Written evidence submitted to the

Public Accounts Committee on Financial Sustainability of the NHS

By

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We welcome this opportunity to submit written evidence to the Public Accounts Committee on the Financial Sustainability of the NHS. This reply draws on recent published academic work, senior level personal experience of public service management and accounting practices, and response to the House of Lords Select Committee on Long-Term Sustainability of the NHS (Ferry and Gebreiter, 2016).

The National Audit Office (NAO) (2016a) has recently repeated its view that financial problems are endemic in the NHS and the situation is not sustainable, and that while there has been effort to stabilise the system by the Department of Health, NHS England and NHS Improvement they have not demonstrated balanced resources and value for money.

We concur with the view of the NAO on the current financial situation and so rather than repeat any of these messages the main focus of our response concerns whether accountability arrangements for sustainability of the NHS are 'fit for purpose', especially given ongoing resource pressures (Ham et al., 2015) and structural fragmentation (NAO, 2014, 2015a, 2016b, 2016c).

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The NHS has been subjected to reforms to address its sustainability since its creation in 1948 (Ferry and Scarparo, 2015). In 1950's there was concerns over cost and performance. In 1960's concerns re-emerged around service efficiency and tripartite administrative arrangements effectiveness. In 1974 problems led to first major reorganisation of NHS. In 1980's and 1990's neo-liberal reforms and New Public Management were introduced in to NHS by Thatcherite Conservative government heralding an era of performance management to improve productivity and reduce waiting times. An internal market resulted from the reforms with market driven incentives and management budgeting, despite government and medical profession being at odds. Financial sustainability of the NHS remained an issue despite these reforms. The New Labour government from 1997 to 2010 therefore provided high levels of investment for NHS, but surprisingly coupled with more upheaval and neo-liberal reforms. This extended era of governance by performance management inherited from outgoing Conservative government beyond financial numbers to encompassing all aspects of managerial and organisational performance through a framework of hierarchical accountability and centralised control.

Following New Labour, Conservative led coalition government from 2010 to 2015 largely maintained accountability and transparency arrangements for financial conformance and operational performance in NHS, but structural and operational framework of hierarchical control was dramatically altered with significant consequences (Ferry and Murphy, 2015). This was due to significant changes from Health and Social Care Act 2012, Local Audit and Accountability Act 2014 and other initiatives such as quality accounts implemented at a time of financial restraint. These changes resulted in fragmentation of services that seriously obscured overall accountability making it more complex and opaque, which undermined ability to determine if value for money was being accomplished and thereby posed risks for financial sustainability (Ferry and Murphy, 2015). In particular, these changes meant healthcare system as a whole, and individual organisations and services within it, increasingly struggled to meet centrally set objectives and targets, most notably Acute Hospitals Trusts (NAO, 2014, 2015b). On other side of coin the NHS finances were under pressure for various reasons. NHS budget was protected relatively to other public services, but arguable whether in real terms this was sufficient. Systemic risks from cuts in local government budgets especially that affected adult care inevitably meant costs were shunted to NHS with more elderly people ending up in hospital that could have been looked after in the community. Attempts to link NHS and local

government budgets and services will take time to bed down to see if they are successful, but given financial issues this time may be short lived. Position is also arguably further complicated by inherited legacy of financial and service issues from New Labour such as servicing PFI debt interest, favourable changes to staff terms and conditions, and fallout from healthcare scandals that continue to have cost implications. In addition, unlike local government that has a statutory requirement to set a balanced budget (Ferry, Eckersley and Zakaria, 2015), there is no statutory imperative to set a balanced budget and so a systemic risk of financial failure is prevalent as services may be continued beyond budget confines. Given these issues it is important to consider how accountability and transparency can be extended beyond traditional hierarchical accountability structures of a NHS based on a public service delivery model so new hybridised and distributed forms of delivery involving various forms of arms-length bodies, commercialisation and privatisation can be properly and appropriately held to account (Ferry and Murphy, 2015).

Within context of this history, while marketization of healthcare and governance through performance management have enjoyed some successes in maintaining services they cannot discipline and control health services and associated costs to solve myriad of long-term problems facing healthcare sustainability in 21st century (Ferry and Scarparo, 2015).

Having said that, it is arguable that concerns around cost of health care are historically contingent rather than inescapable consequences of demographic and technological change. For example, Gebreiter and Ferry (2016) historically examined emergence of concerns for health expenditure in wake of creation of British National Health Service in 1948, and their relationship with health service accounting practices. They suggested nationalization of health services, together with compilation of health estimates and changing notions of health and disease, constituted the cost of health care as an insoluble problem in mid-20th century. Health care became discussed as a cost rather than potential investment in economic and health of citizens that may provide relative benefits to GDP. They also showed health service accounting practices are both constitutive as well as reflective of such concerns, and that this did not merely begin with New Public Management reforms in 1980's as widely believed. In addition, they cautioned that current reforms promoting decentralization of health services in Britain and beyond (e.g., Prime Minister's Office, 2011) could reduce rather than increase accounting's ability to facilitate control of health service costs. Finally, they argued both in 1950s and present day, concerns regarding ageing populations, expensive medical technologies and cost

of health care have focused much attention on accounting practices that seek to encourage hospitals to provide various health services at lowest possible cost (i.e., maximize their technical efficiency). Conversely, questions whether hospitals use most efficient mix of inputs to provide these services (i.e., maximize allocative efficiency of health service inputs), and whether hospitals produce those services which provide greatest health benefits relative to their costs (i.e., maximize allocative efficiency of health service outputs), have attracted less attention. Indeed amidst emerging suggestions that health systems like NHS cannot remain financially viable unless they focus scarce resources on those services that provide greatest health benefits relative to their costs (e.g., Health Foundation, 2015), there needs to be more engagement with issue of allocative efficiency in health services.

In addition, consideration should be given to a broader monitoring regime. Lord Kerslake has floated the idea of introducing a statutory requirement for balanced revenue budgets in the NHS that exist for local government (Ferry, Coombs and Eckersley, 2017). The budget regime could however go further, beyond merely adherence to budget conformance and/or service performance and taking account of risks concerning governance arrangements and cultural specificities when considering sustainability (Ferry and Murphy, 2015). Interestingly, this was also highlighted recently as a concern in local government (Ahrens and Ferry, 2015, 2016; Communities and Local Government Select Committee, 2016; Ferry, Coombs and Eckersley, 2017).

Furthermore, often the NHS is politically construed as a *'national treasure'* that is sacrosanct and somehow protected more relative to other public services. The protection afforded in recent budget rounds relative to say local government is evidence of this (Ferry, Eckersley and Zakaria, 2015). However while it may or may not be justifiable to prioritise the NHS it is important that it is not seen as an isolated and/or untouchable body. The NHS must be viewed as part of a broader health service that encapsulates other parts of the 'welfare state' including not merely adult care in local government but employment, housing and the welfare bill as examples that may have preventative features. Also it seems important to reconsider these preventative features as investments and not merely costs.

The accountability and transparency arrangements of the NHS (Commons Select Committee, 2013), its financial sustainability (NAO, 2014) and the design of public services more generally (Lord Bichard, 2011) therefore requires a broad and fundamental rethink extending to the

foundations of the welfare state itself in order to protect this most valuable ideal for both current and future generations.

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