

Conservative party health policy

'NHS AUTONOMY AND ACCOUNTABILITY: PROPOSALS FOR LEGISLATION'

This briefing analyses and comments on the key proposals contained in the policy document *NHS Autonomy and Accountability*, which was released by the Conservative party in June 2007 (Conservative Party 2007a). The document contains the most detailed policy proposals on the NHS released by the main opposition party since the election of David Cameron as party leader in December 2005.

Background

The Conservative party has already published several documents and papers on the NHS, specifically on public health (Conservative Party 2007b), two mid-term reports on targets and commissioning (albeit with limited detail) and the more substantial final report of the health element of the Public Services Improvement Policy Group, which was set up to collect evidence and make policy recommendations (Conservative Party 2007c) (all reports are available via the Conservative party website www.conservatives.com/). This last document, entitled *The National Health Service – Delivering our Commitment*, contains 99 proposals to the Shadow Cabinet based on oral and written evidence from a range of stakeholders. All the proposals are structured around the theme of how to put the NHS back on track to deliver the 'fully engaged' scenario identified in the Wanless review of 2002 (Wanless 2002). There is particular emphasis on improving public health, better care of people with long-term ill health and reduction of health inequalities as key elements in improving productivity and reducing spending on health in the future. The proposals also include calls for better commissioning, greater clinical and managerial independence from the centre and a strong focus on outcomes data as a means to this end (Conservative Party 2007c).

NHS Autonomy and Accountability represents an initial response from the Conservative leadership to some of the Public Services Improvement Policy Group's proposals. There are some ways in which this response differs from the Public Service Improvement Policy Group's report: it does not use the Wanless scenarios; in the Public Services Improvement Policy Groups' recommendations, the idea of an NHS Board and stronger commissioning is described as the 'sine qua non for the delivery of a 'fully engaged scenario'', whereas they are developed in *NHS Autonomy and Accountability* without this overarching framework.

Content

The proposals are covered under seven headings: values of the NHS; accountability; Payment by Results; autonomy in commissioning; autonomy in delivery; valuing staff; the role of the Secretary of State.

VALUES OF THE NHS

The Conservative party proposes enshrining the ‘core principles’ of the NHS, (as laid out in the NHS Plan (Department of Health 2000)), in legislation. These core principles are very similar to those being proposed by the Labour government (Department of Health 2006), but the Conservative party draws particular attention to the importance of re-stating a principle that ‘public funds for healthcare will be devoted solely to NHS patients’, which was in the original NHS Plan. The Conservative party argues that omitting this principle risks that NHS funds could be used to ‘cross subsidise private healthcare’, a former Conservative party policy known as the Patient Passport (Conservative Party 2004), which was repudiated by David Cameron in 2006 in a speech at the King’s Fund (Cameron 2006).

ACCOUNTABILITY

This section states the Conservative party’s intention to work with the current government’s proposed reforms to patient and public involvement, known as Links (Local Involvement Networks) and enhance them with a national body known as ‘Healthwatch’. They also propose to enhance the powers of local authority Overview and Scrutiny committees, but no further details are given.

The party also proposes to extend individual care budgets to those living with long-term conditions. In addition, PCTs will have to publish a ‘health improvement plan’, over which they are legally obliged to consult with their local authority. Finally, patient choice is recognised as a way of ensuring accountability (as well as better services) and the Conservatives commit to it as a matter of principle. Choice for patients is not fully defined; at this point the document merely refers to choice ‘over where they are treated’.

PAYMENT BY RESULTS

The mechanism for paying for episodes of hospital care that was first introduced to foundation trusts in 2003 and is being extended to other parts of the NHS, is claimed as an essentially Conservative idea and given full support. The paper criticises the current Payment by Results system as too rigid and proposes that the tariff is no longer based on average costs. It argues that it should be reformed to incentivise the most efficient providers, who should also be allowed to offer discounts on the tariff to commissioners after 2008. The paper also proposes that the tariff be set by an independent body to avoid the risk of political interference.

AUTONOMY IN COMMISSIONING

This section proposes that PCTs should no longer be providing services and should be commissioners solely, as was originally suggested by the government in its *Commissioning a Patient Led NHS* in July 2005 (Department of Health 2005). The Conservatives also propose that the current policy of practice-based commissioning be extended, to allow primary care clinicians to hold ‘real’ budgets (compared with the ‘notional’ budgets under the current government policy where actual resources are administered at PCT level). Clinicians will also ‘hold and vary’ contracts with providers. Primary care commissioners would receive an allocated budget (for purchasing services for their patients) based on a weighted capitation formula, and their salaries (for providing services to their patients) would partly depend, as now, on performance. Patients would be entitled to choose their GP and, by extension, their commissioner, which would create ‘contestability’ in commissioning which is absent from current government policy at the moment. The whole commissioning process would be overseen by an independent board for the NHS, which is the centrepiece of the Conservatives’ proposals. The board would be appointed by Ministers and accountable to Ministers and Parliament. It would allocate

resources, set commissioning standards on the basis of advice from the National Institute for Health and Clinical Excellence (NICE), performance manage commissioning, develop contracts for commissioning, directly commission specialist care and resolve disputes between local authorities and PCTs.

AUTONOMY IN DELIVERY

The Conservatives say they plan to ‘encourage’ all trusts to become foundation trusts. More investment and borrowing freedom is proposed for foundation trusts, although the detail still has to be worked out, in particular how to balance the risks of increased freedom to borrow with the need to safeguard public services in the event of financial failure. In addition to NHS providers, the Conservatives enshrine the right of any autonomous provider, who meets the requisite standards, to compete to offer services to NHS patients. In recognition of the challenges created by this new competitive market, dubbed a ‘social market’ in recognition of its social objectives, the Conservatives propose an economic regulator (an expanded Monitor) to work alongside a quality (and value-for-money) regulator (a merged Healthcare Commission and Commission for Social Care Inspectorate (CSCI))

VALUING STAFF

More autonomy is proposed for the various professions, particularly in developing their own training. In relation to workforce planning, it is proposed that NHS (and private) providers take more responsibility for workforce in the future and bear the risk of poor forecasting. There are few details attached to this proposal (and a promise to consult widely) but the Conservatives argue that providers will face a stronger incentive to get planning right, either to avoid the ‘deadweight costs of educating and training beyond requirements’ or hiring extra staff in the event of a shortage. On pay, the Conservatives foresee a reduced role for Ministers and more local autonomy in the future; for now, they plan to retain the national pay review bodies, but envisage negotiations over staff contracts taking place between the NHS Board and NHS Employers, with Ministers advising on overall affordability. The legal right of local health care providers to determine pay will remain.

THE ROLE OF THE SECRETARY OF STATE

A list, (albeit ‘not exhaustive’) of the functions of the Secretary of State is contained at the end of the document. This reflects the realigned responsibilities implied by the NHS board, with direct Ministerial responsibility for delivery mentioned only for public health and emergency planning, but nevertheless includes having to ‘account to Parliament for the NHS’.

A number of themes are threaded throughout the document, including a commitment to avoid future reorganisations of the health service, a commitment to reduce reliance on targets, particularly those based on ‘input’ measures, a determination to introduce more measures of progress based on ‘outcomes’ (for example, improvements in morbidity or self-reported patient outcomes) and a commitment to allow professionals, particularly ‘front line NHS clinicians’ to have more autonomy.

Commentary

NHS Autonomy and Accountability confirms how congruent policy between the two main parties is. Previous Conservative policy statements had already endorsed the idea of a tax-funded, universal NHS, free at the point of delivery. The abandonment of the Conservatives’ 2005 election idea of the ‘patient passport’ is emphasised in this document, with its suggestion of using legislation to outlaw any future cross-subsidy of NHS funds with private funds. This latest paper endorses the main ideological principle underpinning Labour’s reform programme for the NHS in England – namely, to use market-inspired competition for patients and contracts to sharpen the responses of public sector providers (which is not surprising given that this approach to public sector reform took root under previous Conservative governments). But, crucially, the document accepts many of the existing policy tools set up by the Labour government to achieve this, for instance Payment by Results and practice-based commissioning. The Conservative commitment to avoid more reorganisation (a theme that has now

been echoed by the current Secretary of State for Health (2007)) also means they are accepting many of the current institutional arrangements, such as the existing configuration of PCTs and strategic health authorities and the roll-out of foundation trusts.

The document also acknowledges and supports some of the government's future institutional reforms, for instance, the creation of Links, the new patient and public involvement forums and the merger between the Healthcare Commission and the Commission for Social Care Inspectorate. It also suggests some reforms that are very close to current government proposals (without acknowledging the similarities) such as some of the options being discussed for Payment by Results after 2008/9 (Department of Health 2007b) or the close similarity between 'Health Improvement Programmes' and the government's current proposals for PCT 'prospectuses' and Local Area Agreements (Department of Health 2007c).

On the other hand, this document can also be seen as an attempt to carve out some new ground and place some distance between Labour and the Conservatives on health policy. The most significant apparent difference is the creation of greater independence and autonomy for the NHS, which is designed, according to the paper, to reduce day-to-day 'ministerial interference' and make the service more accountable to patients and the public. The vehicles for this include an NHS Board and relocating some Department of Health functions, such as tariff-setting, to independent agencies. Other policy differences include a more extended, radical form of practice-based commissioning, considerably extending Monitor's brief (currently limited to regulating foundation trusts to include market regulation and a host of other functions) and dropping 'process' targets, such as those concerned with waiting times.

Some of the arguments around greater independence are, however, in need of further development and in places are conflated with other policy objectives, such as abolishing national targets. The document gives several examples of the 'political interference', which the NHS Board is designed to prevent. One is the government's alleged focus on 'narrow, process-based targets, such as the speed at which patients receive their first treatment' and the Conservatives pledge that:

To ensure that political interference does not result in the distortion of clinical priorities and the denial of autonomy to front-line NHS clinicians, we will establish an autonomous NHS Board to oversee the commissioning of NHS services.

Here, the NHS Board is held up as a means of ensuring 'autonomy' for front-line clinicians, and implies that it will act as some sort of barrier against 'politically driven' targets of any kind. Leaving aside the question of whether waiting times targets might have actually been in patients' interests, it is quite clear that the Conservatives are not, in fact, offering a vision of complete clinical autonomy from targets. The document goes on to describe something very close to the idea of a target, albeit with a different set of metrics, that the NHS Board would have to deliver:

The Secretary of State will agree with the NHS Board a set of objectives based on improvements in measurable health outcomes (rather than processes) over a given period of time.

Several assumptions underlie this, which are open to question. The first is that these outcome-based objectives will not result in any distortion of clinical priorities or impinge on clinical autonomy in any way. The second is that outcome-based objectives for the NHS, which are performance managed by an NHS Board will feel any different to 'targets' for the NHS, performance managed by Ministers. Third, the difficulty with outcome-based objectives, such as reduced premature morbidity rates from coronary heart disease, is that the precise contribution of health care interventions is hard to measure, raising the risk that the NHS Board could agree to objectives over which it may have limited control or impact.

The Conservatives do offer a short list of specific functions that the NHS Board and/or other agencies might discharge in the search for greater autonomy. One of these would be setting the national tariff that underpins Payment by Results, which the Conservatives propose should be set in the future by Monitor. The Conservatives argue that the decision to increase the national tariff at a rate below inflation (in the health sector) for the past two years amounts to political ‘manipulation’ of the tariff, which would be avoided if Monitor discharged this function. However, Payment by Results is designed to be more than a mechanism for reimbursing paying providers. It aims to be a policy lever to generate greater efficiency, achievable partly through the level at which the tariff is set. So while it might be desirable to improve the quality of data collection (by better scrutiny from an independent agency) or increase the autonomy of those calculating the tariff (or indeed modelling the impact of different types or levels of tariffs), any decision relating to the rate of increase of the tariff can be regarded as essentially a political one, since it relates to the overall budget of the NHS and the specific policy objectives (such as greater efficiency) that are being pursued. For example, if a future Conservative administration wanted to drive greater efficiency in the system by setting objectives that then led the ‘independent’ board to change the tariff, would this be any different from the current system?

Another proposed function for the NHS Board (to be removed from ministerial control) is the allocation of NHS resources. The Conservatives argue that the funding formula has been ‘manipulated’ by ministers in 1998 by adding an objective to reduce avoidable health inequalities, which, the Conservatives argue, as resulted in a ‘mismatch of NHS resources and demands on the service’. It is not clear from the document whether the Conservatives’ real objection here is not to ‘interference’ per se, or a much more fundamental disagreement with the current allocation formula, which, among other factors such as age, disease burden and population size, also includes measures of deprivation (as a determinant of ill health) to calculate need. Previous Conservative campaign documents have explicitly rejected the inclusion of measures of deprivation into the formula to calculate need which has resulted in, according to the Conservatives, ‘some areas with a low disease burden, but deemed to be socially deprived, receive much more funding than areas deemed to be affluent but with a high burden of disease’ (Conservative Party 2007c). *NHS Autonomy and Accountability* states clearly that ‘NHS resources should only be allocated to areas in order to ensure equal access to healthcare for all’, suggesting that actual demand (and burden of disease) rather than unmet need will drive allocations in the future. Further clarification might be needed on whether (and how) the Conservatives plan to fund an attack on health inequalities, since the Public Services Improvement Policy Group recommended that a future Conservative government *should* ‘target resources on the lower [health and deprivation] quartile to close the health inequalities gap’ (Conservative Party 2007b).

To make a fully informed judgement on some aspects of the proposed NHS Board more detail will be needed – for example, the following functions are identified:

- setting commissioning guidelines on the basis of advice issued by the National Institute for Health and Clinical Excellence (NICE).
- setting of standards for commissioning in the NHS, taking into account the available resources.

A wide spectrum of action is possible within these functions, ranging from overseeing broad national standards of care (such as expanding the existing National Service Frameworks, as recommended by the Policy Group (Conservative Party 2007c)) to much more detailed guidance on individual procedures, which might aim to reduce some of the clinical variation around the country, but which would also entail very close scrutiny of clinical decisions and conflict with the objective of greater clinical autonomy.

Apart from the NHS Board, another important area of potential difference between Conservative and Labour is the future development of primary care commissioning. The Conservatives are proposing a big expansion of practice-based commissioning, by giving primary care clinicians real budgets and allowing patients to choose their commissioners. As with the NHS Board, many of the proposals demand more detail. For example, there will be a need to minimise the bureaucratic burden on GP

practices implied by holding budgets and managing contracts with multiple providers. In order to motivate GPs to engage with this more onerous version of practice-based commissioning there will need to be new incentives. The radical idea that under this system patients will choose a 'commissioner' will also require a great deal of further work and would mean a fundamental change in the nature (and capacity) of general practice in England. Many of these new incentives would also have to avoid the danger of GPs selecting patients to improve their outcomes and financial position.

The proposals on regulation likewise require further detail. Although the document lays out a coherent argument for having an economic regulator and for splitting the economic regulator from the quality regulator, the proposed expansion of Monitor does appear to lead to a potential overlap of functions. The document proposes that the Healthcare Commission (once merged with CSCI) monitors quality and safety, while Monitor's role also seems to include 'promoting safety and quality in healthcare services'. Monitor's remit certainly appears very broad: encompassing performance management, setting the tariff, promoting competition and licensing providers. Private and third sector competitors might also claim that for Monitor to performance manage foundation (and other trusts) *and* be responsible for setting the NHS prices for providers constitutes a potential conflict of interest.

Although, as discussed above, the Conservatives do not plan to eradicate targets completely, it is clear from *NHS Autonomy and Accountability* that their intention is to switch the focus from data about 'inputs' to 'outcomes', including patient-reported outcomes. Current government policy has also highlighted the need for a shift of focus to health outcomes (Department of Health 2007b). Many health economists and policy analysts have long called for the routine collection of patient-reported outcomes, as it would allow a much clearer understanding of the relationship between investment in health care services and the efficacy of those services (Appleby and Devlin 2005). It would also generate information that would be of considerable interest to patients needing to choose a provider of care. A shift in focus to 'outcomes' was promised in Labour's 1997 Manifesto ('with Labour, the measure will be quality of outcome, itself an incentive for effectiveness') but never materialised and most of the high-level targets have focused on measures of time waited or procedures performed. The Conservatives 'mid-term' report referred to the use of a specific patient reported outcome tool (known as the EQ 5D). There are many who would welcome further detail on this, including a more in-depth assessment of the costs and benefits of such an approach.

Conclusion

The Conservative party's policy on the NHS now has a much clearer shape as a result of this latest publication. The commitment to avoid further reorganisation will no doubt be welcomed by those working in the NHS. But not all the proposals are without implied upheaval, for instance, the promise to split provision from commissioning in PCTs, which produced a rebellion when it was announced by the current government in July 2005 before being watered down a few months later. The radical extension of practice-based commissioning also implies some upheaval, particularly for the front-line clinicians whom the Conservatives are concerned to free from interference in the future. The idea of an independent board has superficial appeal but a great deal more detail needs to be worked out.

More documents are promised from the Conservative leadership in the near future, which will flesh out the proposals to make public health and the care of people with long term health problems much bigger priorities for the NHS (Conservative Party 2007a). These are to be welcomed and will help to clarify the Conservatives' approach on how the NHS should balance the current demand for efficient and effective health care services with investment in the more complex 'upstream' interventions that might help reduce demands on those services in the future.

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