Recent National Health Service (NHS) Reform Proposals In England

The May 2010 election in the United Kingdom resulted in the creation of the Conservative-Liberal Democratic Coalition Government under Prime Minister David Cameron and Deputy Prime Minister Nick Clegg. The change in government is also heralding a radical and far-reaching change in health policy amid massive budgetary restraints.

In July 2010, the coalition government released a White Paper, *Equity and excellence: Liberating the NHS*¹, outlining its future plans for the National Health Service in England.

The White Paper outlines a number of fundamental changes to the NHS. As described by Chris Ham, Chief Executive of The King's Fund, these are “the most radical reforms since the inception of the NHS”. The Nuffield Trust for Research and Policy Studies in Health Services has published a summary and assessment of the White Paper reforms, *The Coalition Government’s NHS Reforms: an assessment of the White Paper*. The King's Fund has released its response to the White Paper reforms and issued a commentary by Chris Ham on the reforms in general and GP commissioning in particular. As well, the *British Medical Journal* has issued an editorial on the proposed reorganization of the NHS that is critical of the plans for more structural change. The reforms are significant and the provisional timeline is ambitious.

A consultation process has solicited input on various components of the proposed reforms. The content of the Bill that will go to Parliament in January 2011 may be different from what has been proposed in the White Paper. Some components are likely to remain; the scale of some components may be substantially reduced; and other components may be re-packaged.

So what are these reforms in the White Paper? And from where we sit in Ontario, how would the NHS reforms described in the White Paper apply to our provincial health system? The Change Foundation’s *Integrated Health Care in England: Lessons for Ontario* (May 2009) extracted insights from the health reform efforts in NHS England; this update attempts to understand the recent proposals for reform and relate them to the Ontario context. Like many other jurisdictions, England and Ontario are facing financial pressures at the same time as they are trying to ensure that health care system changes are driven by quality objectives.
The White Paper outlines plans to abolish all ten Strategic Health Authorities (SHAs).
The SHAs are essentially regional organizations of the Department of Health and are accountable to the Department – i.e., they are agents of the Department of Health. They were established to manage the local NHS on behalf of the Department – they are system managers responsible for populations ranging from 2.6 to 7.5 million residents. The SHAs direct the performance of the PCTs and the NHS Trusts to ensure that national health system priorities are incorporated into local health service plans. They also have direct control over the funding and development of region-wide services and programs. SHAs are called in to negotiate in all commissioner/provider disputes, including those involving Foundation Trusts. It is interesting to note that at no stage in the history of the NHS has the system been managed without some kind of regional organization. The numbers and functions of these regional bodies have changed over the years, but there has always been an intermediary tier of regional offices to provide management.

How would the reform apply to Ontario’s health system?
The SHAs are regional units of government responsible for planning and monitoring functions – they are akin to staff of the Ministry of Health and Long-Term Care (MOHLTC) responsible for monitoring the performance of the LHINs, as well as having some overlap of responsibility with the Local Health Integration Networks (LHINs) – the planning and monitoring functions of LHINs. The PCTs carry out functions that are the purview of the LHINs – the planning and allocation functions. However, it should be noted that the PCTs have a stronger commissioning authority – i.e., they actually choose between providers – and a broader commissioning mandate than the LHINs – i.e., PCTs commission for primary care which is not part of the allocation mandate of LHINs. This reform would be akin to abolishing the LHINs, and eliminating or redeploying the management and staff in the MOHLTC responsible for monitoring the performance of the LHINs.

The White Paper outlines plans to abolish all 152 Primary Care Trusts (PCTs).
The PCTs have planning and allocation functions. They are responsible for planning health services for populations ranging from 90,000 to 1.3 million. They commission services from a range of preventive, primary, secondary, tertiary and specialist providers, and provide a range of home care, primary care and community based services.

The GP commissioning consortia are to be set up as statutory public bodies requiring their accounts to be audited and made public.
The key differences between this reform and the GP fundholding introduced during the 1990s market-based reforms is that GP fundholders were self-selected volunteers for the programme “tending to be well organized practices in middle-class areas, enthusiastic about taking on commissioning budgets”. The most recent iteration of GP commissioning is the current practice-based commissioning (PBC) where GP practices are given “virtual” budgets with which to buy health services for their population while PCTs continue to hold the “real” money. In this model, PCTs must ensure that PBC plans are in line with national targets and local health plans and targets.

Reactions to the White Paper’s plan to eliminate PCTs and transfer commissioning to GP consortia have focused on concerns about the following:

- conflicts of interest where GPs are involved in both purchasing and providing care;
- the elimination of an oversight body to provide local system-wide planning (as PCTs have done);
- the lack of infrastructure and skills within GP practices to do effective commissioning;
- the significant transitional costs associated with abolishing organizations and establishing new organizations; and
- limited budgets to purchase expertise and management support – i.e., management costs are to be cut by an astounding 45 per cent over the next four years. Significant management cost reduction is already underway in PCTs – the plan is to re-direct financial resources to local authorities, the NHS Commissioning Board, and GP commissioning consortia; but it is not clear how the transition of people resources will be managed.

*How would the reform apply to Ontario’s health system?*

This reform would be akin to handing over commissioning responsibility to Ontario’s Family Health Teams (FHTs) or newly established consortia of GP practices. In this scenario, FHTs and GP consortia would be required to transform from private partnerships with contract accountabilities to statutory bodies with public accounting requirements. They would be expected to commission more integrated care, including commissioning negotiations with hospitals, CCACs and long term residential care facilities to provide health promotion, prevention and coordinated care, and to achieve cost minimization goals.

*The White Paper outlines plans to establish a new statutory national NHS Commissioning Board to support GP commissioning.*

The NHS Commissioning Board will be established to support the GP consortia in their commissioning decisions. The Board is expected to do the following: provide national leadership on commissioning for quality improvement; support the development of GP commissioning consortia; hold the GP commissioning consortia to account for health outcomes and financial performance; commission specific services that are not commissioned by consortia (e.g., maternity, specialized services); and allocate and account for NHS resources. The Board will be accountable to the Secretary of State for Health.

*Foundation Trusts (FTs) are self-governing public benefit corporations free from central government control and SHA performance management. They are community or specialized hospitals that are accountable to a Board of Governors.*
The Department of Health has launched a consultation process seeking input on the implementation of the proposals for GP commissioning and the establishment of an independent NHS Commissioning Board. A separate consultation process has been launched by the Department to provide input into the development of a national NHS Outcomes Framework. It is not clear at this point how the current Quality and Outcomes Framework (QOF) – which directly links GP income to the quality of patient care – will be impacted by the national NHS Outcomes Framework.

**How would the reform apply to Ontario’s health system?**
Application of this reform in Ontario would require the establishment of a similar organization – arms length but with accountability to the Minister of Health and Long-Term Care for public funds that are transferred to commissioning bodies. The Excellent Care for All legislation and the expanded role of the Ontario Health Quality Council (OHQC) could be the closest equivalent organization to enable and spearhead the development of an Outcomes Framework.

The White Paper outlines plans for all NHS Trusts to become, or become part of, Foundation Trusts. In addition, Monitor will be transformed into an economic regulator of all providers of NHS-funded care. Foundation Trusts (FTs) are self-governing public benefit corporations – i.e., health care organizations that are accountable to a Board of Governors. FT status is earned through an assessment by Monitor, an independent regulator.10

NHS Trusts are accountable to the Department of Health via the SHAs and in many cases have not been able to meet requirements to secure self-governing FT status. Monitor has been the regulator of Foundation Trusts and will be transformed into a regulator of all providers of NHS-funded care. National tariffs that will be paid to providers (including hospitals) by GP commissioners will be set by Monitor. At this point, it is not clear what the negotiation process will be for “setting” national tariffs.11

**How would the reform apply to Ontario’s health system?**
Ontario hospitals are somewhat equivalent to the Foundation Trusts – they are governed by a board of directors, trustees or governors. However, the government retains the authority to appoint a supervisor with the exclusive right to exercise all of the powers of the board should it have concerns about the quality of the management and administration of a hospital.12 FTs are accountable to Monitor, a regulator with real authority. Ontario hospitals have accountability agreements with the LHINs – agreements that set out funding levels and a series of performance indicators that hospitals are required to report on.

The reforms in England may include a new negotiation process for setting tariffs. In Ontario, that would suggest a new process to replace the current negotiation process between the Ontario Medical Association (OMA) and the Ministry of Health and Long-Term Care. Within Ontario hospitals, the tariff-setting situation is more complicated – the OMA only negotiates physician fees, in some cases physicians providing hospital care are not on fee-for-service, and the costs (tariffs) of other components of hospital care are presumably rolled into a case-based funding model (or the term most recently used in Ontario – patient-based funding).

Assessments of the White Paper reforms have noted that the time waiting for care is a key component of the patient experience and should not be lost in the quest for outcome targets.
The recent *Excellent Care for All* legislation expands the mandate of the Ontario Health Quality Council to identify evidence-based practices and provide recommendations, in consultation with the public, about the government’s provision of funding for health-care services and medical devices.

The **White Paper outlines plans to eliminate process performance targets, including waiting time targets.**

Key performance targets, including wait time targets, will be eliminated with the exception of the four-hour Emergency wait time targets (although this target will be adjusted from 98 per cent seen within 4 hours to 95 per cent). For example, the 18-week wait target for planned care and the 48-hour GP access targets will be “relaxed”. The stated objective in the White Paper is to move to more outcome targets rather than the existing process targets. Assessments of the White Paper reforms have noted that the time waiting for care is a key component of the patient experience and should not be lost in the quest for outcome targets.

**How would the reform apply to Ontario’s health system?**

Moving to more outcome targets is a challenging aspiration for most jurisdictions, including Ontario. We appear to be moving in a different direction – more system-level performance targets are being put in place. The *Excellent Care for All* legislation is designed to build the foundation for a high performing health system, including requirements for publicly available annual QI plans, public reporting on quality indicators, and quality committees. A critical issue will be the alignment of funding and incentive systems with goals, in an effort to achieve internal consistency. For example, a system that pays for activity and also aspires to prevention will create conflicting incentives for organizations and individual providers.

The White Paper includes plans to replace existing Local Involvement Networks with Local “HealthWatch” groups.

Local Involvement Networks (LINks) were established under legislation to strengthen the statutory duty of PCTs to consult local communities about changes to services. Significant financial resources were committed – £84 million over three years were given to local authorities to establish and support LINks. As well, Health Scrutiny Committees, committees of the local authorities, have had a mandate to monitor health-care provision for their local communities. These committees have had the authority to appeal to the Secretary of State against decisions of PCTs following a formal process of consultation.

The White Paper reform includes plans for Local HealthWatch groups to be funded by local authorities with a national HealthWatch body located within the Care Quality Commission. Within this proposed accountability framework – i.e., accountability process within the local authority and with the overall supervision from the Care Quality Commission – these groups will likely have a more powerful voice within the system. A consultation process, sponsored by the Department of Health and the Department for Communities and Local Government, has been launched to seek proposals and views on how the HealthWatch groups should function.

If the reform in England were applied to Ontario it would essentially mean the establishment of formalized citizen oversight bodies funded by local government with a mandate to influence the planning of both health and social care.
How would the reform apply to Ontario’s health system?
LHINs have a legislative requirement to engage in community engagement. However, the scope of community engagement is not prescribed under the Local Health System Integration Act. A recent report from the Ontario Ombudsman has highlighted some of the weaknesses in community engagement in one LHIN. The report also takes aim at the ambiguous nature of the legislation and the lack of direction from the province. If the reform in England were applied to Ontario it would essentially mean the establishment of formalized citizen oversight bodies funded by local government with a mandate to influence the planning of both health and social care.

The White Paper outlines plans to cut NHS management costs by 45 percent by the end of 2014.
All of these substantial reforms are to happen within a very tight financial environment. The government has stated that it is committed to achieving £20 billion’s worth of efficiency savings in the NHS by 2014 – these savings are to come out of a budget that is just over £100 billion (2010-2011). Compare this to a King’s Fund estimate in late 2009 that 4 to 6 per cent increases in year-on-year budgets over the next five years will be required to maintain existing standards of care. \(^\text{13}\) The message is strong – it is not business as usual.

Both jurisdictions will be challenged to reform their respective health systems to ensure sustainability, as well as improving quality and access – to do things differently to be able to do better with less.
End Notes

1 The NHS in Scotland, Wales and Northern Ireland is the responsibility of the respective devolved administrations.

2 NHS Foundation Trusts are community or specialized hospitals that are self-governing public benefit corporations free from central government control and SHA performance management; they are accountable to a Board of Governors, and have been regulated by Monitor.

3 Personal communication from David Knowles, former NHS executive and senior fellow at The King’s Fund.

4 See The Change Foundation’s Integrated Health Care in England: Lessons for Ontario (May 2009) for a more complete description of the accountabilities and responsibilities of the SHAs and PCTs (pg. 7 to 8).


7 See The Change Foundation’s Integrated Health Care in England: Lessons for Ontario (May 2009) for a summary of the research on PBC achievements (pg. 22 to 24).

8 Personal communication from David Knowles, former NHS executive and senior fellow at The King’s Fund.

9 Some commentators have noted that the new national NHS Commissioning Board constitutes significant centralizing of some important powers of the NHS in contrast to the political rhetoric that the reforms are about devolution.


11 Historically the British Medical Association has played a significant role in the GP and Consultant (hospital physician) contract negotiations for tariffs.

12 See Public Hospitals Act, R.S.O. 1990 available at www.e-laws.gov.on.ca

THE CHANGE FOUNDATION
The Change Foundation is an independent policy think tank, intent on changing the health-care debate, health-care practice and the health-care experience in Ontario. It leads and leverages research, policy analysis, quality improvement and strategic engagement to enable a more integrated health-care system in Ontario designed with individuals and caregivers top of mind.

VISION
To be Ontario’s trusted advisor advancing innovative health policy and practice.

GOAL
• To improve the experience of caregivers and individuals as they move in, out of, and across the health-care system over time.
• The Foundation will adopt a participatory approach to the following four methods: research, policy analysis, quality improvement, and engagement.

MISSION
• To make caregivers and individuals in need of health care part of the health-care discussion about how to find solutions to improve their experiences.
• To stimulate new ways of thinking, behaving, and interacting to foster improved health care for people, especially when they are in transitions.
• To generate robust and independent research and policy analysis of health-care issues related to improving the experience of individuals and caregivers as they navigate the health-care system.
• To lead informed discussion and strategic engagement with the stewards, stakeholders and users of the health-care system.

MANDATE
To promote, support and improve health and the delivery of health care in Ontario.

VALUES
Excellence. We strive for excellence in all we do.
Innovation. We take innovative approaches in developing new ideas.
Collaboration. We work in partnership with others to achieve success.
Inclusivity. We strive to include all voices and views.