NEW ZEALAND INSTITUTE FOR THE STUDY OF COMPETITION AND REGULATION INC.

LESSONS FROM NZ FOR ENGLAND'S PROPOSED NHS FOUNDATION TRUSTS

and vice-versa

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TODAY'S AGENDA

What the NZ experience of the 1990s reveals for England's NHS Foundation Trusts

How observation of the NHS hospital reforms might inform institutional design for New Zealand's public hospitals

“It is in pursuit of high standards, greater local accountability, genuine public ownership, greater emphasis on local service provision to tackle health inequalities, that we are bringing forward proposals for NHS Foundation Trusts”

The Rt Hon Alan Milburn, MP
Secretary of State for Health
December 2002

THE NHS ‘PROBLEM’

System perceived to be

- Dominated by decisionmaking in, edicts from, Whitehall
- Inflexible
- Inefficent

Hospitals perceived to be

- Inefficient as a result of poor management practices
- Unresponsive to patient needs and concerns

An agenda for structural reform

- Devolving control and management of top-performing NHS hospitals onto “independent public interest organisations, modelled on co-operative societies and mutual organisations”

CONSTRAINTS TO REFORM

Hospital services must be free to the patient

Health service assets acquired by the state must remain in public ownership and control

Hospitals must be part of the NHS

- ❖ funded centrally to a national schedule for service quantities and qualities negotiated with Primary Care Trusts
- ❖ “be there to treat patients not to make profits or distribute dividends”
- ❖ “treat patients according to NHS principles and NHS standards”
- ❖ subject to NHS systems of inspection

PROPOSED NHS FOUNDATION TRUSTS

Separation of purchasing (Primary Care Trusts) from provisioning (NHS Foundation Trusts)

Governance and management devolved

- Onto local citizen members (voluntary membership)
- Representing local communities (residence and interest)
- Accountable to members via elections and constitutional processes
- Subject to financial, safety, quality audits

A more corporate-style structure?

- Comparison with private nonprofit hospitals

A FAMILIAR STORY?

NZ health reforms in the 1990s

- Hospitals inefficient, poorly-managed *(Arthur Anderson)*
- Unresponsive to local needs *(Hospitals and Related Services Taskforce)*
- Introduction of the Purchaser-provider split/Quasi-market
- Removal of hospitals from central control (creation of CHEs with independent boards, contracting to provide services negotiated with RHAs)
- But retention of state ownership (despite contracting of some services to the private sector)
- Continuation of central standards-setting, accountability
- Community consultation on quantity/quality of services provided, regional/cultural/other sensitivities in purchasing/provision

NONPROFIT GOVERNANCE PRINCIPLES

Patients = originating principals (customers)

Benefits from nonprofit ownership

- Overcoming information asymmetry between patients and doctors *(Hansmann)*

But require organisational instruments to overcome inefficiencies from lack of ownership interest

- Conflicts from separation of legal, beneficial ownership
- Information to substitute for absence of markets for shares
  - Increased importance of markets for products, factors *(Jensen)*
  - Strength/effective monitoring of fiduciary duties *(Fama and Jensen)*

TYPICAL PRIVATE NONPROFIT HOSPTIALS

Governance mechanisms

- Single-issue boards; direct legal accountability to members
  - Members, boards ‘buy in’ to organisational mission
- Trading signals
  - Patient substitutions (product markets)
  - Donor defections (factor markets)
- Failure to meet objectives leads to failure of the organisation
  - Members lose opportunity to fulfill missionary objectives
- Risks, costs of poor decisions borne by board, managers, members
  - Reputational consequences of poor performance
  - Difficulty recruiting high quality board members

NZ REFORMS PERCEIVED TO HAVE FAILED: *PROMISED EFFICIENCY, SERVICE GAINS FEW*

Systemic, rather than structural, problems *(Howell, 2000)*

- Board members appointed by Minister
  - Supply of board members guaranteed
  - Complex chain of accountabilities
  - Inability for patients to share risks across the political boundary
  - Questionable efficiency of risk-sharing between purchasers, providers

Dual local geographic monopolies (purchaser/provider)

- Captive market (absence of patient, purchaser substitutions)
- Traditional risks of failure absent (political risks too great)
- No incentives to collect information about trading risks – loss of information from which improvements could be made
- Concentration on performing to incentivised targets – financial performance, waiting list targets

CONSEQUENCES

Purchaser-Provider split poses information problems

- Consultation mechanisms used to define services focused at purchaser level
- Hospitals had to ‘purchase’ info from RHAs or recreate it (adversarial process)

Patient disenfranchisement

- Complicated political nexus of accountability

Rise of medical ‘patient-agent’ representatives

- But had own political agendas
- Preponderance of ‘bad news’ stories

Soft Budget Constraint

- Insulation against failure
  - more risky decisions/less ardent pursuit of savings

SUGGESTIONS FOR AMELIORATION

(Howell, 2001)

Locally-elected, rather than ministerially appointed, boards

- ❖ But in control of own destiny, decision-making (including full responsibility for consequences of failure)

Competition at purchaser level

- ❖ Better information for satisfaction, service provision
- ❖ Encouraging improved provider, service variety

Removal of geographic monopolies where feasible

NHS FOUNDATION TRUSTS

Meet most of these requirements

- ❖ Elected citizen boards
- ❖ Provider competition where feasible
- ❖ Theoretically possible for PCTs to compete

Therefore greater chance of NHS reforms delivering anticipated gains

BUT

Still some areas of concern

- ❖ Membership dilemmas
- ❖ Autonomy and risks of failure
- ❖ Accountability and information sharing

MEMBERSHIP

Members

- Local residents
- Patients in last 3 years
- Employees
- Representatives of partner organisations

Board

- Majority elected by members
- Appointees from partner organisations, commissioning PCTs and universities undertaking teaching, research at hospital

MEMBERSHIP DILEMMAS

How members account to non-members

Protecting against actions of vested/conflicting interests

Membership bias

- Costs of membership vs benefits
- Adverse selection – staff, disaffected patients, advocacy groups
- Staff – able to gain balance of power/influence decisionmaking
  - No countering balance from a shareholder/owner
  - Precluded from membership/governance roles in typical nonprofit

Potential solution

- True resident member co-operative
- Advisory role only for staff

AUTONOMY AND RISKS OF FAILURE

Rewards/sanctions for outcomes beyond board's control

- Less ardent pursuit of any actions for fear of incurring sanctions *(Holmstrom and Milgrom)*

Minimum standards, remuneration for services levels set centrally

- Patients may require different services, quantities, qualities
  - may hold board to account electorally for not complying
  - Costs to board members' reputations for bearing someone else's risks
  - constrains incentive for higher quality members offering selves; leaving only lower-calibre candidates => poorer quality decisions

RISK-SEEKING AND THE SOFT BUDGET CONSTRAINT

Central intervention in event of NHS Foundation Trust financial or operational failure

Higher likelihood of board pursuing more risky projects (e.g. at behest of patients) and such projects continuing longer before being identified as failures and discontinued

- ❖ No loss of service to community
- ❖ No personal cost to board members
- ❖ Fewer incentives for patients to monitor/report on activities

POSSIBLE SOLUTIONS

Positive rewards for exemplary board performance

- e.g. retirement bonuses, civic awards

Debarring failed board members from similar positions

Avoiding mismatches between allocation of risks, costs and decisionmaking powers

ACCOUNTABILITY AND INFORMATION SHARING

Conflict between statutory and electoral duties

- Favouring incentives that offer greatest reward – especially acute for appointed board members

Elected members seeking to retain office

- Total voter reliance on voluntarily disclosed information for assessing board member performance
- Concealing information easier in absence of commercial trading information – voluntary disclosure of adverse information extremely unlikely *(Prendergast)*

Requires higher disclosure requirements than usual

- e.g. fully public meetings, fully open books, permission to disclose rather than obligation to release on request

WHAT CAN NZ LEARN FROM OBSERVING THE NHS REFORMS?

Power of the staff board member

Interest group capture vs. public voter apathy

Cohesiveness of the mixed appointment/elected board

Calibre of decision-makers

threats to reputation from bearing risks outside of decision-makers' control limiting decision-making quality

Other issues?

CONCLUSION

Institutional design challenges posed by continued public ownership but divested control are complex

- If not well-considered, may thwart ability to achieve desired outcomes