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The NHS Plan: An Economic Perspective

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DISCUSSION PAPER 186

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ABSTRACT

The NHS Plan, published in July 2000, presented an ambitious blueprint for the transformation of the way the NHS delivers health care. The backdrop to the Plan is the substantial increase in resources for the NHS promised for the next 5 years. At the heart of the Plan is the aim of ensuring these resources are used effectively to provide a health service “designed around the patient”.

After reviewing the perceived flaws in the current system and dismissing the notion of alternative systems of health care funding, the main part of the Plan outlines the strategy for tackling the shortcomings. The discussion is wide-ranging and includes not only those areas we would expect to see covered, such as the interface between health and social care and the performance management system, but also issues such as investment in infrastructure, the relationships between the NHS and the private sector and key personnel issues such as the supply of health care professionals and their contractual arrangements.

This discussion paper summarises the main elements of the Plan before focusing more closely on seven key themes on which economic analysis has a distinctive insight to offer – investment, information, labour markets, the independent sector, waiting times, performance management, and patient and carer responses. Some of the preconditions for success of the Plan are outlined and gaps in the available evidence to support various aspects of the Plan are highlighted. Our conclusions suggest that there is reason to be optimistic that the Plan will deliver many of its lofty aspirations *if* two key conditions are met. First, that front-line staff are on board and have the resources and the will to help implement the Plan; and second, that political expediency and the desire to achieve short-term goals does not drive out the commitment to the long-term aims for the NHS.

INTRODUCTION

Amongst many other connotations, the Oxford Dictionary defines a plan as a 'formulated or organized method by which a thing is to be done' or 'a way of proceeding'. The construction of a plan implies a desire to prescribe actions and to shape the world in a purposive fashion. The concept of planning is unfashionable. It achieved its apogee in the Soviet economic system, and the breakdown of the Soviet experiment is often ascribed to the failure of planning. It is conventional to contrast the planning model of social organization with the use of markets as a basis for economic exchange. In this respect, economic theories of industrial organization, as put forward by authors such as Williamson and Ouchi, offer important frameworks for analysing the purpose and role of planning. Loosely speaking, planning is a process used by hierarchies (as opposed to markets) to organize their activities.

The NHS is one of the largest hierarchies in the world, and so there is good reason to believe that planning has an important role to play in its management. The NHS has indeed sought to give the appearance of a planned organization. The central executive has always promulgated central policy to local managers through guidelines and instructions, in what was termed a planning process. Even when in 1991 the 'internal market' experiment was introduced into the NHS, in an attempt to mimic the functioning of a conventional market within the organization, the stream of central directives and guidance remained unstaunched. In short, the NHS exhibited all the rhetoric of a planned organization.

Nevertheless, although the semblance of a planning process has always been in place, the reality has been that the NHS is a largely *unplanned* organization [1]. Managerial attention has traditionally been narrowly focused on inputs, in the form of manpower planning and cost control. More recently, local management has also been encouraged to address waiting times for elective surgery. However, the bureaucratic structures needed to direct attention towards broader issues, such as clinical quality, have never been in place. There exists an extraordinary degree of local professional autonomy and many parts of the system have been barely touched by managerial concerns. Indeed many managers would argue that hitherto they have deliberately sought to protect professionals from such concerns. Thus the NHS planning process has in many respects represented the antithesis of a 'plan'.

Published in July 2000, *The NHS Plan* seeks to change that by setting out a broad central vision and putting in place numerous instruments designed to secure compliance [2]. The stimulus for the Plan is the enormous and sustained increase in resources promised for the NHS over a five year period. This paper assesses the extent to which the measures set out in the Plan are likely to achieve their objectives. The next section summarizes the content of the Plan. There then follows a discussion centring on seven key elements of the plan, which raises a number of issues that will need to be addressed as implementation of the Plan unfolds. It is followed by a brief concluding section.

A SUMMARY OF THE NHS PLAN

The Plan starts with a statement of ten ‘core principles’ which effectively set the strategic vision which the Plan seeks to make operational (see Table 1). In principle the success of the Plan should be judged by its performance in relation to these principles, although it is difficult to see how such performance can in practice be measured. The Plan proper then starts in earnest (Chapter 1) with an elaboration of the vision for the NHS: ‘a health service designed around the patient’.

Table 1: The NHS Plan: ten core principles

1. The NHS will provide a universal service for all based on clinical need, not ability to pay
2. The NHS will provide a comprehensive range of services
3. The NHS will shape its services around the needs and preferences of individual patients, their families and their carers
4. The NHS will respond to different needs of different populations
5. The NHS will work continuously to improve quality services and to minimise errors
6. The NHS will support and value its staff
7. Public funds for healthcare will be devoted solely to NHS patients
8. The NHS will work together with others to ensure a seamless service for patients
9. The NHS will help keep people healthy and work to reduce health inequalities
10. The NHS will respect the confidentiality of individual patients and provide open access to information about services, treatment and performance

There follows an analysis of the current strengths and weaknesses of the NHS (Chapter 2). The chapter claims that many of the traditional strengths of the NHS, such as fairness and value for money - remain intact. However, it concedes that important weaknesses have developed which need to be addressed. Prominent amongst these concerns are:

- serious inadequacies in staff numbers, morale and skills;
- long waiting times for care;
- lack of a patient focus;
- inadequate cooperation between professions and between services;
- poor physical infrastructure, cleanliness and catering;
- over centralization and excessive bureaucracy;
- variations in standards between areas.

These issues are amongst the most important expressed by both the public and NHS staff as part of a large consultation process undertaken to inform the Plan. The key conclusion is that the *principles* of the NHS remain as relevant as ever. However, many of its *practices* are now outdated. Furthermore, the NHS has suffered from chronic under-investment, in terms of personnel, training, equipment and physical infrastructure. This diagnosis forms the main basis for the contents of the Plan.

Given the acknowledged weaknesses of the current NHS, the Plan next examines whether alternative systems of funding health care might now be appropriate (Chapter 3). It assesses options such as private insurance, social insurance and user charges against the two broad criteria of efficiency and equity. The chapter argues very cogently (although unsurprisingly) that the current system of tax-based funding is not the cause of current NHS failures, and that any other system of funding may compromise important and popular principles of the NHS. The chapter therefore reaffirms that the focus of attention should be the practices of the NHS, not its principles.

The Plan proper then proceeds to set out the investment priorities for hospital and primary care, in terms of infrastructure (chapter 4) and NHS staff (chapter 5). The infrastructure developments include increased hospital capacity, improved quality of catering and cleanliness, modernized primary care premises, and new equipment and IT systems. The personnel developments include major increases in numbers of doctors, nurses and other professionals, more attention to conditions of service, and additional training and international recruitment.

Central to the success of the Plan will be the performance management systems put in place to ensure that its objectives are secured (chapter 6). Numerous initiatives are described which seek to ensure that the new arrangements are successful, some of which were in place before the writing of the Plan. Some of the more important performance management instruments are:

- extended use of national standards of care, through the National Service Frameworks for key conditions and diseases;
- further development of guidance on best treatments and interventions by the National Institute for Clinical Excellence;
- creation of a Modernization Agency to help localities redesign local services in line with local patients' needs and to identify and promulgate good practice;
- further development of the Performance Assessment Framework as the central instrument for measuring success;
- a comprehensive programme of inspection by the Commission for Health Improvement;
- a ‘traffic light’ system for categorizing the success with which local NHS organizations are securing national objectives;
- a progressive decentralization of NHS decision-making, with a system of ‘earned autonomy’, under which central intervention in local activity will be in inverse proportion to success;
- a National Health Performance Fund to be used to reward local achievement, with local discretion in its use increasing as more autonomy is earned;
- creation of a Modernization Board to advise the Secretary of State on implementation.

Health care in England is delivered by the NHS, social care by local authorities. This institutional division of responsibilities has historically given rise to difficulties in delivering appropriate care to certain vulnerable groups, most notable older people. In Chapter 7, major new investment in ‘intermediate care’ is proposed, which will seek to provide appropriate care outside acute hospitals for older people in need of

support, rehabilitative, recuperative and home care services. The Plan puts in place new incentives for closer partnership, in the form of a national performance fund for social service authorities to reward joint working with the NHS. Provision is made for more formal integration of health and social care by allowing the creation of joint health and social care purchasing organizations (to be known as ‘care trusts’) when local agencies deem this appropriate.

The contracts under which most NHS doctors work stem from the arrangements put in place when the NHS was created in 1948, and are perceived to contain some serious lacunae and perverse incentives. Chapter 8 proposes major changes to the contractual arrangements of doctors working for the NHS. For general practitioners, it proposes a major expansion of the Personal Medical Services scheme, under which GPs are paid on the basis of meeting locally agreed quality standards, rather than on the basis of activity, as under the traditional GP contract. In the same way, the Plan signals a major attempt to realign the incentives and rewards for senior hospital doctors, in the form of a radically revised contract. Annual appraisal will become mandatory, and the clinical governance arrangements signalled in the earlier White Paper will reinforce an emphasis on clinical quality. An attempt is made to tackle the potential conflict of interest of NHS hospital doctors also undertaking private work by suggesting that no such private work will be permitted for the first seven years of a consultant's career. In a similar vein, a serious attempt will be made to align rewards, in the form of bonus payments and salary progression, with NHS objectives. Doctors renouncing private work will be eligible for larger rewards.

Contractual details are less problematic for non-medical NHS staff. The Plan therefore directs its attention towards more flexible working arrangements by challenging traditional professional boundaries for nurses and other professions. It proposes a major investment in professional and leadership skills (Chapter 9).

A perennial criticism of the NHS is the scant opportunity it offers for patient choice, patient empowerment or more general citizen involvement. A range of initiatives to address this issue are proposed in Chapter 10. They include:

- reforms to procedures and information availability to make it easier for patients to change their GPs;
- a major increase in the use of pre-booked dates for hospital inpatient and outpatient care;
- a range of more comprehensive and thorough mechanisms to investigate adverse events;
- a patient advocacy service and ‘patients' forum’ based in every NHS trust;
- rights of redress in a new NHS Charter;
- increased use of patient satisfaction surveys and feedback;
- financial rewards for trusts based on results of the National Patients Survey;
- increased public and local government scrutiny of NHS organizations.

The NHS is the dominant supplier of health care in the UK. The private sector is nevertheless significant in some parts of the country and for some treatments. Traditionally the NHS has purchased very little care from non-NHS providers. Chapter 11 announces a ‘concordat’ between the NHS and private and charitable

providers, which makes provision for increased cooperation in the fields of elective care, critical care and intermediate care. The particular focus of the concordat will be the reduction of inpatient waiting times and the relief of the traditional winter inpatient bed crisis in the NHS.

Long NHS waiting times are addressed in Chapter 12. This makes provision for substantial reductions in maximum waiting times for access to GPs, accident and emergency treatment, outpatient appointments and elective inpatient treatment. For example, the maximum time for inpatient elective surgery is to be reduced from its current level of 18 months to six months by 2005, and eventually to 3 months. A major increase in the use of booked appointments is also planned.

The Government's public health priorities, originally set out in the White Paper *Saving lives: our healthier nation*, are reaffirmed in Chapter 13 [3]. Strategies to address health inequalities include redirection of resources to deprived areas, a range of initiatives aimed at children, a smoking cessation programme, and promotion of partnerships with non-NHS agencies. Chapter 14 describes specific strategies and targets to address the clinical priorities of cancer, heart disease and mental illness. Chapter 15 addresses services for older people, most specifically long term care and the problematic interface between health and social care. Although a range of new initiatives are announced, the Plan does not remove the means tested user charges for social care and accommodation sought by some commentators.

The plan is replete with specific actions and targets. It acknowledges that many changes - most especially relating to the recruitment and training of staff - will have to be incremental, and adopts a ten year horizon for phasing in new arrangements in many areas. The Plan will be financed by a staged increase in the real resources available to the NHS. A series of task forces will be responsible for its implementation, which will be overseen by the Modernization Board.

DISCUSSION

The Plan is in many respects a remarkable document. The NHS has long been the jewel in the crown of Labour Party policy, so the frank admission of shortcomings set out in Chapter 2 represents an unusually fundamental public reappraisal. Relying on large, albeit unscientific, surveys of public and staff, it pulls few punches. The question such criticism raises is whether the fundamental structure of the NHS is now inappropriate. The Plan’s analysis and rejection of alternative insurance arrangements to general taxation is comprehensive and cogent. However, the Plan does not explicitly address possible changes to structure on the delivery side. The system of general practice and geographically-based purchasers is not challenged. Although there is recognition of the increased importance of intermediate care, hospitals remain the central focus of secondary care organization. There are some moves towards closer integration between health and social care, but the split of responsibilities between NHS and local government remains largely in place. It may well be the case that such structural arrangements are indeed appropriate, but the decision to take them as given circumscribes the scope of the Plan. There is a clear need for periodic debate on such institutional arrangements. However, we do not propose to challenge them in

this paper, and our comments assess the Plan within the existing structural framework of the NHS.

The key question to be addressed is: in terms of NHS objectives, will the Plan result in the best possible use of NHS resources over the long term? In principle, economic evaluation of the Plan should probably seek to answer this cost-effectiveness question. In practice, there is not enough evidence on which to make such a judgement. For most aspects of the Plan, the best that we can do is to offer some judgement as to whether the new arrangements are likely to help move towards desired objectives – that is, we shall generally comment on effectiveness rather than cost-effectiveness. In this context it is consistent to seek to evaluate the plan in terms of the six domains of performance embodied in the Performance Assessment Framework (PAF), the central performance measurement instrument in the New NHS [4]. The domains are:
health improvement:

- fair access;
- effective delivery;
- efficiency;
- the patient / carer experience;
- health outcomes of NHS care.

Where possible, we try to do this. In doing so, we are not necessarily claiming that the PAF embraces all possible aspects of outcome relevant to the NHS. And we would certainly take issue with the relevance, quality and appropriateness of many of the performance indicators that are currently included in the PAF (shown in Table 2). However it is hard to dispute in broad terms the importance of all six domains to any evaluation of NHS performance.

We now discuss the Plan in the context of seven topics on which economic analysis may have a distinctive insight to offer:

- investment;
- information;
- labour markets;
- the independent sector;
- waiting times;
- performance management;
- patient and carer responses.

Investment

Central to the Plan is the notion of investment, in both physical and human capital. The NHS has traditionally been weak in this area. Capital planning and capital investment have not traditionally been seen as managerial priorities in the NHS. Rather, the capital planning preoccupation in recent years has been with the implementation of Private Finance Initiative (PFI) schemes. The pattern of major capital investment has therefore been driven by the extent to which schemes can be made attractive to private financiers.

Table 2: The Performance Assessment Framework

	I. Health improvement
1_i	Deaths from all causes (for people aged 15-64)
1_ii	Deaths from all causes (for people aged 65-74)
1_iii	Cancer registrations
1_iv	Deaths from malignant neoplasms
1_v	Deaths from all circulatory diseases
1_vi	Suicide rates
	II. Fair access
2_i	Surgery rates
2_ii	Size of inpatient waiting list per head of population (weighted)
2_iii	Adults registered with an NHS dentist
2_iv	Children registered with an NHS dentist
2_v	Early detection of cancer
	III. Effective delivery of appropriate health care
3_i	Disease prevention and health promotion
3_ii	Early detection of cancer
3_iii	Inappropriately used surgery
3_iv	Surgery rates
3_v	Acute care management
3_vi	Chronic care management
3_vii	Mental health in primary care
3_viii	Cost effective prescribing
3_ix	Discharge from hospital
	IV. Efficiency
4_i	Day case rate
4_ii	Length of stay in hospital (case-mix adjusted)
4_iii	Unit cost of maternity (adjusted)
4_iv	Unit cost of caring for patients in receipt of specialist mental health
4_v	Generic prescribing
	V. Patient / carer experience of the NHS
5_i	Patients who wait less than 2 hours for emergency admission (through
5_ii	Patients with operation cancelled for non-medical reasons
5_iii	Delayed discharge from hospital for people aged 75 or over
5_iv	First outpatient appointments for which patient did not attend
5_v	Outpatients seen within 13 weeks of GP referral
5_vi	% of those on waiting list waiting 12 months or more
	VI. Health outcomes of NHS health care
6_i	Conceptions below age 16
6_ii	Decayed, missing and filled teeth in five year old children
6_iii	Adverse events / complications of treatment
6_iv	Emergency admissions to hospital for people aged 75 and over
6_v	Emergency psychiatric re-admission rate
6_vi	Infant deaths
6_vii	Survival rates for breast and cervical cancer
6_viii	Avoidable deaths
6_ix	In-hospital premature deaths

It is not at all clear how the continued reliance on PFI for major capital schemes will affect the ability of the NHS to meet the objectives and targets of the PAF. The Treasury is more willing to approve major capital schemes if they are financed by PFI than if they are financed by public sector borrowing. Therefore, in an aggregate sense, PFI will contribute to the relaxation of physical capacity constraints that have affected achievement in several PAF domains. But there is no guarantee that continued use of PFI will lead to an *optimal* use of capital resources. It will moreover be virtually impossible to undertake meaningful economic assessments of PFI schemes as they are governed by a high degree of commercial confidentiality.

The ‘Capital and Capacity’ Task Force will be overseeing capital developments associated with the Plan. Its objective should be to secure a pattern of capital investment which will yield maximum benefits in terms of the PAF. Rather than seeking out some concept of ‘fair shares’ of capital investment, the priority should be to identify the capacity constraints that impose the largest opportunity costs on the NHS, regardless of where they occur. Pursuing this might in principle result in quite markedly skewed patterns of investment. Investigation of the capital investment consequences of the Plan represents an interesting research issue.

In the same way, the implied investment in staff will require the introduction of major new instruments, such as a Leadership Centre for Health, which are largely a step in the dark. It will be imperative that proper evaluation of such initiatives is undertaken, again in terms of their long run contribution to the six PAF domains. There is a strong case for controlled experimentation of alternative models of staff development, and there will be a need to change arrangements organically as evidence on ‘what works’ begins to emerge.

Labour markets

Some of the most interesting economic issues raised by the Plan concern the new arrangements for doctors and other professionals. Underlying the proposed reforms is a desire to realign personal and team incentives in accordance with the objectives of the NHS. Amongst general practitioners, the Plan signals a desire to move away from the straitjacket imposed by the traditional GP contractual arrangements, and instead to base incentives on local priorities. The NHS is currently experimenting with locally developed GP contracts, in the form of the Personal Medical Services scheme. The intention is that PMS should offer more flexible arrangements which are sensitive to local requirements. Some areas of the country have embraced PMS with enthusiasm. Again, the extent to which it secures improved performance along the PAF domains will need to be evaluated. And there will be a need to assess and disseminate good practice.

The ‘toxic’ incentives implicit in the traditional NHS hospital consultants contract have been a long-standing source of concern. The Plan proposes a radical revision, in which attention will focus on the removal of the potential conflict of interest that arises for NHS consultants undertaking private practice. In addition, the current focus of consultant bonus schemes is a vague concept of ‘distinction’. There is a clear need to realign this towards some measure of contribution to NHS objectives, as reflected in the PAF. However, doing so will be a delicate undertaking, particularly if the notion of performance bonuses is to be extended to other professions.

Modelling the incentives operating on NHS consultants and their associated behaviour appears to be prime material for traditional microeconomic analysis. There is also scope for examining less conventional models of clinical performance, which incorporate concepts such as leadership, trust and organizational culture on performance. Here the scope for 'real' trials and experiments seems limited. However, there may be scope for more creative exploration of alternatives using devices such as laboratory experiments.

Central to the success of the Plan will be the extent to which the required increases in numbers of doctors, nurses and other professionals materialise. To what extent will increased financial rewards, better working conditions and more attention to career development improve the ability of the NHS to recruit and retain professional staff? In principle, such labour market analysis should be highly amenable to economic analysis, but there is in practice little evidence on which to judge this aspect of the Plan.

The independent sector

To observers from overseas, the increased use of the independent sector implied by the concordat with private sector providers is likely to appear to be a very modest step. However, it represents a major ideological departure for the political party that introduced a public sector NHS, and its symbolic importance should not be underestimated. The principal focus of the concordat in the acute sector is initially likely to be where there is private sector slack capacity. In principle, one would expect the NHS to use the private sector selectively only when marginal financial cost of private treatment is low relative to the marginal financial cost of treating in NHS facilities. However, the myriad targets, rewards and penalties implicit in the PAF mean that in some localities the opportunity cost to managers of *not* using available private sector capacity may have little to do with relative financial costs of treatment.

There is an important distinction to be made between short-term use of excess private capacity and planned long-term use of private sector acute facilities. In the long-term, if the private sector invests in and maintains capacity to treat NHS patients, it will have to charge prices no lower than long-run average costs. In the past we would have expected NHS long-run average cost to be lower than that in the private sector. Now, however, with virtually all new NHS hospital capacity financed by PFI, it is not clear what the relative costs of public and private capacity will turn out to be.

One issue that makes it difficult to predict the effect of the concordat on NHS performance is uncertainty over the effects on the cost of private treatment and the capacity to treat NHS patients if the proposed changes to the consultants contract go ahead. Restricting the number of NHS consultants who are allowed to do private work could reduce the effective capacity of the private sector even if there are empty private beds (labour, not capital, becomes the constraint). If a shortage of consultants leads the private sector to bid up the rates it pays doctors for undertaking private work, then the cost to the NHS of using private capacity will rise.

Numerous other issues relating to patient outcome are raised by the increased use of the independent sector. Again, the key touchstone of success must be whether the objectives of private providers are compatible with the PAF domains. There is

substantial scope for microeconomic analysis of the various principal/agent relationships which may exist between the public and private sector. Much will depend on the extent to which the numerous instruments of quality control being introduced into NHS providers are applied equally to private providers used by the NHS. The framework for monitoring quality of NHS health care was developed before the concordat and when DH policy was to maintain a rigid distinction between the public and private sectors. Consequently legislation to create a regulatory framework for the private sector was separate from the legislation to create a regulatory framework for the public sector. The concordat introduces some urgency in merging the regulatory mechanisms so that one standard of quality control will exist whether an NHS patient is treated by an NHS Trust or in the private sector.

In other parts of the public sector, use of private contractors has often been seen as a useful expedient to circumvent public sector constraints, such as national employment conditions or capital investment constraints. If the concordat is used in this way, because unnecessary contractual or investment constraints prevent the NHS from operating efficiently, then we would suggest that the constraints themselves could be relaxed, without recourse to the expedient of using outside private contractors. If the constraints are necessary, then they should apply equally to non-NHS providers of health care.

Information

From an economic perspective, perhaps the single most important investment area is information. Almost all economic models of individual and organizational behaviour suggest that outcomes are enhanced as the information base gets stronger. Of course such improvements in outcome must be balanced against the additional costs of new information sources. However, the NHS does not historically appear to have seized the opportunities offered by information technology developments, and has a tradition of underachievement in this area.

A 1998 policy paper *Information for Health* set out a bold vision for NHS information systems [5]. However, implementation appears to have been patchy and slow. The vision for the NHS information base is that the individual longitudinal electronic health record (EHR) should form its core. This should be capable of capturing the patient experience across all relevant institutions whenever health or social care is consumed. The core function of the information base should be to provide for patients and staff a 'real time' resource which is an essential element in the delivery of patient care. For this to be effective, staff will have to recognise that accurate and timely updating of an individual's record is an intrinsic part of the patient's care.

High quality information is essential if the Plan's objectives are to be achieved because:

- it makes a central contribution to communication between patients, NHS professional staff, managers, board members, other organisations and the general public;
- it can help patients make effective use of health care resources;
- it can enhance the capacity of all front line staff to deliver effective and efficient care to the patient;

- it serves as the basis for organisations to optimize delivery of the services under their control;
- it plays a central role in the individual performance appraisal process;
- it plays a central role in quality assurance and benchmarking;
- it is the buttress of the Performance Assessment Framework;
- it can contribute to accountability at all levels within the NHS;
- it contributes to the development of good partnership relationships;
- it is a natural resource for evaluating innovations and identifying 'what works'.

The EHR should indicate the extent to which the care patients receive conforms to guidelines and expectations, and so good quality performance information, at any desired level of aggregation, should be a natural by-product of the information base. Given the control of front line staff over the collection of data, it will be imperative that the information should be capable of being audited and quality controlled. The Audit Commission and CHI will have a crucial role in independent validation. From an economic perspective, the key consideration is that investment in the information base is at an optimal level (allocative efficiency) and that the information it yields is used to best effect (technical efficiency).

In the past the NHS has placed importance on the quality of financial data but little interest in the quality of other information. In countries where the income of hospitals is partly dependent on patient coding and activity, the level of skill (and cost) of personnel producing and auditing the information is much higher than in the UK. The Plan promises to put in place significant rewards and penalties for NHS organizations depending on how the 'data' suggest they are performing. Trusts may therefore find it in their interests to invest more in the production of the relevant data. Experience also suggests NHS units on the receiving end of these rewards and penalties may have an incentive to game the data, leading in turn to a need for more refined audit and data quality control measures. Thus, if the Plan succeeds in changing professional behaviour, the centre may attach a higher priority to audit and data quality control than hitherto.

Waiting times

The Plan's concern with waiting times is inevitable, given the widespread public dissatisfaction with this aspect of the NHS, the poor performance relative to many other developed countries, and increasing evidence that long waiting may be having an adverse influence on health outcomes for some conditions. This area of the Plan is extraordinarily ambitious. Highly visible targets have been set, and it will be surprising if local managers do not view achievement of these targets as one of their highest priorities. Therefore, despite protestations to the contrary, it is likely that elective surgery will remain the top priority of many NHS managers. In terms of the PAF, the domain of fair access is likely to dominate.

Whether the Plan's waiting time ambitions are achievable is a matter for conjecture, although the chosen targets are likely to have been tested for feasibility. A central area of uncertainty is the extent to which reduced NHS waiting times will stimulate demand for NHS care, as patients switch from private providers or choose to undergo a procedure where before they would have sought other forms of care. Our estimates

suggest that the 'induced demand' effect is likely to be modest, but this issue will undoubtedly be monitored carefully.

The reduced NHS waiting times may have substantial knock-on effects throughout the health care system. Private insurers have hitherto used NHS waiting as one of their prime marketing devices. When an individual is not covered by private health insurance, NHS waiting time is often the crucial motivation for purchasing a procedure privately. The NHS Plan is therefore likely to imply some reduction in demand for private health care, although econometric evidence suggests that any decline may be quite modest. It will nevertheless be interesting to see how the private insurance and provider markets respond to this challenge.

The targets for booked admissions may have important implications for hospital throughput. In effect, a booked admission represents a fixed call on resources and reduces the volume of beds and theatre time available for other activity, such as emergencies. Given random demand for such other services, managers are likely to seek to build in additional slack to the resources at their disposal. One might therefore expect to see a lower level of throughput in acute NHS beds as a response to the increased use of booked admissions. It is important to recognize that such reduced intensity of use may be an efficient response, and is part of the price that must be paid in order to increase the use of booked admissions whilst retaining a capacity to handle fluctuating emergency demand, most notably what have become known as 'winter pressures'. There may be a need to fine tune incentives in order to ensure that managers balance the competing demands of elective and emergency sector satisfactorily. And the development of appropriate computerised booking systems which enable hospital bed managers to manage their resources efficiently would seem to be a priority.

Performance management

Successful management of performance is central to securing the objectives of the Plan. The *New NHS* White Paper had already put in place a daunting panoply of performance management instruments, such as National Service Frameworks, the National Institute for Clinical Excellence, local Health Improvement Programmes, the Performance Assessment Framework, the Commission for Health Improvement and clinical governance arrangements [4]. We have discussed the broad economic issues surrounding these initiatives elsewhere. The Plan fleshes out many of the details surrounding the new arrangements, and introduces some new instruments, notably the system of 'traffic lights' to indicate the performance status of NHS organizations; the establishment of a performance fund, with unfettered access conditional on traffic light status; and the establishment of the Modernization Agency to promulgate best practice in organization and delivery.

The Plan shows a good awareness of many of the difficulties inherent in managing health care performance, most notably the dangers of centralization. The rhetoric of the Plan suggests a willingness to let go of some of the reins of central control. For example, the system of earned autonomy will give green light organizations lighter inspection burden and freedom from the attentions of the Modernization Agency. There is a recognition that – to be universally effective – performance targets must be tailored to the starting point of an organization, rather than be based on crude national

standards. There is (section 6.6) a recognition that 'trust' in frontline staff is a valuable asset that – if properly used – can yield considerable benefits. And a large part of chapter 6 is given over to explaining increased devolution of powers from the centre.

At the same time, most of the performance management instruments are intrinsically centralist in nature. There is throughout the document a concern with the reduction in variations in all aspects of performance, and a desire to effect national standards wherever possible. If crudely implemented, a system of national performance standards may be seriously dysfunctional, perhaps in the extreme leading managers and clinicians to seek out only congenial environments in which to work, in turn leading to recruitment difficulties in deprived areas and even greater disparities in many aspects of performance. There is therefore a strong case for rewarding progress towards national standards in the light of the difficulty of the environment.

Successful management of the tension between the twin concerns of national consistency and local discretion will be a crucial determinant of the Plan's success. Excessive centralization is likely to lead to many of the well-documented dysfunctional outcomes associated with soviet-style management. Excessive devolution may result in considerable scope for excusing poor performance and unacceptable variations. This tension is reflected in the Plan. For example, section 6.19 indicates that efficiency targets will be based on 'levels of service already being achieved by the best trusts', whilst section 6.31 indicates that the Performance Fund will be used to 'encourage year-on-year improvements regardless of different local starting points'. These statements reflect a desire to search for targets which reflect a judicious mix of cross-sectional comparison with peers and continuous individual improvement. If these sentiments are respected in implementation then there is a good prospect that the Plan's ambitions might be realized. However, the complexity of measuring, monitoring and implementing the different targets set in different ways – especially given the well-known shortcomings in NHS data – may produce a complex and unwieldy set of measures. Progress in this area will therefore depend on the ability to improve data collection and recording methods as well as setting out a clear framework within which the various aspects of performance are drawn together.

One issue highlighted by the opening paragraph in this section is the proliferation of agencies and initiatives to manage performance. Will the NHS be overwhelmed with guidelines and inspections? The model of performance management adopted by the Plan involves a great deal of duplication. For example, regional offices of the NHS Executive are in principle already responsible for performance management, so why is there a need for an external inspectorate? The answer is hinted at in the recent NHS document *A service with a memory*, which addressed the emergence of a series of high profile performance failures in the NHS [6]. The document adopted what it calls a 'Swiss cheese' model of accident causation, in which – for a hazard to be translated into a disaster – it needs to pass through a hole in each of a series of independent layers of cheese.

In the context of the NHS, the cheese layers are the performance management instruments. The intention is that each should act as a check on performance. Their independence from each other is therefore a critically important aspect of the model,

as without independence there is a much greater chance that the system becomes ineffective – the holes in the cheese become aligned. Thus the apparent duplication in the Plan may be a deliberate attempt to avoid system failure. Of course it comes at a price: the extra managerial costs associated with the additional layers of inspection. It is difficult to envisage circumstances in which ‘the share of NHS spend on management costs will be cut’ (Plan paragraph 6.62), or indeed circumstances in which such a cut is likely to lead to improved NHS performance against the PAF domains.

Patients

In assessing the likely impact of the Plan, a key unknown is the response of patients and their carers. Will the new concept of the ‘empowered’ patient lead to more assertive and increased levels of demand, or indeed a proliferation of legal actions? How will patients respond to the new booking procedures? Will new routes of patient access, such as NHS Direct, increase or reduce demand for care? Will patients in practice change GPs with increased regularity once performance information is made available? How will targeted populations respond to the inequality initiatives set out in the Plan, and what are the implications for demand?

The answers to many of these questions have crucial implications for the effectiveness of the Plan, most notably in the areas of health improvement, fair access and health outcomes of NHS care. Yet there is a profound lack of evidence on which to base any judgement, and one must hope that appropriate measurement and evaluation is put in place to address such issues.

CONCLUSION

In drawing conclusions, it is worth considering whether the concept of a ‘plan’ is appropriate for an industry as complex as health care in which technology, expectations and external environment are changing so rapidly. Is there a danger that the assumptions on which the Plan is based become quickly obsolete, rendering the Plan useless? Planning has become unfashionable, and some spectacular large scale planning disasters have undoubtedly contributed to its fall from favour. Hall [7] judges that the critical element in such failures are the lack of the plan’s robustness to unexpected developments, and the lack of consideration of behavioural responses to the plan. So key yardsticks for assessing the durability of the NHS Plan should be the extent to which its conclusions are robust to the unexpected, and its attention to the likely responses of key individuals, most notably front line staff.

In both respects the initial impression is favourable. A major area of uncertainty to NHS planning has hitherto been the level of resources available. However, the three year budgetary settlement for the NHS removes some elements of financial uncertainty. Furthermore, there is throughout the Plan a recognition that key actors can respond in unexpected ways to new arrangements, and instruments have been proposed that – at least in principle – seek to accommodate such responses.

The devil will be in the detail. Will the precise implementation of the Plan, in the form of instruments as diverse as the new consultant contract, the inspection style of the Commission for Health Improvement, and local performance management

processes, be able to make operational the lofty aspirations of the Plan? There will be much hard work, imagination, testing, evaluation and analysis needed to ensure that it does. Will ministers be prepared to wait for the longer-term aims to be addressed, or will attention remain on short-term objectives? Indeed, is long-term planning possible in an organization so vulnerable to short-term political imperatives?

This paper has raised many questions in relation to the NHS Plan, and a potentially enormous research agenda. The introduction of much of the Plan is supported by solid evidence. Other elements must perforce be introduced in the absence of evidence, and are largely a step in the dark, so require careful evaluation. And other elements reflect political imperatives rather than any evidence or theory. However, the broad impression is that the Plan addresses in some form most of the key performance issues raised by modern systems of health care. If it fails, the question must be asked: is a high quality, efficient, universal, comprehensive, publicly funded health service viable?

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