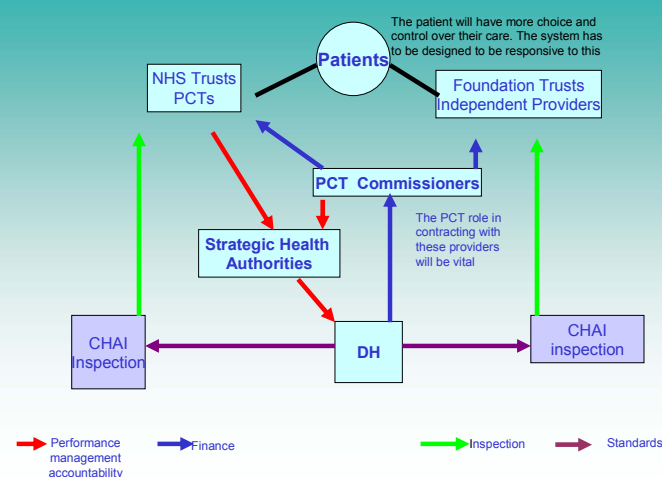
The impact of patient choice is to create a cultural shift from a paternalistic health service to one where patients have more control over their own care. Consultants will no longer ‘own’ their own lists of patients and providers that attract patient choice will be financially rewarded. If this works it is going to destabilise the private healthcare sector because if one can get treatment quickly in a public hospital why would they bother paying to go to a private hospital? It will break the consultants’ monopoly but there are serious doubts as to how realistic it will be outside the big cities.

There are some common misconceptions which it has suited politicians to perpetuate. Such as, the Foundation Trusts are part of the NHS perpetual revolution and an end in themselves; FTs are the most fundamental change to the NHS by this Government; the single most important thing about FTs is private sector borrowing; and FTs are the privatisation of the NHS. None of these things are true.

FTs are one part of a wider reform programme and are about improving services for patients in line with the NHS

(Continued on page 4)

### How the system will work: 2006



A major question is how failure is going to be handled. It can be argued that when you give people the managerial freedom to succeed you have to give them the freedom to fail - and then what do you do with them when they fail? There is an entrenched attitude in the NHS that if you hold out the government will have to give in because no government can allow a hospital to go bankrupt. The health system has got to believe the government will allow some to fail; otherwise the old system will just carry on.

Paying by Results offers Primary Care Trusts the opportunity to drive service changes. (PCTs are more like our DHB funding arm than a PHO) The challenge for providers will be to be at least as efficient as the average. For PCTs and providers the key is the adoption of cost and volume contracts and financial planning within the tariff. Foundation Trusts are being supported in taking the lead in the transition process.

The second leg of change is an emphasis on patient choice, or the “waiting list” agenda. This is where Labour may have made a rod for its own back. Back in the 80’s and 90’s in the Thatcher years the government got more and more worried about the increasing waiting lists and Labour, before it got elected, made promises that it would cut waiting lists. When it got elected waiting lists did not shrink so it brought in this command and control mentality – either get

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Plan. The Department of Health says that the single most important thing about FTs is the governance structure, which is a complete change from the corporate governance model of the NHS. A more pragmatic view is that the most important thing is it is a means of getting the Department of Health off your back.

People are debarred from being members if they are a bankrupt, have been imprisoned for more than 3 months in last 5 years, or for any other relevant circumstances. Governors, who must be members of the Trust, are elected for a three year term and their duties are to: approve annual reports and accounts; approve the appointment of the auditor; hold public and non public meetings; and set remuneration and allowances for the executive directors.

The Trust Board of Directors has the usual governance restrictions. There must be a non-executive Chairman and as a minimum, the Chief Executive and Finance Director must be members. Non executive directors must make up the audit and remuneration committees and there is a duty to consult with the governors on the annual report and strategic plan.

If you are running a Foundation Trust hospital what will seem most important is the Independent Regulator, the body set up to scrutinise you. The Independent Regulator is an office appointed and paid by the Secretary of State and accountable to Parliament. The setting up of this office has been a real culture shock to both the Department of Health and the hospitals. The Regulator alone, independent of parliament and ministerial pressure, has the ability to authorise the establishment of Foundation Trusts.

Bill Moyes, the current Regulator has a commercial/banking and NHS background and his approach has been to operate with a light touch. He has a small team of advisors with non NHS backgrounds and they are unlikely to ring up a chief executive and tell them to get their waiting lists down or face the sack. The Regulator is at least 90% financially focussed and the big message he is trying to get across the Foundation Trusts is that he has not got any money. They can not go to him and say “we have a hole in our accounts, bail us out,” he has not got any money and can’t bail them out. If they are going to go bust they will go bust.

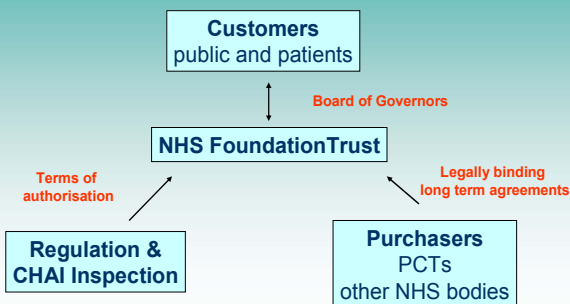
The Regulator is responsible for ensuring Trust’s compliance with their ‘terms of authorisation.’ CHAI, the normal health inspectorate, has the right to inspect but it is the Regulator who decides what action to take as a result of inspections and he will only intervene in cases of significant breach of the terms of a Trust’s contract.

The Foundation Trusts enjoy the freedom of being genuinely independent companies. The Secretary of State has no power of direction and there is no performance management. (Most) NHS operational requirements do not apply – existing directions become good practice guidance only. The Trusts have a greater flexibility to raise capital and a greater flexibility to retain and reinvest surpluses for NHS purposes.

The Trusts generate income through long term legally binding agreements with PCTs and this income can be augmented by partnership in other related commercial activity. The legally binding agreements with PCTs shift the risk from the hospitals alone to a shared position and have alarmed the PCTs who will now have to be much more precise in their planning for the purchase of procedures. Initial contracts are for a period of 3 years and this will extend to 5 years or even longer in future contract rounds. This different way of doing business builds on the commissioning of the Trusts and emphasises risk sharing, conflict

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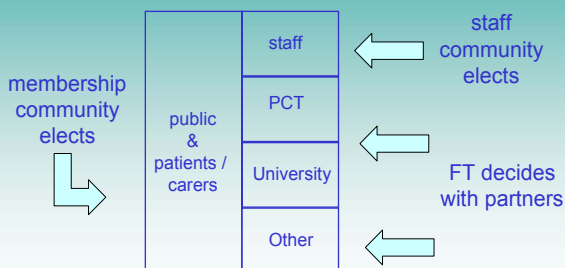
## Accountability



What is new about the NHS Foundation Trusts is that they are a new organisational form with a new accountability structure, new governance arrangements and new freedoms. They are a new legal entity called a Public Benefit Corporation. While dressed up in another name they are really a co-operative or mutual aid society - a company with no shareholders and no dividends that must adhere to the values and integrity of the NHS. Their purpose is locked and the return on any assets sold must be invested back into the business.

The governance body of a Trust, about 30 or 40 people representing the members, probably only meets 2 or 3 times a year. The chair of the governance body is also the chair of the Board of Directors and acts as a link between the two. The Trust membership is voluntary and made up of people living in its catchment area, patients and staff. Members elect the Governors who have a responsibility to represent the community that elected them. The majority of governors must be patients/public and there must be at least one staff, one University Teaching Hospital and one Primary Care Trust representative.

## Board of Governors



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avoidance, greater transparency and working in partnership.

So why does the Department of Health think the Foundation Trusts will work? Reforms in European Systems have raised performance across the piece and there not for profits have outperformed the rest. In Sweden breast cancer diagnosis to treatment takes 13 days; in Spain hip replacement referral to OP appointment is 8 weeks; in Denmark elective surgery is performed within 2 months and cancer diagnosis to treatment takes 6 weeks.

Will Foundation Trusts work? When Stephen explains them to New Zealand health managers the usual response is that "it sounds like our CHEs." He notes that we got rid of CHEs and suggests that there must have been a good reason for us to do so. He questions - is there something England should be learning from our experience? There has always been a massive reaction to 'payments by results' and the Strategic Health Authorities got very concerned just 6 months into implementation and have been trying to draw the PBR scheme back. The result has been a power struggle between the Strategic Health Authorities and the Trusts whose view is that after being started down this road they can't be pulled back and retrenched after only 6 months.

How the system will cope with failure is a major uncertainty. The implication with all these changes is that hospitals are going to have to be allowed to fail – otherwise everyone will just keep carrying on in the same way and look to get bailed out when they fail. Like our PHOs, some of the Primary Care Trusts are large and some are small, some are well set up and resourced and some are not.



Stephen responding to a question from his audience

How successful the PCTs will be in negotiating hard nosed contracts with the Foundation Trusts is questionable with most of the best managers, almost by definition, being located in the Trusts. The Foundation Trusts are saying they would like to see a building of increased capacity into the PCTs otherwise they are unlikely to be able to cope with the demands of the system.

Finally, this whole structure is very IT dependent for tracking patients and for patient choice. The government has just introduced what has been described as the biggest IT project in the world. Will it work? World wide the track record for IT projects is not good.

Will these changes work? Stephen's view is that they have to. This is the Last Chance Saloon. The government has poured in resources and if the sector can't make it work the next option will be to privatise healthcare. We will sit and watch with interest.

## **For richer, for poorer: Lifestyle gurus set to advise people on healthier behaviour**

IN responding to the latest English Health White Paper The Economist commented, "In the case of nutrition and health, just as in the case of education, the gentleman in Whitehall really does know better what is good for people than the people know themselves." It was Douglas Jay, a minister in the post-war Labour government, who wrote those words; but it might as well have been Tony Blair or his health minister, John Reid. There is a lot in the white paper and the conditions it seeks to combat that will be familiar to us in New Zealand. Can we expect to hear similar words from our Molesworth Street mandarins?

Mr Reid says that the government's proposals on public health, published on November 16th, are designed to promote "informed choice". But the centrepiece of the white paper is a ban on smoking in most public enclosed places. The government is also seeking to curb television advertising of junk food and drink to children, and wants to use the National Health Service to cajole patients into healthier behaviour. The NHS, which already employs 1.3m in England, will hire "health trainers"—instantly dubbed "lifestyle gurus"—who will advise people on how to mend their ways.

One reason for the new strategy is money. The government is pouring cash into the NHS at the moment, but the spending spree is due to end in spring 2008. The new measures will cost around £1 billion (\$1.85 billion) over three years. But Mr Reid told the House of Commons this week that "many times that amount will be saved".

Such potential savings arise from the strong link between behaviour and health. This has long been recognised. In his classic text "Who Shall Live?" published 30 years ago, Victor Fuchs, a health economist at Stanford University in California, wrote that "differences in diet, smoking, exercise, automobile driving and other manifestations of 'lifestyle' have emerged as the major determinants of health."

Since then, a lot of the improvement in life expectancy in Britain has resulted from a decline in smoking. Thirty years ago, 45% of adults smoked, now the rate has fallen to 26%. This has contributed to hefty declines in death rates from lung cancer and

*(Continued on page 6)*



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Inform Editor Bruce Parkes

## Seminar Programme

The Auckland Branch Committee thanks all those who have so willingly given their time to present during our 2004 Seminar Programme.

We also thank members and friends who have supported the programme and trust the opportunity to network and join in ongoing professional education has been worthwhile.

We look forward to your continued support in 2005.

Our seminar programme is supported by



*(Continued from page 5)*

coronary heart disease in the past decade.

However, the decline in smoking has levelled out since the early 1990s. And other changes in behaviour are likely to undermine health. In particular, Britons are becoming fatter. In 1980, 8% of women were obese; in 2001, 24% were. Worryingly, children have also been getting fatter. In 1995, 9.6% of children aged two to ten were obese; by 2002, this had risen to 15.5%. If these trends continue, more and more people will develop diseases such as diabetes, both threatening the prospects for further gains in life expectancy and pushing up the cost of the NHS.

But it is not just the prize of better health at low cost that inspires the public-health strategy. The policy is also designed to reduce persistent health inequalities. Male life expectancy at birth for Britain's top social class was 7.4 years higher than for the bottom social class in the late 1990s. The gap has widened since the early 1970s when it was about 5.5 years.

The link between health inequalities and behaviour is manifest. Smoking is now concentrated among lower social groups. For example, 42% of male unskilled workers smoke, compared with 15% of professional males. Research suggests that such differences in smoking rates account for more than half the difference in male mortality between the top and the bottom social classes.

As people get fatter, another class divide is opening up. Some 28% of women in the bottom social class are obese—twice the rate among those in the top class. Obese children, especially girls, are more likely to come from lower social groups, which also eat about 50% less fruit and vegetables than professionals do.

For a government that is sensitive to accusations that it has pandered to the middle classes and done too little for the poor, such dramatic inequalities look like an opportunity. But observing that there is a large gap between the poor and the well-off is a lot easier than reducing it.

Even banning smoking in public places won't achieve that much. The government estimates that it will lead to a fall in the smoking rate of about 1.5 percentage points—way short of its goal to reduce the national rate from 26% to 21% by 2010 and the rate among routine and manual workers from 31% to 26% over the period.

Changing diet may be even harder. The government wants restrictions on television advertising of foods and drinks that are high in fat, salt or sugar. But Ofcom, the communications regulator, says that television has "modest direct effects on children's food choices", so such curbs are unlikely to have much impact.

Attempts to prod people into healthier lifestyles—whether by nurses, doctors or the new "health trainers"—are also unlikely to produce quick results. For example, research into such interventions for alcohol abuse shows only "small to medium" effects six months later.

Habits take a long time to change. Yet the health of the poor has improved in the past decades, and will continue to do so. Where the rich lead, the poor will eventually follow; and government chivvying probably encourages them along.

These comments, with a few appropriate changes to reflect our population mix, seem an appropriate summary of the health status of New Zealanders and the populations of all "developed countries."

### Contributions Welcome

1. The Auckland Branch welcomes contributions to **Inform** on subjects of interest to managers in the health and disability sector. Articles may be longer researched contributions, comments on current practice, or shorter notes and/or reviews. The range of possible subjects is very wide.
2. The maximum length is generally 3000 words. Shorter contributions are very welcome. Please include an e-mail address so authors can be contacted and a brief list of key points or an abstract.
3. Copy should be provided by electronically
4. Contributions may be passed to the Editorial Committee for consideration.
5. Make submissions or e-mail the Editor for more information at [admin@nzihm.org.nz](mailto:admin@nzihm.org.nz)