King's Fund

The Future of the NHS

A framework for debate

Discussion paper
January 2002

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King's Fund

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Summary

- A clear and structured debate about the future of the NHS is imperative. In the wake of the *NHS Plan*, the King's Fund brought together a group of commentators, academics and practitioners from health and other sectors to consider the best ways forward. *The Future of the NHS: A framework for debate* presents the group's broad analysis of current problems and three approaches to change.

- Health care policy debate needs to recognise a number of constraints and realities:

  – The NHS has a history of underfunding and, consequently, the UK suffers a lack of capacity (in terms of both staff and facilities) in comparison with European neighbours.

  – Reforms of complex health care services must proceed cautiously and on the basis of experimentation and evaluation, and avoid over-rapid reform driven by political expediency.

  – All modern health care systems face similar problems, and 'cut-and-paste' reforms across countries are unlikely to work. Politicians and the public will need to face up to the fact that change will require inevitable trade-offs between different, often equally desirable objectives.

  – While funding is an important part of the incentive framework for health care organisations, the key issue for improving the NHS is not source of funding. On the grounds of equity and efficiency of collection, the existing financing arrangements – predominantly through general taxation – are currently the best way of paying for health care.

- *The Future of the NHS* identifies three immediate and inter-related problems that need to be tackled: over-politicisation of the NHS, excessive centralisation, and a lack of responsiveness to individuals and local communities. The key to these problems is enabling frontline staff, patients and the public to assert greater influence over how health care is managed and delivered. This discussion paper identifies three approaches to change:

– A new legislative settlement could be implemented that would create greater distance between the Government and the NHS. It would foster the local initiative and leadership on which successful reform depends. An NHS corporation, at arms-length from Government, could oversee national standards, local funding allocation, regulation and institutional learning. This would leave the Secretary of State and health ministers free to focus on funding, setting the broad strategy for health (not just health care) and establishing an ethical framework within which policy and practice should evolve.

– Consideration should be given to a more permanent separation of local health care provision from central control. This might involve establishing NHS hospitals as new types of not-for-profit organisations, answerable to the local community and local health care purchasers. This would stimulate local accountability and initiative, and create new managerial and financial freedoms to engage in the development of services that better match local needs.

– There is a need to extend opportunities for patient choice. The NHS has to recognise and harness growing consumer awareness in public services, and use choice to ensure that services develop in line with patient preferences. High-quality performance information, stronger, more transparent systems of regulation, and financial incentives for service providers must underpin this. But choice in health care systems is very different from other areas of consumer choice. Opportunities for greater choice have to recognise certain limits and constraints, given that the NHS has to use its finite resources for the benefit of all.

- Taken together, these ideas provide a timely reminder of the need to base reform on a devolution of power from the centre. A clearer separation of Government from the delivery of health care, greater freedoms for provider organisations, and more patient choice offer a potential framework for evolutionary, incremental change, driven by both professional insight at the frontline, and the expressed needs of service users.

- These suggestions represent the King's Fund's contribution to the emerging debate about the future of the NHS. All need further analysis and exploration. But a reasoned, pragmatic consensus about the way forward is critical to the future of health and health care in the UK.

Introduction

The need for debate

The need for a clear and structured debate about the future of the NHS has become even more pressing in the past few months, as unprecedented increases in funding have combined with growing calls for radical change.

The Futures Group

In the wake of the Government's NHS Plan, the King's Fund – an independent charitable foundation working for better health – brought together a group of senior commentators, academics and practitioners, from health and other sectors, to consider the future of the NHS.

The Futures Group took part in a series of discussions, chaired by Lord Haskins, Chairman of the Better Regulation Taskforce. The group was given the broad remit of addressing the future of health care in the UK, with no preconceptions as to the conclusions that would be reached. This discussion paper draws upon the areas of consensus that developed across this diverse group of experienced commentators.

Approaches to reform

This discussion paper does not offer a blueprint for the future of the NHS. Rather, it proposes a framework for developments that could enable modernisation, while also ensuring that frontline staff and the public are able to have more control over their own lives and work. All the suggestions presented here need further exploration and discussion. But that debate now requires the involvement of the widest possible group of stakeholders so that a future approach may be based on pragmatic consensus.

We hope that our approaches to reform will stimulate debate. We open by addressing the constraints and realities that need to be borne in mind when addressing health care reform, and go on to offer a diagnosis of three current challenges for health care. We then outline three future options that aim to address these challenges. The discussion paper ends with a brief conclusion and a review of the next steps that the King's Fund intends to take in order to explore further the potential these ideas may have for improving the NHS.

The Futures Group

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Sir William Wells	Chairman, NHS Appointments Commission

Contributions were also made by Anthony Harrison, Fellow, Health Systems, King's Fund and Professor Julian Le Grand, Richard Titmuss Professor of Social Policy, London School of Economics and Political Science.

Constraints and realities

Any sensible discussion of future changes in the NHS has to take account of a number of constraints and realities. The Futures Group identified four broad issues that too often receive scant recognition in debates about health care reform:

All health care systems face difficulties

Many of the problems confronting the NHS are not unique to the service but are also faced by other systems. Knowing this should – and must – temper suggestions for reform. The complexity of health care systems, and their historical context, means that a simple 'cut and paste' approach to policy – crudely, taking bits from other countries' systems and grafting them onto the NHS – will inevitably produce unintended and undesired consequences.

All health care systems make trade-offs

The organisation and practice of health care involves inevitable trade-offs between different objectives. This is part of its complexity. For example, the NHS sets fairness and equity of access against some aspects of individual choice. This means that ideas for reform need to be accompanied by a clear consideration of where the balance should be drawn between competing health care goals. Reform requires ethical debate as well as knowledge.

Approach change cautiously

Policy change needs to be approached cautiously because policy failure can result in increased ill health, disability and death. Health care is complex, and the knowledge of how such systems work is poor. For example, there is no clear understanding of the connection between financial inputs, quality of care and health outputs. Much about health care systems is unknown and under-researched.

Experiment and evaluate

Given the complexity and unpredictability of health care systems, too much attention has been paid to reforming the organisational structure of the NHS without seeking to understand and take into account the impact on patients and staff. There have been too many examples of reforms implemented too rapidly, often to a politically expedient timetable. There have been fewer attempts at the sort of experimentation and evaluation that would allow rigorous assessment of the best way ahead.

Current challenges for health care

The context for debate

Just 16 months ago, 25 national representatives of health care staff, managers, patients and the public signed up to a comprehensive set of principles that were intended to underpin the NHS. The *NHS Plan* went on to set out the Government's programme of reform for the next ten years. But as planning has given way to delivery, and despite large increases in funding for the NHS, debate is again focusing on basic principles, reflected, for example, in calls for wholesale changes to the system of NHS funding.

Funding issues

While sources of funding are important elements of the incentive framework for health care organisations, the Futures Group does not believe that the key issue for how to improve the NHS is the source of funding. We believe that on the grounds of equity and efficiency of collection, the existing financing arrangements – predominantly through general taxation – are currently the best way of paying for health care.

Recent and planned increases in levels of funding are significant and there is now consensus across all political parties that more money is needed – although disagreement remains over how this should be raised, as well as uncertainty over the level of taxation the public is willing to bear.

The Government has embarked on an investment programme for the NHS that will significantly increase the share of the UK's national wealth devoted to health care, but it will take time to achieve levels of funding comparable with the rest of Europe. Historic underfunding has been the main reason for lack of capacity in the NHS, with the UK lagging behind many European countries in terms of clinical staffing, equipment and the quality of its assets.

Three inter-related problems

The related issues of funding and the capacity of the UK health care system are crucial to the long-term future of the NHS. Similarly, the artificial divide between health and social care will, in the long term, need to be addressed. The Futures Group focused its attention on three further pressing problems within the NHS that need to be tackled if the service is to improve:

Over-politicisation

Health care – in all countries and regardless of funding source or organisational form – is an intensely political issue. Access to health care is considered to be a human right – and one that citizens expect Government to assure. All governments in all countries are involved in health care. A reasonable conclusion to draw from this is that the high-level policy question is not, as some assert, whether the state should or should not be involved, but how and to what extent.

However, problems flow from excessive political involvement in the NHS. While Government has the mandate to align policy with the democratically expressed social and political values of the day, it cannot ensure the delivery of policy in practice. Delivery depends on the activities of different stakeholders outside Government.

There is also a potential conflict between the need for ministers to demonstrate the success of their policies and a recognition of the difficulty in achieving change across a complex system. The intense political pressure on the NHS to achieve certain targets was demonstrated by the recent National Audit Office study, *Inappropriate Adjustments to Waiting Lists*, which found that some NHS trusts had manipulated waiting list figures in order to meet Government targets.

The dynamics of the current system draws the Government into taking responsibility for every 'dropped bedpan'. Inadequate clarification of political and managerial responsibilities means the former will always, under the intense scrutiny of media and political opponents, prevail. The structure pulls ministers into the operational detail of the biggest organisation in Europe. This is not necessarily an issue about the style of this Government or of particular ministers, but about who runs the NHS on a day-to-day basis.

Over-centralisation

Linked to over-politicisation, over-centralisation is evidenced in the continuing dominance of national priorities over local issues in driving change. Over-centralisation hinders improvement because it stifles appropriate, locally sensitive innovation, and limits local responsibility. The NHS is compromised and over-burdened by an excessive number of frequently conflicting objectives. As a result, staff can become disillusioned and, as a consequence, the process of modernisation may not meet public expectations or Government pledges.

Lack of responsiveness

The third area that the NHS needs to address is that of patient responsiveness. This issue affects a number of aspects of patients' experiences – from the way in which they are dealt with by individual staff to the length of time they wait for care. The NHS is a national service seeking to meet the needs of the whole population. But it also has to deliver services and care to individuals that respond to their particular needs and wishes. Is there scope for improving the ability of the NHS to respond to our individual needs? Is there a way to empower individual patients without compromising the needs of others?

Future options

New approaches

We suggest three new approaches to these fundamental problems of over-politicisation, over-centralisation and lack of responsiveness:

- To address the problems of excessive political engagement in health care, a new legislative settlement for the NHS could be an option for clarifying and, importantly, demarcating roles.

- In response to the problems of over-centralisation, new organisational forms and new freedoms for health care providers could encourage locally sensitive innovation and local accountability in the delivery of health care.

- To ensure a health care system that is more responsive to the needs of patients, a greater element of choice should be offered, while understanding a consensus needs to be reached on the trade-offs between collective interest and values around equity, and personal choice.

These suggestions are described in more detail on the following pages.

A new legislative settlement for the NHS

The essence of a new legislative settlement would be to reduce the involvement of Government in the day-to-day running of the NHS – effectively making a clear separation between the political centre and the service. So long as the NHS is publicly funded, ministers will, of course, need to take ultimate responsibility for overall strategy and levels of funding. But under the pressure of high-profile media scrutiny and political argument, ministers have been drawn into excessive involvement and intervention in the management of the service.

Creating distance between the Government and the NHS could bring considerable benefits. The settlement could:

- create the right environment for NHS staff to take responsibility for reform
- help the development of local leadership
- allow for a more open debate about policy failure as well as success.

Under a new settlement (see box right), the Government could remain responsible for setting the overall level of state funding (through general taxation) and establishing a broad strategy for health and health care. The Secretary of State could provide leadership and advocacy for health and social care in relation to other aspects of Government responsibility. Importantly, this separation would enable the Secretary of State to focus the Government on strategic questions associated with health rather than the narrower issue of management of NHS health care provision.

The Government's new role could include establishing the broad ethical framework for health care services, including how principles of equity and humanity apply to the particularly vulnerable, such as children, people suffering mental illness and those in custodial care. Such a framework would encompass the need for ethical and legal positions in relation to issues such as genetics and reproduction.

Creating an NHS corporation

Central to this new settlement would be the creation of an NHS corporation, an organisation working at arms-length from Government. The corporation would take responsibility for necessary national guidance and national regulation of the service. Government would relinquish responsibility for the direct implementation of strategy and the management of performance, and ministers would only retain the

A new settlement for the NHS: a summary of responsibilities

Government

- Raising finance (through general taxation)
- Setting the broad strategy for health and health care
- Establishing an NHS corporation
- Establishing a broad ethical framework for health care
- Providing leadership and advocacy for health, and health and social care
- Developing an integrated and co-ordinated approach to health and social care

NHS corporation

- The equitable allocation of funds to local health services
- Setting national standards for service provision and quality
- Co-ordinating regulatory inspection and action, and organisational learning
- Leading national direction for NHS strategy on issues such as information management and technology, performance data, research and development, and workforce availability

Parliament

- Scrutiny of Government functions
- Holding the NHS corporation to account

Primary care organisations

- Priority-setting for local services (in the light of corporation guidance)
- The provision of local primary care services
- The purchasing of secondary care
- Joint planning, purchasing or provision of social care with local government

minimum of controls necessary to monitor strategic direction.

Core functions

The NHS corporation's core functions would include:

- overseeing the equitable distribution of funds to local health services via primary care organisations (primary care groups, primary care trusts, core trusts)

- producing strategic guidance on models of provision, such as National Service Frameworks
- maintaining the National Institute for Clinical Excellence (NICE) as a source of system-wide clinical and cost effectiveness information
- setting national quality standards
- protecting the work of the Commission for Health Improvement (CHI), and ensuring its independence from Government
- enabling better linkage with other professional regulators and national bodies involved in complaints, adverse events and organisational learning
- managing the NHS Research and Development programme.

The corporation might also adopt a decentralised structure and incorporate strategic health authorities as regional bodies to help it guide and regulate the service at a local level.

Devolved responsibilities

The NHS corporation would be distinctive. Devolved responsibility would be a theme of the new settlement: the corporation would not exercise direct control over local health service providers. Instead, it would work to deliver national strategy and assure national standards through a strong regulatory system. This would be the main link between corporation and health care providers, and would replace the system of direct and detailed management that currently exists.

There are strongly held views on the division of responsibilities between Parliament, Government, the NHS corporation and existing national organisations representing professional interests. Establishing the exact division of responsibility would be a controversial debate – one that would have to take account of the corporation's role in a number of areas. For example, it could have a part to play in identifying and ensuring workforce availability. It could also aggregate data on the NHS to promote patient choice and develop Government strategy.

Within the NHS corporation, the regulatory regime – CHI, in particular – would be independent of Government. However, there may well be merit in locating such regulation outside Government and the corporation, with direct accountability to Parliament.

There are several models that could be used to help establish a new body to manage the NHS at arms-length from Government. The Higher Education Funding Council, the Environment Agency or the Housing

Corporation might all provide useful points of comparison.

Attention would need to be given to the nature of the new NHS corporation board, whether elected or appointed. Appropriate cross-community public participation would be essential. But the extent to which the board of the corporation could be elected might be a moot point. Elections might re-politicise the NHS – exactly the problem that we are seeking to resolve.

There are responsibilities that would not sit with the NHS corporation. Responsibility for local priority setting (in the light of corporation guidance) would lie with local primary care organisations and local communities. Primary care organisations would take responsibility for the provision of primary care, the purchasing of secondary care and the joint planning, purchasing or provision with local government of effective services involving health and social care professionals. We strongly support the need to bring health and social care finance, decision-making and accountability together.

Parliamentary accountability

Parliament would be responsible for holding the NHS corporation to account. There would need to be a clear division of responsibility between the broad policy-setting function of the Secretary of State, the standard-setting and regulatory roles of the corporation, and the overall scrutiny role of Parliament. The corporation would need to enjoy day-to-day independence from ministers. The implementation of policy would, as far as is possible, be the responsibility of the NHS, allowing greater experimentation, innovation and evaluation than at present.

A less detailed and more strategic role for ministers means that they would not be in a position to answer detailed Parliamentary questions about the operation of local services. But Parliamentary committees, and local arrangements for close questioning of agencies by local councils and Members of Parliament, could provide appropriate forums for ensuring that the service is fully accountable.

A new relationship

A new relationship between Government and the NHS does not, and cannot, take the politics out of the NHS. It does, however, make politicians responsible for their part of the enterprise, while leaving responsibility for the delivery of a responsive system to professionals and local communities. This is in marked contrast to current arrangements, where the onus of

responsibility for all aspects of the NHS falls upon the Secretary of State and the Department of Health.

We acknowledge that positive change rests as much on changed behaviour (of politicians, civil servants and others) as on new structures. But this behaviour change needs to be facilitated. A new environment created by a clearer separation of Government and NHS could be the first step.

By its nature, a new legislative settlement cannot be undertaken in an experimental or incremental way. But such a settlement formalises and safeguards a devolution of power, rather than requiring any wholesale organisational change across the health care system.

New organisational forms

Providers of health care need greater freedom if they are to be more responsive to their patients and purchasers of care. They need incentives to improve their performance, to engage with their community, and to attract and retain staff. Our second proposed approach to change is a more permanent structural separation of the organisations that deliver health care from the central Government and central organisations that fund, direct and regulate it.

This could be done most easily with NHS hospitals. It would involve transferring the ownership of NHS assets from Government to individual hospitals. Hospitals might become a new type of not-for-profit organisation. A number of formats could be considered for these new organisations – one possibility would be the 'public interest company' proposed by the Public Management Foundation in June 2001, in their publication: *The Case for the Public Interest Company*. Universities may provide another model.

The new body would be committed to public benefit within a secure, accountable, not-for-profit organisational form that included the ability to raise capital from money markets and exercise an independence from direct political control. It would also be characterised by substantial involvement at board level from the local community.

New freedoms

A new organisational form could help free health care providers from three problems:

- At present, accountability is problematic – the chain of command is too long and the process for holding chief executives to account too opaque.
- The desire of the political centre to direct change is overbearing and prevails over the need to respond to local needs and establish local accountability.
- Providers have little control over their own future: long-term incentives to improve their organisation and deliver quality services are weak. Too often, time horizons are shortened to match political rather than health care imperatives.

A new type of body, such as the public interest company, could provide more direct accountability to the community. It would balance responsibility to meet NHS corporation standards (backed by strong regulation) with greater potential to respond to local need. And it would offer real opportunities for the organisation to become much

more accountable to its various stakeholders.

Independence and innovation

The freedoms associated with a new organisational form offer positive opportunities for better health care. The new bodies would be able to manage the delivery of their services in any way that meets their contractual and regulatory obligations. They would have the incentive to innovate in order to improve health care. They could be given the power to generate and use financial surpluses to re-invest and reconfigure services, and the opportunity to raise additional finance on the private market. They might manage their own workforce in respect of pay and conditions of service.

The new bodies would still receive funding from the NHS via contracts with local primary care organisations, and be subject to a tough regulatory regime. But they would be expected to develop new types of service to match local needs and compete for patients (for whom we suggest a gradual expansion of opportunities for choice). The new freedoms could re-invigorate the personal motivation of health care staff to engage more actively on behalf of the local public interest and establish a new opportunity for corporate pride. Coupled with greater patient choice, the financial independence of the organisational form would create an incentive to attract more patients, and more staff.

Risks of new freedoms

Clearly, there is no guarantee that establishing greater freedoms for health care providers would lead to improved quality of care in all organisations. Some might see their income from NHS contracts decline substantially – partly as a result of the pattern of choices made by patients and purchasers, and partly due to the failure of management teams to take full advantage of the new freedoms available to them. Some form of support or special measures might sometimes be necessary for failing organisations in order to protect local populations from catastrophic loss of services.

Similarly, there is a danger that providers might well exploit what are, in many areas, near monopoly positions. However, the regulatory regime, the power of patients and purchasers, and the new constitution of the new provider organisations, would, in combination, minimise any tendency to cling to existing practices and cultures.

Testing benefits over time

We acknowledge that the UK health system is under enormous pressure. Giving providers greater freedoms

will not be the only solution to these difficulties. The problems of lack of capacity, years of comparative underfunding, and pent-up demand represented by long waiting lists, mean we will have to be patient.

New managerial freedoms, direct engagement with greater accountably to the community, responding to new opportunities for patient choice – all will develop slowly.

Patient choice

There are two compelling reasons for extending patient choice: an increasingly consumerist approach to public services on the part of the public, and the belief that choice will help drive up quality in the NHS.

There are many types of choice that could be made in health care: choice of health care professional (GP, doctor, nurse, surgeon); choices concerning treatment options; choice of location of treatment (at home, in hospital); and choices about the timing of treatment. Currently, the NHS provides limited choices in some areas (choice of GP, for example), and virtually no choice in others (choice of hospital, for example).

But, where patient choice exists, it is viewed as beneficial to patients. Maternity services offer a good example of a hard-won choice: mothers are now offered a greater range of options for delivery of their babies. The proposed pilot scheme to offer cardiac patients who have waited six months a choice of treatment is a start in exploring the extension of patient choice. But greater commitment is needed.

Some areas of patient choice can be extended immediately and do not necessarily involve significant extra expenditure. Some will require additional NHS capacity; others will depend on effecting a change in culture. The question is how to allow patients to exercise choice in a way that is practical and affordable to the NHS, and does not undermine access to good-quality care for all.

GPs and other purchasers of care must play their parts in extending the options from which patients can choose and helping them make informed choices about their care. Purchasers should be responsive to the wishes of patients when commissioning services. For example, purchasing many more services outside of hospital settings might better meet patients' preferences for their care.

A responsive system

Greater opportunities for patient choice should also result in a more dynamic and responsive system. Many patients and families become highly informed about health and health care, particularly in relation to long-term conditions. Often, these patients and their families are not only willing, but expect, to make decisions about their own health care. The opinion of professionals might be one source of information but not necessarily the only influence on those decisions. If health care is to serve the needs of patients, then their choices must play a significant role in shaping the way health care providers understand good-quality health care.

However, securing greater opportunities for patient choice requires developments in six key areas:

Increasing capacity

In the medium term, it may be possible to extend the range of options. But this will largely depend on an increase in the capacity of our health care system. Expanding the supply of staff and services to the level needed to allow choice across a real range of options is a lengthy process. Until there is sufficient capacity and diversity of good-quality services, the extension of options will have to progress slowly. Maintaining increased capacity will be a challenge not only for the public funding of health services, but also for patients, who will need to be realistic in their expectations.

Extending options – particularly in terms of choice of GP and the timing and location of secondary care – has a financial cost. But making choice a reality opens up the potential for services to become more responsive to patients, rather than driven by professional or ministerial interpretations of patients' needs. Obtaining this responsiveness is a crucial part of a wider interpretation of service efficiency.

Supplying high-quality information

Extending patient choice relies crucially on high-quality information. The NHS will need to make much more information available (including consultant/consultant team-specific clinical performance data) than it does at present, to help both patients and their GPs make informed decisions. We are now rapidly approaching an important decision concerning the level of detail of such information. Performance data on whole organisations is often irrelevant to patients (and indeed the purchasers of health care). Increasingly, what will be needed is performance information at the level of individual hospital departments, clinical firms and clinicians.

Improved systems of regulation

Stronger, more coherent and transparent systems of regulation are required to extend patient choice. Those making choices need to know that services are safe and that health care professionals are validated for practice. The regulatory framework must be consistent across health and social care, public and private provision, and health care professionals. It must also check the reliability of standardised performance information.

Financial incentives for service providers

To improve service quality, the mechanism that connects the choices patients make with such improvements needs careful consideration. Broadly, chosen providers need a reward and those that are not chosen have to face some sort of consequence. In short, we believe that money has to follow the patient's choice. Health care providers may also want to extend options for patients to pay for additional services over and above national standards, as exists now in some non-clinical areas.

A financial incentive must be sufficient to provide a real reward, while not being so large as to easily destabilise a local health care economy. For many patients, accessing anything other than their local services may be difficult. The regulatory system needs to ensure that special measures are taken where there is a risk of organisational failure that might leave the needs of local populations unmet.

The system also needs to ensure minimal transaction costs. Low administration costs represent a point of positive comparison between the NHS and international systems of health care, notably the USA – we should endeavour to keep it that way.

Experimenting with complex systems

An expansion of patient choice will involve learning about the relative value patients place on things such as speed of treatment, location of care and quality. These patient assessments will be set against those made on their behalf by professionals, policy makers or planners. As professional oversight and planning are traded off against personal freedom and choice, the impact and consequences of such changes are difficult to predict, but personal freedom and choice need an emphasis they have never had before in a centrally 'planned' system.

Choice and responsibility

Opportunities for greater choice need to recognise certain limits and constraints. The NHS seeks to use its finite resources for the benefit of all. Choices therefore need to be exercised within this framework.

Challenges for the NHS

The nature of health and health care means that expanding choice will pose particular challenges for the NHS. Many patients require complex care at a time when they may know little about the details of their own health care needs. Patients may be in a physically and emotionally dependent position in relation to the health care professionals around

them. They may need to enter into a relationship of trust with health care professions and will often face a high degree of uncertainty or risk regarding treatment and outcome. Frequently, the patient is likely to know less about possible approaches to their problem than health care professionals.

There are other distinguishing features unique to systems that provide health care, not shared by other areas of consumer choice. The NHS was founded on the notion of equity of access, and a key objective of the service is to provide equal access to care for patients in equal need. Increasing choice can conflict with this goal. This challenges us to broaden our understanding of equity of treatment to take into account not only clinical need, but a combination of other factors important to patients – such as preference for location, speed of treatment, and perceived clinical quality. Taking this broader view of equity means striving for an equal opportunity for patients to choose the best available option to meet their individual needs, without denying similar choices to the next person.

Conclusion

Stimulating further debate

The three approaches to change outlined in this discussion paper have emerged from a long and ongoing debate about health care. We hope that, taken together, they will stimulate discussion about what needs to happen in the NHS over the coming years. From this, there should emerge an iteration of incremental change, analysis of that change, discussion and learning – and, importantly, the support of NHS staff who need to be inspired by any proposed reforms.

Devolving power

The approaches are not separate initiatives. They are inter-connected; all focus on devolving power and together should be greater than the sum of their parts. Greater opportunities for patient choice could help drive a service that is more responsive to what patients want. Greater freedoms for provider organisations could fuel the desire of staff to deliver that responsive service and provide the incentives for organisations to innovate and modernise.

The clearer separation between Government and the delivery of health care places responsibility on the service to manage its own affairs and learn from the experience, while introducing a strong and independent framework for regulation of standards. All three approaches together move the pivotal role in shaping the NHS from Government to local communities, frontline staff and patients.

The potential for change

We want to move the debate away from methods of funding – the predominant use of general taxation is currently the appropriate way forward (within the general framework of public and political support, where taxes have to rise to pay for increased costs).

We acknowledge that the capacity of our health care system needs to be increased through sustained investment in people and facilities. We recognise that the need for greater co-ordination between health and social care has to be addressed. But our focus is on improving choice and local accountability in order to develop a more responsive NHS that better meets the needs of all its stakeholders.

These changes are aimed at:

- reducing the amount of day-to-day intervention by Government
- increasing the sense of accountability and ownership amongst health workers and local communities
- gradually introducing more choice to patients without reducing equity of access
- ensuring that national standards of health care are achieved.

We accept that defining the exact nature of the appropriate new institutions and structures is problematic. In such a vast and complex system we are not suggesting revolution but rather evolution, driven by discussion, experimentation and analysis. These are important matters for debate.

Next steps

Additional challenges

The Futures Group recognised that there were important challenges to the current delivery of health care that are not addressed by the three approaches outlined here. As well as working on the issues of capacity and workforce, the King's Fund acknowledges the importance of bringing the finance, planning and governance of health and social care together.

The relationship between health care organisations and local government is clearly a crucial aspect of this – and it demands more attention. There may indeed be elements of current local authority responsibility that would be better encompassed by local health care organisations, as well as some responsibilities currently held by health organisations that would lie more sensibly within the ambit of the local authority.

Further exploration

In addition, the approaches each raise a host of significant questions that need further exploration. Of these, the King's Fund is keen to look further into the potential for new organisational forms, such as public interest companies, to add value to the dynamic provision of the highest quality UK health care. Tasks would include:

- pinning down a prototype constitution for these new organisations
- further exploration of the appropriate funding mechanism to allow for a degree of competition by comparison between health care providers, without – insofar as possible – threatening the stability of the local health care economy
- looking to existing models of corporations that represent a separation of Governmental strategic functions from management responsibilities, so that we might better understand how a new legislative settlement might work.

Finally, the expansion of patient choice is a clear area where a programme of local schemes can be explored and evaluated more fully. For example, to what extent might better information about providers empower patient choice? How might GPs and other health care workers present and discuss choices concerning the providers of treatment in a more effective way?

A clear and structured debate about the future of the NHS is now imperative, as unprecedented funding increases combine with growing calls for radical change. Many suggest the way ahead lies in wholesale review of the funding system, but is improving how the NHS is run a better solution?

Should the Government remain responsible for every 'dropped bedpan', or is it time for a decisive separation of political and managerial responsibilities? How can local responsiveness and innovation be supported, alongside the drive for national standards? And could the extension of patient choice lever up quality?

This King's Fund discussion paper, which brings together ideas from a group of commentators, academics and practitioners from health care and beyond, chaired by Lord Haskins, aims to stimulate the wider debate on which a reasoned, pragmatic consensus for the future depends.

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