Reconciling Equity and Choice?

Foundation Hospitals and the future of the NHS

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Executive summary

1. Introduction

- Legislation to create new Foundation Hospital Trusts in the NHS has polarised the Parliamentary Labour Party. Behind what are presented as modest and sensible administrative reforms, bigger political and ideological issues are at stake.

2. New times, new Labour, new NHS

- New Labour is keen to emphasise that it has moved on from the 1970s and is echoing the rhetoric of the **Conservative New Right** in its attacks on "top down", "command and control", "one size fits all" models of public provision.
- In fact by the end of the war there was little alternative to hospital **nationalisation** which was seen as a necessary response to the failings and inequities of inter-war municipal and voluntary provision.
- NHS **planning** in the post-war period was about strategic investment in response to social need; its shortcomings had as much to do with external circumstances as with inherent problems of state intervention.
- Arguments that greater diversity and choice run with the grain of a more **individualistic and consumerist society** provide only part of the explanation for Labour's new policy – a key rationale is a perceived need to cater to middle class voters in marginal constituencies.
- Invocations of a lost **co-operative and mutualist** inheritance often overstate the importance and success of such models in the past. Moreover, the emphasis on competition between hospitals cannot easily be reconciled with such traditions.

3. The implications of Foundation Trusts

Planning

- Encouraging **patient choice** runs the risk that the choices of the few rather than the needs of the many will determine the trajectory of hospital development – the effect may be to financially destabilise smaller hospitals and segregate patients.
- The Treasury/Department of Health compromise over **borrowing powers** creates the likelihood of distortions in the prioritisation of capital projects within the NHS.
- **Asset disposals** by Foundation Trusts will distribute proceeds according to the accidents of geography and the vagaries of the market rather than pooling them and reallocating according to need.

- Freedom of Foundation Trusts to depart from **national employment terms** can only exacerbate staffing difficulties faced by other hospitals in many parts of the country.

Privatisation

- **Co-payments and charging** for some services are not in the plans but the idea has been floated. The time-limiting of "intermediate care" may provide one opportunity.
- The scope for **commercial activities** is increased by the ability to borrow against income streams from "unprotected" assets and set up subsidiary companies.
- Experience in other countries suggests that **competitive pressures** will drive not-for-profit hospitals to increasingly emulate private providers.

Democracy and accountability

- It is not clear how the members and governing body of a Foundation Trust can be truly **representative** of the large and diffuse community a hospital serves.
- There is a risk that Trust boards end up simply **rubber-stamping** business strategies rather than challenging them, because the majority of members, whatever their local connections, lack the expertise needed to challenge professional interests.
- Studies of the social economy show that the performance of not-for-profit enterprises is highly **contingent** upon local leadership and circumstances.

Regulation

- The duty to meet "reasonable demand" for services may offer scope for **patient selection** according to demographic profile to avoid expensive caseloads.
- Much remains to be clarified about **rights of access** to services – for example, whether the regulator would approve of changes in configurations of services which involved substantially increased travel for patients and visitors.
- In fact, the Regulator's powers may entrench the **private sector** as the main provider of aspects of NHS care in some locations.

4. Conclusion: pragmatism, principles and the future of the NHS

- At present Labour policy seems informed more by pragmatism than by principle, resulting in a dangerous drift back towards a pattern of services determined by the ability of hospitals to compete in markets rather than one determined by social needs.
- It might be bolder to return to principled arguments for integrated, egalitarian public services and concentrate on how to improve the NHS within that framework.

1 Introduction

Provisions for the creation of "NHS Foundation Trusts" contained in the new Health and Social Care (Community Health and Standards) Bill (1) have polarised the Parliamentary Labour Party.

Supporters claim that the legislation will modernise the NHS, empower staff, democratise the service, and stimulate innovation. Opponents are concerned that the effect will be to drive a stake through the fundamental principles of the NHS, so that the trajectory of service development will depend entirely on competition between Trusts rather than cooperation. More fundamentally, the reforms signal a move away from the pursuit of equality to an agenda of consumer choice and preference; citizenship entitlements become defined in terms of the opportunities available to individuals in markets.

In common with the extension of competition and choice elsewhere in the public sector (e.g. schools), the proposals rest on arguments that "top-down" models of welfare provision cannot deliver the goods in a society in which people are no longer so willing to be grateful recipients of standardised services. The 1945 settlement was the "social equivalent of mass production", being highly centralised and directed, and offering almost no choice (2). As Alan Milburn has put it, the NHS was founded in a world where "everyone was given the same rations"; equity for the population was produced only at the expense of choice for the individual. What Milburn termed "greater plurality of providers" would henceforth strengthen the levers available to consumers, by removing obstacles to patient choice (3). In this view of history, nationalisation in the welfare state is clearly seen as something that the party must jettison in an attempt to respond to individual aspirations and choices. The presumption is that decentralisation and local control will release local managers from the shackles of top-heavy, top-down governance structures, and stimulate a wave of innovation that will enhance efficiency for all. If there are inequalities as a result, presumably the hope is that these will be tolerated because of the visible improvements in quality and quantity of services delivered across the board.

The details of the legislation are explored below, but the basic idea is that a select group of hospitals regarded as having earned the right to additional autonomy (those which have obtained three stars in the current – far from perfect – ranking system) will be given Foundation Trust status. (Subsequently, it has been proposed that all NHS Trusts will be able to apply for Foundation status.) They will no longer be directly accountable to the Secretary of State for Health. They will have greater managerial freedoms, including the ability to borrow for capital developments, and freedom to dispose of certain assets (retaining the proceeds) and to depart from nationally-agreed terms and conditions of

employment. New arrangements for governance will be devised, in which citizens can become members of a Trust, and vote in elections to its governing body. To placate critics who see the initiative as heralding privatisation, there will be a cap on private patient activity at its existing level, and some restrictions on the disposal of public assets (4). In parallel, arrangements are being made to give patients greater choice of hospital (and, indeed, within a few years, of clinical teams within hospitals). It is difficult to believe that Foundation Hospitals will not act as magnets to those in a position to exercise choice. Non-NHS providers will also be able to apply to become NHS Foundation Trusts.

Presented in this way the reforms sound like a fairly innocuous extension of other initiatives. Who, after all, could object to a little more flexibility or to greater accountability to the local community? And don't other health care systems incorporate a broader range of providers than does the NHS? Moreover, if one of the key objections has been that Foundation status would only be eligible for an elite, hasn't this been met by the announcement that Foundation status will ultimately be rolled throughout the health service?

Against these views it can be argued that this legislation (which has attracted opposition from many backbench Labour MPs, while being generally welcomed by the Conservatives) is not merely an administrative reform. It can be seen as an attempt to distance new Labour from its problematic past and as a response to the changing economic and social landscape.

2

New times, new Labour, new NHS

Labour is keen to emphasise to the electorate that it has moved on from the bad old days of the 1970s. It has therefore constructed a narrative in which old modes of state intervention, such as top-down, bureaucratic planning, are discredited. By selectively misrepresenting past failures "new" Labour can be distanced from "old", and its policies presented as pragmatic and necessary accommodations to new economic and social realities.

The disavowal of planning

Milburn and Blair's arguments about "top down", "command and control", "one-size-fits-all" models of public sector provision directly echo those used by the Conservatives when introducing the 1991 NHS reforms – then, spokesmen such as Malcolm Rifkind represented the NHS as a massive, hierarchical and lumbering bureaucracy, comparing it with the outdated institutions of state socialism in Eastern Europe (5). Clearly, the solution is that hospitals and their staff require a good dose of "perestroika" to liberate them from the dead hand of the state. (I will ignore the question of whether there has been an associated "glasnost"). Labour also find themselves sharing common ground with commentators such as David Green of the Institute of Economic Affairs, noted for advocating greater extension of market forces into the public sector, who has described the NHS as the "Aeroflot of international health systems" (6); by implication, it was an inflexible behemoth, which could not do anything other than provide standardised, poor quality services.

The inference to be drawn from such attitudes is that hospital nationalisation was an unavoidable, but rather distasteful measure. But it's questionable whether there were feasible alternatives by the end of the war, for a variety of reasons to do with the obduracy of the voluntary hospitals, the resistance of the medical profession to local government control, and the variable performance of local authorities (7).

Moreover, the disavowal of central planning ignores its very real achievements. Even Enoch Powell, while Minister of Health, acknowledged the need for coordinated and systematic planning on a regional basis. Launching the Hospital Plan for England and Wales in 1962, Powell stated that hospital provision was now being planned on a scale unmatched by any government, "certainly not this side of the Iron Curtain" (8). The Plan

promised a steady increase in hospital investment, the ultimate aim being to create a network of general hospitals serving defined catchments, with populations of 100-150,000. It exemplified an attempt to think in "whole-system" terms. Regional proposals were scrutinised carefully for their thinking about how hospitals related to one another (though critics pointed to the failure of local authorities to deliver parallel investments in community care on which improvements in hospital efficiency depended – there are parallels here with the later Private Finance Initiative).

It is true that the Plan had its technical weaknesses, reflecting the speed of its preparation and the absence of up-to-date research into hospital planning and design. Nevertheless, there were considerable achievements, as new hospitals were built in many locations that previously lacked them. Nor is there any doubt that this was driven by social priorities; it involved the identification of areas with a non-existent or poor hospital infrastructure and strategic decisions about which places had the strongest claims for new investment – in contrast to the competitive logic of the system now proposed.

The Plan was ultimately blown off course for a variety of reasons, many of them beyond the control of the Ministry of Health and hardly attributable to the bureaucratic structures of the NHS: inflation, the inadequacies of the construction industry, devaluation and public expenditure cuts which fell disproportionately on long-term capital programmes, and the difficulties of reconciling the grandiose aspirations of some hospitals and health authorities within the available sums.

The frustrations this engendered were used, then as now, as arguments for managerial reorganisation and for greater localism and competition in service delivery. Where such arguments are mistaken is their implicit assumption that the experience of implementing the Hospital Plan reflects inherent problems of state intervention. Before we consign previous efforts to plan health care delivery to the dustbin of failed attempts at social engineering, we should remember the unpromising external circumstances in which the Hospital Plan was to be implemented. Yet it is these apparent failures which have been deployed in defence of greater private finance and greater independence for individual hospitals.

The ironies of this situation – Enoch Powell defending central planning; a Labour minister arguing for an apparent reversion to localism, competition and greater private finance - –barely need pointing out. But Milburn's disparaging references to the pre-reform NHS as a command bureaucracy are being used to justify pro-market policies which in certain respects go even further than those of Powell's Conservative successors. As well as Foundation Trusts, we should also refer here to the PFI, to Labour's Concordat with

private sector providers, to their indifference to who provides services, and to proposals to expand patient choice. These policies sit uneasily with Labour's previous commitments to rolling back the Conservatives' "internal market" reforms.

The changing economic and social landscape

The Foundation Hospital legislation is part of a broader agenda of promoting choice within the public sector. The suggestion is that the electorate have become more discerning and are no longer willing to tolerate standardised services and lack of respect for individuality. For Neal Lawson, we are in a "new era of diversity and individualism" and we must embrace this and "use it to champion a popular socialism", though he emphasises that it is vital for the most vulnerable that minimum standards are guaranteed (9). External economic changes are also invoked: connections are made with changes in the organisation of production: in a "post-Fordist" era, the model for the welfare state is what Milburn terms "high-performing private sector organisations" who can deliver "customisation where it can be made" (sic) but "standardisation where it is appropriate". The implication is that the consumerist genie has been let out of the bottle, first with housing policy and later with schools, and can't be put back. Policies are therefore simply running with the grain of a more consumerist society which doesn't any longer tolerate mediocrity and standardisation.

This is part of the explanation, but it doesn't go far enough. A second answer is that these reforms are a price to pay for binding the middle class into the system. Here, I want to emphasise social segregation and polarisation, between the prosperous majority and those who depend entirely on public services. The problem is persuading the prosperous majority (many of whom can afford private services) to contribute to funding public services. Baldwin's analysis of welfare state development is highly relevant here. He argues that explaining solidaristic social policies "only in terms of the needy's ability to wrest concessions" is one-sided. It ignores the "acquiescence of the self-reliant" which is an equally necessary pre-requisite for reform (10).

So in order to keep the taxpaying middle classes on board, they need to be reassured that, as active consumers, they can shop around for the best services within the public sector. We can understand some of the thinking behind this if we consider the distribution of the privately-insured population. It is true that only around 12 per cent of the population have private health insurance nationally. But the proportions are likely to be very much higher in many areas in which Labour achieved electoral success in 1997 and 2001, quite plausibly as high as 30 per cent in many southern and suburban

constituencies (11). Substantial further growth in private insurance would run the risk that large numbers of voters would have less of an interest in supporting the NHS and, to head this off, initiatives like Foundation Hospitals can be presented as offering a better quality of public provision and also a choice. Similar arguments can be made for schooling where the promotion of alternatives to the "bog standard" comprehensive is central to securing middle-class support.

A mutualist revival?

In an attempt to head off opposition from old-fashioned defenders of the public sector it is suggested that these reforms are compatible with neglected traditions in British socialism. There is recognition of the achievements of the post-war settlement, combined with an insistence that governments must not become prisoners of it (12). This justifies a search through time and space for alternatives to a centralised socialism. With characteristic "third way" rhetorical antithesis, it is asserted that this changed situation requires alternatives to "monolithic health care provision" (i.e. the public sector) on the one hand and shareholder-led for-profit providers on the other (13). Thus recent articles by Ian McCartney and Peter Hain describe Labour's proposals as emanating from a cooperative and mutualist tradition (14). There are also proposals from thinktanks which climb on board the same bandwagon.

Some of this is a tad disingenuous and makes exaggerated claims through a selective use of evidence. In support of this argument that mutuality is not new to British health care Peter Hunt of "Mutuo" states that as many as 3118 independent hospitals, many of which were "steeped in the not-for-profit traditions of mutuality", were nationalised in 1948 (15). In fact the actual number was nearer 1100, the vast majority of the rest having been provided by local authorities or by central government via the wartime Emergency Medical Service. It is also questionable whether many of the pre-NHS voluntary hospitals could be regarded as cooperative and mutualist enterprises. Democracy and consumer control were not strong features of these hospitals, with a few exceptions (16). And any serious assessment of the pre-NHS era would have to acknowledge the enormous variations in provision and finance, such that there were five-fold variations in your chances of obtaining treatment in a voluntary hospital, depending on where you lived (17). Assertions that the NHS "simply mounted the already-galloping horse of voluntarism" (18) are simply not credible; that horse lacked steering mechanisms and had not found its way into all parts of the country.

Not all advocates of such initiatives treat historical evidence in this selective fashion, but by seeking to make connections with a cooperative and mutualist past, the general aim is to insist that while venerating traditional Labour values, other left-of-centre traditions can provide innovative ways forward. At best history is being rewritten selectively; at worst, these are attempts to make palatable a policy direction to which the government is irrevocably committed regardless of its potential consequences.

3

The implications of Foundation Trusts

The central proposition behind the policy is that by relaxing the Department of Health's grip on the NHS, the new "Foundation Trusts" will be free to innovate and respond to local needs and preferences without constantly referring developments upwards for approval. I discuss four implications of the policy under the themes of planning, privatisation, accountability, and regulation.

Planning

New Labour has always claimed that it would base policies on whole-systems thinking and that it would govern in a joined-up way. How does establishing autonomous hospitals facilitate integrated policy-making?

In terms of health policy Anthony Harrison of the King's Fund points out that the hospital is – or should be – only one element in an integrated system, which includes primary and community care. The time a patient spends in hospital is only part of the "care pathway" which is required to treat and cure their condition. Services therefore need to be designed to reflect this, and hiving off hospitals appears to contradict that goal. He also argues that in terms of the politics of the NHS Foundation Hospitals will have the economic and political muscle to reinforce their clinical strengths and secure priority access to resources, thus making it harder to shift resources away from hospitals (19). Rather than allowing an elite set of institutions to move further ahead of the rest, it would make more sense to bring the standards of the poorest-performing hospitals up to those of the best.

There are several reasons why Foundation Trusts might lead to an unplanned development of services. They relate to the ways in which they can access or raise capital (in particular, borrowing powers and asset disposals) and to pay policy. However, the real genie being let out of the bottle here may be patient choice.

Patient choice

The discredited era of top-down planning was characterised by the definition of catchment areas served by General Hospitals, to which patients were normally referred

unless they required specialist services or facilities not available in the immediate locality. The novelty of Labour's policies is that patients will now be able to exercise choice of hospital.

Enabling patients to do so, while simultaneously advertising the superior qualities of Foundation Hospitals, is certain to stimulate demands to be treated at those hospitals. Relatively small changes in patient demand, equating to a few million pounds of contract income, might be small change to some Foundation Hospitals but might well destabilise smaller General Hospitals. Is the trajectory of hospital development to be determined in large degree by the choices of the few, rather than by a planned process that considers the needs of the many?

This process also has the potential to promote segregation in the clientele using hospitals. Those patients in the best position to exercise choice are the articulate middle classes. For illustrations of how this might work we only have to look at schools; Gibson and Asthana have shown that "open enrolment greatly exacerbates existing differences between schools in terms of both their social status and performance" (20). This is because of the ability of the middle classes to afford housing in the right place and to manipulate the system to advantage (as well as their ability to afford transport costs).

Such arguments are not undermined by the announcement that all trusts will ultimately be able to apply for Foundation status. It will take some years for this to happen and in the meantime processes of patient choice will work through the system with adverse consequences for those Trusts at the back of the queue.

Borrowing powers

The key issue here is the extent to which borrowing is on or off the government's balance sheet (the PSBR). In the original formulation of the Foundation Hospitals idea, freedom to borrow was seen as an essential incentive to stimulate bids for Foundation status and was understood to be the preferred approach of Blair and Milburn, on the grounds that this would bring additional private capital into the service. This was opposed by Gordon Brown and the Treasury on the grounds that either the government could be faced with picking up the tab for excessive borrowing, or alternatively hospitals would move much more towards private provision in order to service their loans.

The compromise reached is that borrowing by Foundation Trusts will count towards Department of Health spending limits. This seems likely to distort the prioritisation of capital projects within the NHS. If Foundation Trusts come up with proposals, negotiated

individually with private lenders, which turn out to account for a disproportionate share of the Department of Health spending limit, the resources available for capital development in non-Foundation Trusts must, ipso facto, be squeezed. This will mean that commercially-viable or "near market" schemes from Foundation Hospitals will take precedence, and it does not seem compatible with the rational and planned development of hospital services in accordance with need.

A further implication of private borrowing concerns what Foundation Hospitals will do to configure a scheme in such a way that it will be a viable proposition for private finance. The resultant debt can be serviced only through expanded revenues. There is a cap on private patient income, so such revenues can only be generated at the expense of other NHS hospitals, implying that the government is willing to dismantle planning capacities. The government must therefore answer questions about the accessibility and equity of these arrangements, and about how the proposed Independent Regulator will be able to secure equitable access to services.

Asset disposals

Initial presentations of the idea of Foundation Trusts implied that there would be a "lock" on the disposal of assets, but the guidance issued suggests that this is not entirely the case. Some categories of assets are to be designated as "protected" if the regulator deems them to be necessary to the provision of services in furtherance of the objectives of the health service. Assets which are not "protected" can be disposed of. Foundation Trusts can retain the proceeds of such disposals.

Given substantial disparities in land prices this is likely to be inequitable, giving some hospitals and advantage. It would be more sensible for the proceeds from such disposals to be placed in a central pool, from which allocations could then be made according to need. It also exposes individual hospitals to the vagaries of the market. We've been here before: the collapse of property prices in the early 1990s undermined the investment strategies of several regional health authorities but the regions were still large enough to cope with this by rephasing investment programmes.

The general point is that the prospects of an individual hospital ought not to be determined by an accident of geography. In the past the fact that receipts were returned to a regional or national pool typified the way in which the NHS pooled risk.

Pay policy

Foundation Trusts will be free to depart from nationally-agreed salary scales and the inference is that through innovative methods of work organisation and reward structures they will achieve improvements in quantity and quality of services delivered. How they will do this in the context of tight labour markets without attracting staff from neighbouring hospitals is an interesting question. It's surely inconceivable that granting extra freedoms to some Trusts in respect of reward structures will not exacerbate difficulties faced in many parts of the country by NHS Trusts. The concern here is that "poaching" of staff will take place. Of course, there is much movement between Trusts already on the basis of individual decisions by staff, and demonstrating that poaching has occurred will be very difficult.

The government appear to believe that regulations can be drafted which will cover circumstances in which one Trust "poaches" from another, but it is not clear what sort of regulations could be drafted which did not entail consistency between Trusts in their reward structures, although it has been indicated that pay flexibilities will be more limited than at first envisaged.

Privatisation

Private patient income

The previous generation of NHS Trusts was established for similar reasons to those now being used to justify Foundation Trusts. They responded by seeking to attract greater numbers of private patients, not least because it offered them access to capital (sometimes in the form of public-private partnerships to refurbish private wings). Treatment of private patients provided a steady source of income for most of the first-wave NHS Trusts, and by the late 1990s well over half of all acute Hospital Trusts were showing year-on-year increases in private patient income. In order to counter the charge that Foundation Trusts represent privatisation, they will have to operate within the constraint that private activity cannot expand beyond its present level.

"Co-payments" and charging

While government statements have strenuously denied the possibility that Foundation Trusts will be allowed to extend charges for services, organisations such as the New Economics Foundation, whose work is believed to have been influential in the design of

this policy, have floated this. Among the novel suggestions in one of their policy papers, drafted with the Institute of Directors, is that a health care mutual could decide "whether co-payments or fixed charges for non-core services are appropriate" (21). The implication would be that charging for at least some elements of public health care will become a matter for local discretion rather than national policy, and the time-limiting of "intermediate care" in the NHS to a maximum of 6 weeks may provide an opportunity for such charges to be introduced (22).

Unregulated commercial activity

Private patient activity and charging may in fact be less important than the distinction between the "protected" and (by implication) "unprotected" assets of a Foundation Trust. Broadly, assets deemed essential to the Trust's operating license for the provision of health care will be regarded as protected (presumably, operating theatres, beds, equipment); all other assets – land, car parks, circulatory space and retail property within the hospitals – will be unregulated. These are likely to be treated in a de facto commercial manner, imposing additional costs (higher parking fees and charges for use of phones or TVs, etc.) on patients, their visitors and staff.

If trusts have income streams from such unregulated assets, the policy guidance suggests that they will be able to borrow against such income; they can also set up subsidiary companies. The distinction between protected and unprotected assets therefore expands the scope for commercial activities on the part of Foundation Trusts and raises the question of what happens if and when any projected revenues from such activities fail to materialise.

Lessons from abroad

The government is insisting that these developments are entirely consistent with the ideals of the NHS and that they do not represent privatisation. They declare that similar organisations exist elsewhere and that they deliver outcomes of which the NHS would be proud. But the experience of not-for-profit hospitals elsewhere suggests that we should not assume that social ownership per se will guarantee socially-desirable outcomes.

While Milburn et al have drawn lessons from the policy analyst's experience of the European grand tour, it is not the case everywhere that establishing hospitals independent of state control guarantees the desired results. The validity of the lessons drawn by the government from other European states – Sweden and Spain for example

– have been questioned (23). The experience of New Zealand's Crown Health Enterprises in the 1990s, mentioned by the Secretary of State in evidence to the Health Committee, certainly does not inspire confidence and in fact New Zealand has drawn back from that policy (24).

If policy lessons were being drawn from across the Atlantic one would not be advocating not-for-profit status. Hospitals cannot be insulated from competitive pressures: a respected American commentator warned that

> "the voluntary, not-for-profit enterprise that we think of as Main Street and Community Values has changed to one that is Wall Street and Commercial Values." (25)

In a market environment, non-profit hospitals were finding it increasingly difficult to sustain important elements of their historic mission like their community orientation, leadership role and capacity to innovate. Financial pressures were common to both for-profits and non-profits because of the underlying dynamic of American health care. Not-for-profits in the USA were characterised as the "American health empires" because of their propensity for extravagant capital schemes, borrowing for which was funded by exacting high levels of reimbursement from insurers and public-sector purchasers.

This might seem an exaggerated parallel to draw but the point is that as standalone entities, relying to a growing extent on private borrowing, there must inevitably be pressures on Foundation Trusts to act in a commercial manner (26).

Democracy and accountability

Which community?

The problem of devising appropriate representative structures for hospital governance was captured well by Kenneth Clarke in 1989, when he rejected demands for consultation about the establishment of hospital Trusts, on the grounds that "hospitals do not belong to any particular section of the public" (27). He was right, but the Tories' preferred solution, the recruitment of board members whose links to anything but their Party were tenuous or non-existent, was unsatisfactory. Are the arrangements proposed for Foundation Trusts likely to resolve the democratic deficit in the NHS?

The proposals set out in the guidance leave much to local circumstances but in general anyone who is a resident of the area served by the hospital, a recent patient, or an employee, can become a member of the Trust. This gives them voting rights on the governing body. It is envisaged that patient and resident nominees will constitute the largest single group on this body. But while hedged in the language of participation one wonders how a balanced representation of community interests will be achieved. Given what we know about patterns of civic participation (28), this will not be easy. Nor is there a definition of the "community" served; of course, this varies from Trust to Trust, but a clearer definition of the electorate would be useful – for example, in the case of a typical General Hospital, could there be an electoral process which enfranchised all residents of the relevant local authority, combined with representation for others with an interest in the hospital's affairs such as patients and workers?

One could argue that almost any solution to hospital governance has disadvantages but a self-nominating electorate is not most people's idea of democracy. If the idea is drawn from mutual organisations, the parallel is problematic because mutuals provide services for their members but the members of a Foundation Trust will constitute only a small fraction of those whom the Trust serves.

Can mutualised healthcare work?

In terms of accountability, moreover, how will elected representatives on the boards be in a position to challenge entrenched professional interests? Supervising the complex professional and technical activities of major hospital Trusts requires strong governing bodies with appropriate expertise and the confidence to hold people to account. There are no easy answers to this dilemma but the odds are surely in favour of governing bodies simply being there to provide a rubber stamp for business strategies which are devised by managers and medics. It is hardly a new problem, but it is one which is unlikely to be solved by these arrangements.

Even if a mutualist model invigorates democracy, one might question whether it is appropriate to health care. The government draw inspiration from cooperative and mutualist traditions, but hospitals are very complex and large-scale organisations: how many co-operatives deliver a vast range of professional services and have a turnover of several hundred million pounds per annum? Reviews of work on the emerging social economy – the development of not-for-profit enterprises in spheres like training, housing, recycling, and regeneration – show how difficult it has been for such businesses to establish themselves and grow (29). Their performance has been highly contingent on local leadership and circumstances, and while one could argue that there are

considerable variations in the performance of the NHS, establishing Trusts which seem likely to enhance that variability does not seem the most obvious way to universalise the best.

Regulation

The legislation also provides for a new Independent Regulator who will issue the operating license which will specify the services to be provided by a Foundation Trust. Any departures from this license need to be agreed with the Regulator.

Patient selection

Foundation Trusts must undertake to meet "reasonable demand" for regulated services, but this clearly leaves scope for interpretation of what "reasonable" means and how "reasonable" demand is to be met. If "reasonable" demand is set at an approximation of its present level that still leaves scope for selectivity in the choice of patients.

For example, could a Trust decide to meet demand for a procedure from a carefully-selected subset of the population? From a Trust's point of view, by doing so it would reduce the risk of carrying an expensive caseload of patients whose demographic profile suggested they were likely to use above-average amounts of hospital resources. It could conceivably do this without breaching the terms of its license but this would leave the problem of finding a place for those whom the hospital had decided not to treat.

Such a scenario would appear very like the pre-NHS era in which, as one commentator put it, the municipal hospitals were seen as "dumping grounds for the expensive chaff of the voluntary system" (30). Of course, these patients would still be treated, but perhaps not in the hospital of their choice, nor in the hospital nearest to them. How would the Independent Regulator protect their rights? It is not clear how these rights would be enforceable – for example, do patients have a right to treatment at a hospital within a distance threshold, or can they be forced to travel well outside their area if it is not possible to meet "reasonable" demand locally because competing hospitals have driven general hospitals have driven small General Hospitals out of business due to scale economies?

Cost-shifting

Nor is it clear how the Regulator would ensure that "reasonable demand" is met and in the contracting regime for NHS services, Foundation Trusts will clearly have an incentive to minimise lengths of stay. This is because they will be paid at standard national tariff rates for each patient admitted, and they will be allowed to retain any surpluses from treating them. They could attempt to extract such surpluses by reducing lengths of stay to a minimum and discharging patients (either to their homes, or to nursing homes) as soon as possible. There is nothing wrong with this if clinically appropriate but the potential is clearly there for cost-shifting. There are other forms of regulation and inspection, such as the Commission for Healthcare Audit and Inspection, but these are concerned largely with financial matters rather than quality of care.

NHS Trusts now have the scope to exact penalties from local authorities who fail to provide appropriate community care facilities, and standalone entities like Foundation Trusts will clearly have an interest in making maximum use of these powers to minimise their financial exposure. There is reference to imposing on Foundation Trusts a "general duty to cooperate" with other statutory bodies, but – rather like the duty not to poach staff referred to above – it is not clear whether this could really be enforced by the Regulator.

Nor does the guidance have anything to say about how services are to be provided in communities presently lacking them, other than the statement that a Foundation Trust cannot be "required to provide a new service (or expand a service already provided) without its prior consent". It is true that fifty years has closed gaps in the availability of services, but how does a new service get provided in a community in which the existing institutions are operating at capacity and in which there is no private sector alternative? What is missing in all this is the idea of a planned service containing the elements of secondary and tertiary services, backed up with appropriate community care, which one might expect to see in any locality. In this sense the reforms run counter to the emphasis – as in the Hospital Plan mentioned earlier – on integration and planning on a region-wide basis.

Regulatory disputes

Finally, given the expansion of private treatment the Regulator will also have to deal with relationships between the public and private sectors, because the private sector might well be expected to complain about the ability of NHS providers to cross-subsidise for

services. This has recently happened in a court judgement about the purchasing of nursing home care in Northern Ireland (31).

The potential is also there for disputes about whether facilities developed by the private sector – e.g. the new Diagnostic and Treatment centres, fast-track facilities for large-scale throughput of elective surgery – can be protected from competition from other NHS facilities. In deciding to license Foundation Trusts, the regulator is required to consider the availability of services provided by "other health service bodies in the area in question".

The consequence will be to institutionalise the private sector as a key provider of publicly-funded health care, guaranteeing that the NHS will be prevented from investing in a locality if there is already a private provider in existence. But what happens if private providers subsequently close down, or decide that other areas of economic activity offer greater potential for profit, and how will the resultant gaps in NHS services then be closed? Labour's usual response to this is that ownership and control do not matter if the care being delivered is NHS care, but in this system there will be a greater role for profit-driven health care and ultimately the companies involved may decide to switch into other sectors of the economy, depriving communities of essential services.

4

Conclusion: Pragmatism, principles and the fragmentation of the NHS

The government can be credited with allocating unprecedented levels of funding to the NHS and one could reasonably argue that there should be a moratorium on further structural change until the service has benefited from these higher levels of resources.

A corollary of increased funding is that it will be hard to differentiate the effects of introducing Foundation Trusts from the effects of growth in resources, allowing the government to claim success as a result of new ownership rather than because of increased funding. But their claim that this policy allows reconciliation of the goals of equity and choice sits uneasily with policies which have the potential to balkanise health care.

Labour is creating institutions and funding mechanisms largely for pragmatic reasons – the need to distance the Party from its problematic history and to demonstrate an ability to innovate and respond to social change. Crucially, this means sustaining the "acquiescence of the self-reliant" in funding the welfare state by preventing middle-class defection. But this may well have as its consequence greater diversity, at least at the margins. Labour seem agnostic about this, sanguine in the belief that increased resources will blunt any conflicts that may arise. But the key issue appears to be the degree of inequity that is tolerable.

Labour may believe that it can ensure that these novel forms of organisation operate in ways which are compatible with the NHS's public purposes; if so, the powers of the Independent Regulator, on whom much seems to depend, require clarification.

Alternatively, the government can attempt to remould public expectations of what the NHS's public purposes are, such that we come to tolerate much more of a patchwork of services than is currently the case. The response to this would probably be that the NHS has always had its good and bad parts, but it is undeniable that for most of its existence there has been a process of convergence in the distribution of resources. Of course, there are no proposals for a return to the 1930s, but the question is whether competition between hospitals and increased patient choice will widen, rather than reduce, disparities between places in access to health care.

The government appears to be comfortable with such an outcome and has not acknowledged that there is a danger in the present unreflective and agnostic drift of policy (32). Blair has suggested that the party is best where it is at its boldest, but it might be a bolder step to return to principled arguments for integrated, egalitarian public services and think about how best to improve the NHS within that framework (33). Competition between hospitals under the internal market appears to have been associated with reductions in quality on one indicator – the likelihood of survival in emergency admission for heart attacks (34). On this basis one would not argue that promoting additional competition between NHS Trusts was desirable. Labour ought to be concentrating on ways in which it can raise standards throughout the NHS, rather than pursuing a policy which is likely both to fragment support for collective, public provision as selected institutions gradually pull ahead of the remainder.

Notes

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