

NHS Trusts in the UK.

Prior to 1990 health services in the UK were organised into geographical areas with each area having a health authority which was responsible for hospitals and community health services and a Family Practitioner Committee which was responsible for Family doctor services, opticians and pharmacies. By 1990 these had been amalgamated with the health authority in some parts of the UK (e.g. Wales) and elsewhere became Family Health Service Authorities (e.g. England). The National Health Service saw major changes in its organizational structure in 1989-1991 under a Conservative Government and subsequently in 1997 under a Labour Government.

The first round of reforms was initiated to respond to a growing dissatisfaction with the services provided. In essence, the internal market was the Government's attempt to address problems, such as growing waiting lists, which had risen in the 1980s as a result of shortage of money while demand rose inexorably. The proposals had been designed to increase the responsiveness of the service to the consumer, to foster innovation and to challenge the monopolistic influence of the hospitals on a health service in which services in the community were increasingly important. The spending on the service was slowing whilst the demographic and technological developments were increasing demand. The reforms were proposed in 1989 and implemented in 1991. The aim was to preserve largely free access to health care, essentially financed by taxation (for over three fourths) and national insurance contributions (for over one-eighth), but to have providers of specialist services compete in a "quasi" or "internal" market for secondary health care by separating them from, and having them contract with, purchasers.

The method for doing this was through the establishment of the NHS Trust. These hospital organisations had much wider authority than previously enjoyed by hospitals- independent organisations with their own management, competing with each other. The first wave of 57 NHS Trusts came into being in 1991. By 1995, all health care was provided by NHS trusts. An Internal market for health care was introduced, which meant that the health authorities managed their own budgets and purchase healthcare from hospitals and other health organizations- these were known as "providers". Over the same period, many family doctors (GP) were given budgets with which to buy health care from NHS trusts (and also the private sector) in a scheme called GP fund holding. Each year more and more GPs joined this scheme. Those who did not have budgets had services purchased for them by health authorities, which bought 'in bulk' from NHS trusts. Patients of GP fund holders were often able to obtain treatment more quickly than patients of non-fund holders. This led to suggestions of the NHS operating a two tier system, contrary to the founding principles of the NHS of fair and equal access for all to health care.

The NHS Trusts assumed responsibility, for the ownership and management of hospitals or other establishments or facilities which were previously managed or provided by Regional, District or Special Health Authorities. They were given the power to provide and manage hospitals or other establishments or facilities. Consultation with the public before introducing these new autonomous bodies was required by the legislation.

Every NHS Trust is a corporate body having a board of directors consisting of a chairman (appointed by the Minister) and executive and non-executive directors (that is to say, directors who, are not employees of the trust); and has the functions to run and organise health services conferred on it by the legislation. These appointments were publicly advertised and there was open competition. An independent panel interviewed and made recommendations to the Minister who then made the

appointments. The executive directors are appointed by the non-executive members and the Chairman.

NHS Trusts are able by their constitution to exercise functions by committees and sub-committees of the trust (whether or not consisting of or including any members of the board) and, without prejudice to the generality of the power In establishing the NHS Trust organisations, the law provided for the transfer of the hospital and community staff to the new NHS trusts. This enabled all staff working immediately before an NHS trust's operational date having an automatic right of transfer to the new organisation. Their contracts of employment were transferred to the NHS trust on its operational date.

The second round of reforms proposed the abolition of the internal market and a set of organizational structures whereby the purchaser/provider split was to remain but with an emphasis on cooperation relationships, although purchasers could still switch away from providers. The purchasers were to become Primary Care Groups (PCGs) led by GPs. These subsequently became Primary Care Trusts (PCTs). Trusts were to remain and could now retain surpluses. Health authorities instead, lost their purchasing role and became an instrument for PCG accountability. Finally, a performance framework was introduced. This was composed of 37 performance indicators and two new entities: the National Institute for Health and Clinical Excellence (NICE), which set standards, and the Council for Health Improvements (CHIMP), responsible for enforcing them.

In practice however, competition or at least contestability was bound to remain, due to the persistence of the purchaser/provider split. The reform appeared consistent with the lessons from the first reform attempts, however concerns continued. If PCTs are too large there is the danger that purchasing constitutes too great a portion of local trusts' income, restricting the ability to shift this. Conversely as a result of amalgamations between some Trusts the PCT in places did not have enough influence to change service patterns. Moreover, a great degree of lip service has been paid to decentralization although the management framework remains centralised, with the government curtailing market mechanisms.

Evidence suggests an increase in efficiency attributable to the NHS reforms despite the enormous increases in transaction costs. No equity of access problems were actually found although they had been predicted. There has only been a limited increase in choice for patients- people have been reluctant to travel any distance even when immediate access was available. This is in part due to the false belief that many people have that their "local" hospital provides the best services when this is not necessarily the case. Measurable changes have been modest probably due to the limited amount of competition, the lack of incentives and the constraints being too inflexible.

What have been the Outcomes? The positive outcomes have been the development of the independence of hospital trusts. This has enabled individual trusts to develop services as they saw the need and has allowed some innovation to take place. Independence whereby financial savings could be retained by the trust encouraged efficiency measures to be found and introduced. This was not only in areas like utility supplies but also in the way services were organised. There has been a widening of peoples knowledge of the strategic planning process and the development of business plans as the Commissioners or Purchasers of services (The PCT) would

need to be convinced of the benefits being offered by the trust. The quality of services also became an important issue for hospitals and efforts are made to improve on the clinical treatments and the working environments in hospitals.

There have been as well some unexpected outcomes of the process of establishing NHS Trusts. Firstly each body wanted to be totally independent but there was a cost to this- support services e.g. IT were expensive and there was a need for national standards. The first wave of trusts did not take this into account and there were problems of equipment and system compatibility. The freedom to set local pay arrangements and staff contracts required additional expertise which was not necessarily readily available and this created new problems. The competition between hospital trusts was fierce in some areas which meant that there were winners and losers. The less successful trusts experienced a rapid turnover of the top people- the working life of a trust chief executive could be as short as 22 months in some places. Finally there was often too much emphasis given to local needs and the national focus was not clear. From this came a common understanding that there had to be well organised regional health strategic planning in place to make the most of the scarce resources.

Where are we now?

First there is a range of NHS Trust models- all of which work and there is also a more sophisticated way of contracting for health care. Mistakes were made but from these, lessons were learned. There is greater value for money and better quality services as a result in many places. The regional government arrangements in the UK has lead to services not being the same everywhere- England, Wales, Scotland and Northern Ireland each have different approaches to how to organise and deliver services.

There are still some waiting lists for treatment – the shortest waiting times are in England because that is their health priority. Throughout the UK however there are still pressures on health budgets. It is recognised that there is unnecessary duplication of services in some localities. However, making rational decisions can be difficult for politicians and if they are made they will happen **following** an election not before.

There is a process whereby there are and will be mergers of some Trusts into larger organisations to make them more efficient and to enable them to rationalise the way services are organised in the geographical area they serve. It is also evident that the medical technology developments will bring further reduction of the numbers of hospitals and smaller hospitals will close and bigger hospitals will begin to specialise in certain treatments and not try and provide a full range of services.

Finally, it is certain that the process of structural change for health services will continue into the foreseeable future throughout the UK and is unlikely ever to stop.