Journalists' Briefing Pack
What's the argument over Foundation

How are Foundations different from existing Trusts?

■ While only the top-performing 3-star Trusts can become Foundations, *any* other organisation may apply to become a Foundation Trust (eg BUPA, PPP, or American private medical providers such as Kaiser Permanente).

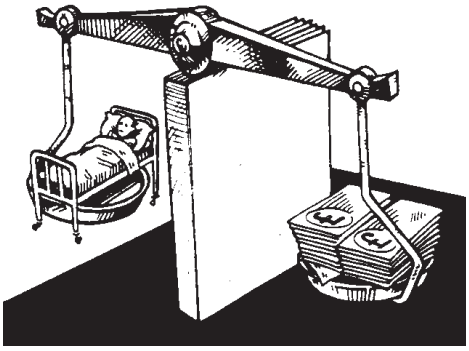
■ NHS Trusts that become Foundations will no longer be the property of the Crown: they will also have additional freedoms to sell "unprotected" assets and to borrow money within "prudential" limits (yet to be defined).

■ Each Foundation will be a 'Public benefit corporation' – in other words a not-for-profit *company*: a copy of the authorisation will be held at Companies House. While their non-profit status means they cannot share surpluses out among shareholders, they are expected to run as a company, to at least break even, and to generate surpluses. In a cash-limited NHS, this can only come at the expense of reduced revenue for non-Foundation Trusts.

■ These new companies will be governed by a new "independent Regulator", who will be appointed by the secretary of state, and theoretically answerable to Parliament. The Regulator will have extensive powers to decide local health care needs in any area, and to shape the license for each Foundation Trust. He will also have powers to approve subsequent changes, and to permit Foundations to sell 'unprotected' assets.

■ While their 'principal' purpose has to be the provision of "goods and services" for the NHS, Foundations are also free, provided the Regulator agrees, to carry on other activities on their own behalf or jointly with private sector organisations.

■ Foundations will be outside the NHS planning process: they are not directly accountable to ministers or to local Strategic Health Authorities – and will have purely a contractual accountability to the Primary Care Trusts, which will commission services from them.



■ Foundations are also free to ignore existing NHS systems of consultation and complaints: they are not obliged to operate Patients Forums.

Why do we need them?

We don't. The 3-star Trusts that are being urged to seek Foundation status have achieved their standards within the existing NHS framework, showing that it is not an obstacle to success.

Trusts already have extensive powers to co-opt, consult and cooperate with local people, groups and communities. Few – even among the first wave applicants for Foundation status – have shown any genuine desire to do so.

They already have powers to borrow, within cash limits, to finance new equipment and buildings. The Foundations have been promised a new right to borrow from the private sector, but it is unlikely they will be able to afford large-scale loans. One accountant has calculated that to service a loan equivalent to a quarter of a Trust's turnover could require the Trust to double its income.

What difference will they make to patients and the public?

Foundation Trusts make it *less* likely that gaps in local service provision can be filled, since their establishment is part of the run-down of any national or regional planning framework within the NHS and its replacement by market-style systems.

Foundation Trusts are likely to concentrate their resources on those services which deliver the largest and most secure return. They may therefore seek to pull out of provision of other forms of care, leaving this to other Trusts.

The freedoms and privileges to be granted to the top-performing hospitals are likely to widen the gap between them and the other non-Foundation Trusts, creating an even bigger gap between the 'haves' and 'have-nots' within the NHS.

The extra resources that will be directed to the Foundation Hospitals and their expected larger share of the new NHS "market" will undermine the ability of less well-resourced Trusts to maintain a comprehensive range of services for their local population.

Neither Foundation Trusts not the Regulator are under any obligation to pay attention to issues of equity in the distribution of health care services.

What do ministers mean when they say Foundations will be 'locally controlled'?

VERY LITTLE: the Foundation Trusts are in essence accountable to the Regulator, and not to local people.

■ There is no requirement to show any local support for the establishment of a Foundation trust: indeed the first wave applicants for Foundation status have submitted their applications without any prior reference to local people or staff – and made it clear that they will press their application through, regardless of local opinion.

■ All day to day decisions on policy will continue to be taken by the same Board of Directors that currently runs the Trust.

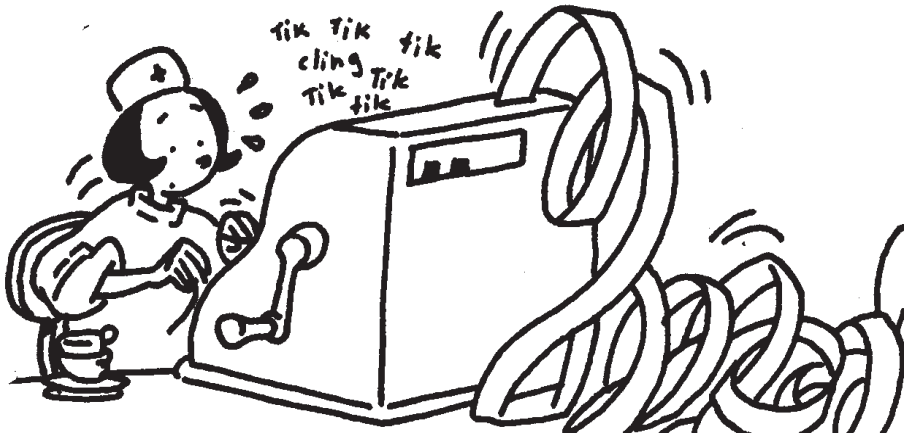
■ A handful of local people may see a value in signing up as "members" and seeking a place on a new 'Board of

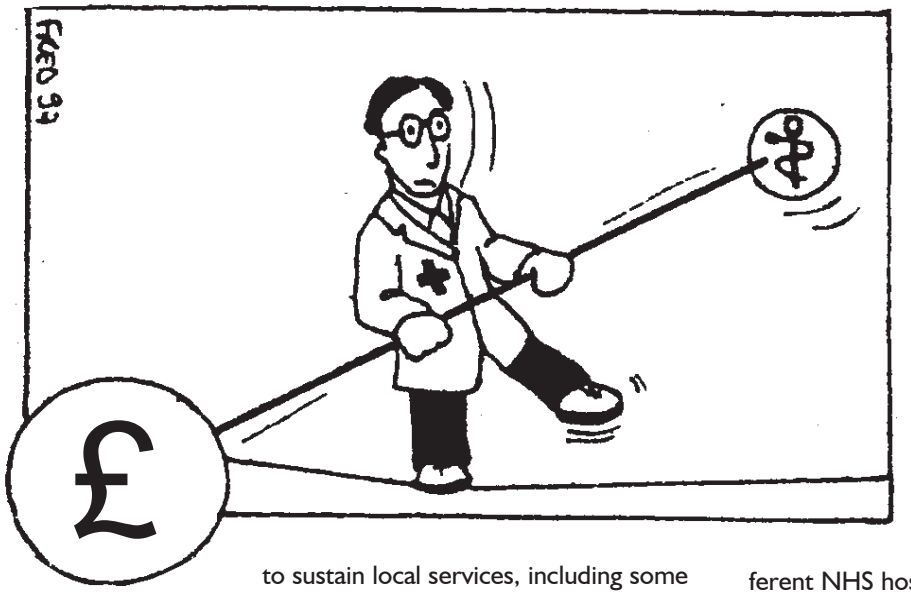
Governors', or "members' council": but these bodies are marginal to any decision-making, and will have no real control over the hospital or its services.

■ Even a relatively large "Board of Governors" with members elected from a larger pool of "members" will be tiny and unrepresentative in relation to the wider catchment population of patients and potential service users.

■ The administrative effort and costs of setting up the "membership" and running postal ballots for Board of Governors for a Foundation Trust will divert resources from patient care.

■ If Trusts really want to consult with and involve wider groups from the local community they already have powers to do so: most have decided not to.





Will Foundation Trusts lead to more competition between hospitals?

YES. Foundation Trusts are intended to "unleash local entrepreneurialism" – in other words to compete and take risks to expand as businesses. Since their main customer will be the cash-limited NHS, this puts Foundations in conflict and competition with non-Foundation Trusts.

The new system for funding hospital treatment is being changed to one of payment by results, to give Foundations the incentive to compete for more referrals from their existing catchment area and beyond.

There is no doubt that Foundations in many areas will seek to use their elite status and 3-star ratings as a means to persuade more patients to exercise their new right to choose, and to choose the Foundations' services rather than those of non-Foundation Trusts.

Since the new system replicates Margaret Thatcher's internal market in which "the cash follows the patient", the success of Foundation Trusts in increasing revenue and generating surpluses must inevitably be at the expense of "losers" elsewhere.

This could leave non-Foundation Trusts struggling for viability as they battle to sustain local services, including some expensive services which the Foundations opt not to offer.

Will Foundation Trusts treat more private patients?

YES! The promise to "cap" the expansion of private medical treatment in Foundation Trusts has taken the form of a clause in the Bill which prevents Foundations from increasing the proportion of their income that they derive from private patients.

This means that if Foundations succeed in increasing their overall income, by attracting additional NHS contracts from PCTs, they will also be able to expand their private work.

Several of the Trusts seeking Foundation status are already among those most financially dependent on private patient income.

Foundations are also free to sign up to agreements with private medical companies, including for-profit companies, which will result in an expansion of private medical treatment – some or all of which may be carried out by consultants and staff employed by the Foundation Trust.

And of course the Regulator can agree to changes proposed in any Foundation Trust's license.

Will this bring a new two-tier system?

YES. Of course there are already different levels of resources, performance and quality of care in different NHS hospitals.

But instead of focusing resources on improving those currently the furthest below standard, the gap between "failing" hospitals and the 3-star elite will widen as more freedoms and resources are funnelled towards those that are already succeeding – at the expense of the rest.

Foundation hospitals will get preferential access to a limited pool of capital, will be able to retain windfall surpluses that arise from the new funding formula, and will implement that formula a year earlier than other Trusts.

Ministers have argued that other Trusts and PCTs will be able to seek Foundation status, but any chance of 2 and 1-star hospitals attaining the performance requirements to apply as Foundations is undermined by the privileges for the first-wave elite.

While some patients may enjoy the choice of deciding whether or not to use a Foundation Trust, patients in many areas will have no real choice but to continue to use their local non-Foundation Trust, even if it is struggling to retain the staff and resources to maintain services.

Why are the trade unions so opposed to Foundation Trusts?

Ministers dismiss any opposition to Foundation Trusts from the trade unions as no more than special pleading by "producer interests": but in reality the "producers" with the largest axe to grind are the Trust Boards of the first-wave Foundation Trusts, which have submitted applications regardless of the level of local opposition.

The health unions opposed the market-style reforms when first proposed by the Thatcher government in 1989-91, and are still opposed to them today.

They have expressed concerns both with the principles and with the practical impact of the Foundation Trust proposals.

Most of the trade union criticisms have centred on the impact of the changes on the NHS as a whole and on patients rather than on staff, though there are significant concerns over the long term impact, especially in areas where key groups of staff have been hard to recruit.

Trade union concerns include:

- The 2-tier NHS,
- The return of a market system in the NHS which New Labour committed itself to abolish in 1997
- The scope for greater links between Foundations and for-profit private companies
- The charade of local control and democracy while in practice Foundations offer neither
- The prospect of a new round of asset-stripping as Foundations sell off land and property
- The financial viability of Foundations and non-Foundation Trusts
- The collapse of planning and further fragmentation of an increasingly fragmented service, in which there is no provision to remedy inequalities in access to services
- The freedom for Foundations to tear up nationally-negotiated pay structures and impose local-level pay scales – which may also be used to "poach" key sections of staff from neighbouring hospitals.

However unions also remember that some Trusts in the 1990s used their 'freedoms' to reduce pay levels for some sections of staff, while increasing the salary range for the most senior levels of management.

Why is the government so intent upon forcing changes through?

Despite the lack of any evidence that this return to a new internal market system can deliver improved services, it is clear that ministers are ideologically committed to press these measures even at the risk of a damaging Commons defeat.

Some ministers, and even the Cooperative Party, have attempted to present the changes as a new form of "social ownership", "socialism" or a new turn towards "mutualism".

However many will find it strange that this attempt at "decentralisation" focuses on empowering not the ***commissioners*** of health care (the PCTs) but the ***providers***, the Trusts – and encouraging them to act in more ways like private sector businesses rather than as an accountable public service.

Despite warnings from friendly forces within the Parliamentary Labour Party and the trade unions, ministers appear to have decided no compromise can be made. And of course they are advaised by many of the same civil servants who urged on Margaret Thatcher's costly bureaucratic and unsuccessful market style reforms in the early 1990s. As one academic notes:

"The failure to learn by systematic evaluation and use of evidence is impressive".

What has happened in other countries where Foundations or similar bodies have been set up?

SPAIN

Health Secretary Alan Milburn visited Madrid's Alorcon Foundation Hospital in 2001, and soon afterwards announced the scheme to promote similar autonomous hospitals as not-for-profit companies in England.

Yet a year before Mr Milburn's visit, the Spanish government had stepped back from its promotion of foundation hospitals after encountering strong opposition from unions and public health organisations, who were critical of the unfairness of allowing foundations to borrow money or do deals with the private sector, since this would lead to inequalities in access to care.

Only four hospitals – two of them in Majorca – had launched as foundations before the scheme ceased to be a priority of the right wing government.

Unions have also complained that staff at foundation hospitals work longer hours than elsewhere: doctors at Manacor hospital in Majorca were reportedly working 32 hours without a break. One top manager has pointed out that the higher salaries can only be paid in exchange for restricted numbers of staff.

Subsequent criticisms of foundation hospitals have also pointed to the fact that they focus heavily on "cherry-picking" the more profitable sectors of treatment, involving short-stay and younger patients, and deal with fewer long-term and elderly people, who wind up being treated in other hospitals. This in turn can skew the statistics to make foundation hospitals appear more efficient.

Foundation hospital bosses admit to problems in working with non-foundation hospitals.

SWEDEN

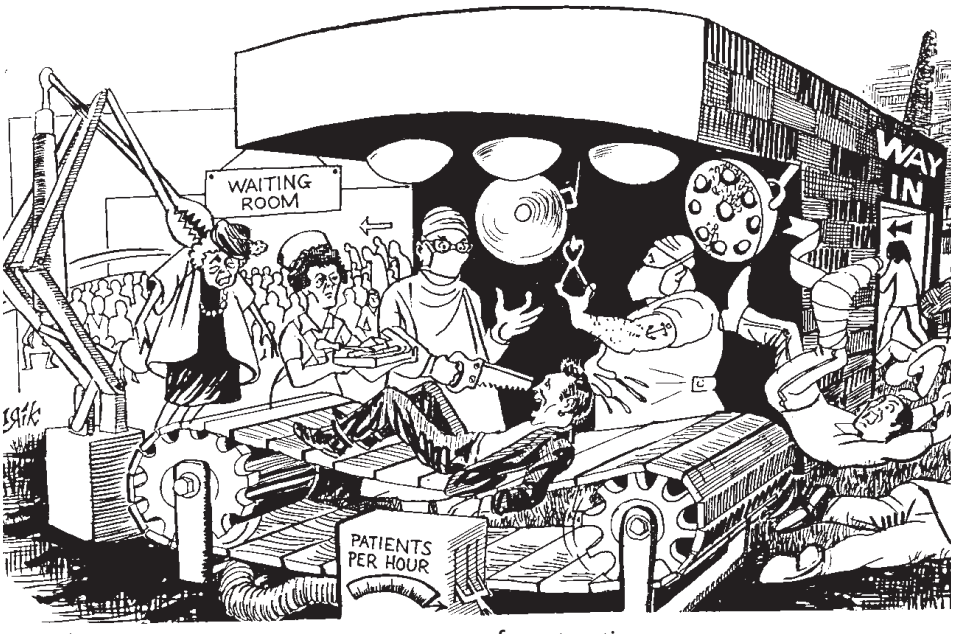
In Sweden, two thirds of expenditure on health comes from county taxes, and the local level of control by elected bodies has led to the possibility of political shifts, such as when the victory of right wing parties in several counties led to them adopting more market-style policies, including the contracting out of hotel services and the floating of hospitals as publicly-owned companies.

In Stockholm, one such foundation hospital, St Goran's, was sold in 1999 by the county council — against the wishes

of the central government — to a private company, Capio, which operates in other Scandinavian countries, Poland and the UK. St Goran's is now described as "Sweden's largest private emergency hospital".

In 2001 the government legislated to prevent further public hospitals being privatised.

Despite early claims that the privatised hospital had cut costs and increased caseload, the experience in this and other 'corporatised' hospitals has been of failure to achieve cost savings or productivity increases. The chief executive of another Stockholm foundation hospital has warned that Swedish planners have not answered the question of what happens if standards and performance levels fall in a foundation hospital.



NEW ZEALAND

In New Zealand the market-style reforms which came into force in July 1993 instituted a 'purchaser provider split', and sought to create competition between the public sector providers, and between public and private hospitals.

The equivalent of NHS Trusts were 23 new "Crown Health Enterprises" (CHEs), which were at first required to run on commercial lines and deliver a profit, despite widespread public unease with the notion of for-profit hospitals.

Like NHS Trusts in Britain CHEs were told they could fix their own local pay agreements for staff – but unlike British NHS Trusts, they were permitted to borrow money from private lenders: indeed CHEs were even denied access to cheaper government-backed capital, and charged above-market rates of interest in a deliberate attempt to force them into borrowing from the private sector.

By the end of 1996, the Ministry of Health concluded that there was little evidence of success from the implementation of the reforms:

"Health sector performance over the last 3 years has been disappointing in a number of areas: costs have not been constrained in line with planned funding growth; both CHEs and RHAs have experienced deficits; although total output has increased, access to some services appears to have reduced; and only 35% of public health targets are expected to be achieved."

It was evident that the promised advantages of the reforms would not materialise. The claims of 20-30% savings as a result of competition were especially unrealistic, and costs of running the Regional health authorities increased 40% over two years.

Far from making a profit, CHEs ran up losses and large-scale borrowing, and required government cash handouts. Private sector borrowings increased in five years from 16% to 69% of total hospital debt. A government report noted:

"The financial claims of banks and other lenders over the public hospital system have grown from a negligible level to around one third of the total capital".

The 1996 election saw health emerge as the top issue among voters' concerns, and the party that had opposed the reforms won a place in the new coalition government that was formed.

The result was a fresh turn in health policy, to one which stated that "principles of public service replace commercial profit objectives", and called for cooperation and collaboration rather than competition.

What are the features of health care prior to 1948 that the advocates of Foundation Trusts find so attractive?

Promoting Foundation Trusts, Alan Milburn set the tone for subsequent ministerial arguments, claiming that with the establishment of the NHS, "1948 silenced the voice of the local community in the NHS." Which community?

Milburn implied that hospitals should be returned to the type of local autonomy they had before Nye Bevan's bold reforms nationalised the existing hospital systems and launched a new health service free to all at point of use, and funded from taxation.

However the 1,143 voluntary hospitals nationalised in 1948 were generally very small – they had just 90,000 beds between them. They were neither mutual nor democratic: they were charitable organisations funded by fees, subscriptions, flag days – and occasional donations from the rich and powerful. They were controlled by exclusive boards, with barely token representation of the local population.

By 1948 they were nearly all broke: civil servants warned Bevan that if the voluntary hospitals were left 'independent' they would soon wind up receiving 90% of their funding from the government. Such local control as there was left hospitals dependent on the state of the local economy: the wealthiest, healthiest areas had the best-resourced health services, while the poorest had the least. Access to services, and the quality of care varied enormously from one area to another. This was no golden age of localism.

It's not clear that anyone who knows the shape of health care prior to 1948 would want to revive any aspect of that period, which was dominated, as Bevan pointed out, by the fact that even middle class people were forced to mortgage the future to pay doctors' bills.

Compared with the preceding decades, the NHS was a bold and historic step of modernisation. Returning to pre-war models is not modernisation, but a vain quest for a non-existent golden age.

Drafted by John Lister, London Health Emergency, November 2003. Phone 07774 264112, health.emergency@virgin.net

15 Fifteen freedoms that Foundation Trusts should not be given

Freedom to privatise

Although Foundation Trusts will not have "shareholders", and will not be allowed to share out surpluses, they will be able to contract out services, including clinical services, to the private sector, including for-profit companies that will generate profits for shareholders.

Freedom to withdraw from unprofitable work

Each Foundation Trust will be issued by the regulator with a "licence", which will stipulate which existing services – such as A&E – will be "protected". The Regulator will decide what services are required for any locality. Foundations could only pull out of "protected" services by permission of the Regulator. However Trusts will be free to choose which services they wish to invest in and promote, and which they wish to deliver as the bare minimum required by their licence.

Freedom to poach patients

The first applicants to become Foundation Trusts clearly expect that the new 'patient choice' system that will allow patients to select a hospital from a range of options will benefit them as high-profile 3-star performers. The new system of funding hospital services through "payment by results" will mean that the extra patients treated by Foundations will take with them money that would otherwise have gone to NHS Trusts – many of which are already struggling to cope with the resources they have. The gap between "have" and "have-not" hospitals will widen: the financial viability of some NHS Trusts could be called into question.

Freedom to poach staff

Foundation Trusts will be able to offer enhanced "recruitment and retention" premium payments and other non-cash benefits to attract staff in hard-to recruit specialist services – while these freedoms will not be available to NHS Trusts.

Freedom to scrap NHS pay and conditions

Although the first Foundation Trusts will begin as "early implementers" of the national pay system known as 'Agenda for Change', they will be free in future years to set pay and conditions for their staff. The Bill setting up Foundation Trusts gives them "maximum freedom to apply the flexibilities of new pay systems", and power to "do anything which appears necessary" to carry out their functions. When Trusts were originally given powers to fix local pay back in the early 1990s many took the opportunity to award fat increases to top managers. Some even set out to reduce pay and conditions for lower-paid sections of staff.

Freedom to keep surpluses – at the expense of other NHS providers

Foundation hospitals will get preferential access to a limited pool of capital, will be able to retain any windfall surpluses that arise from the new NHS funding formula, and will implement that for-

mula a year earlier than other Trusts. Some applicant Trust expects to benefit by millions a year from this arrangement.

Since the new system replicates Margaret Thatcher's internal market in which "the cash follows the patient" in a cash-limited NHS, the success of Foundation Trusts in increasing revenue and generating surpluses must inevitably be at the expense of "losers" elsewhere.

This could leave non-Foundation Trusts struggling for viability as they battle to sustain local services, including some expensive services which the Foundations opt not to offer.

We want more resources for our local hospital – but not at the expense of wrecking services in other parts of the NHS.

Freedom to set up, or to contract with, for-profit companies

The Bill establishing Foundation Trusts stipulates that the "principal purpose" of the Trust must be the provision of goods and services to the NHS – but also allows it to engage in other activities. Foundations are explicitly allowed to form or participate in forming, or to acquire shares in companies, and to enter into contracts with companies. Such arrangements could include breaking up existing clinical departments and sub-contracting all or part of their work to commercial companies.

Freedom to bring bankers and private companies onto the board

Already the Project Director for the University College Hospital London's Foundation Trust application is a merchant banker. Oxford's Nuffield Orthopaedic Centre wants to give a seat on the Board of Governors to a private company – the hospital's "PFI partners". The token representation of local communities, NHS and local government in the new structure of Foundation Hospitals could be easily outweighed by growing influence of business fat cats with a financial interest in Foundation Trust services, and an eye to future profits.

Freedom from patient forums

There is no requirement on Trusts to get local consent before applying for Foundation Trust status: the Regulator will decide whether or not a consultation process has been adequate. Nor is there any requirement to show that the "membership" that will elect non-executive directors and the chair of the Foundation Trust is representative of the local population, or in any way answerable to local people.

Unlike NHS Trusts, Foundation Trusts are not obliged to operate Patient Forums or independent advocacy services – though they are free to do so if they wish.

The Regulator will decide whether Foundations need to consult on issues with their local councils' 'overview and scrutiny committee' – but neither the Regulator nor the Foundation Trust is obliged to follow any findings or recommendations that such committees might offer.

Freedom from Strategic Health Authorities (SHAs)

SHAs are supposed to plan services over wide areas and monitor the performance of Trusts: but Foundation Trusts will no longer be answerable to SHAs, or required to comply with management and operational guidance from the Department of Health. Although Foundation Trusts will, like NHS Trusts, be inspected by a new Commission for Healthcare Audit and Inspection (CHAI), the inspectors' report will go to the Regulator – and only the Regulator will decide whether or not the findings must be acted upon.

Freedom to strip assets

Foundations will be free to retain any proceeds from the sale of surplus land or buildings, unlike NHS Trusts, which can retain a maximum of £10m. At least one London Trust is predicting asset sales in excess of £100m: once these public assets have been disposed of, the entire NHS asset base will be reduced.

The Bill does contain a clause that might protect some NHS property, but the decision on what is or is not protected is in the hands of the Regulator, who can subsequently agree to deregulate assets and free them for sale.

Foundations are forbidden from mortgaging their "protected" assets – but they will be given freedom to borrow against future income from "unprotected" assets such as car parking and other commercial activity on site.

Freedom to run up debts and go broke

Unlike NHS Trusts, Foundations will be allowed to borrow money from the public or private sector – provided borrowing is kept within "prudential" guidelines. Access to capital will be based not on any measurement of local health needs, but on the level of surplus generated by the Foundation Trust: those already well-endowed with resources will be able to borrow more than those struggling to cope.

But as 'public benefit' companies, Foundations will also run the risk that if they are allowed to over-borrow and fail to secure enough income to pay their debts, they could go broke.

This means that Foundations seeking to borrow will be forced to maximise their income – in competition with other Foundations and NHS Trusts.

Freedom to expand private patient income in line with total Trust income

Ministers have argued that there will be a "cap" on the amount of private work a Foundation Trust may carry out – but the Bill has watered down this limitation, and given the Regulator power to decide whether or not to impose it.

In any event the "cap" is simply to prevent Foundations increasing the proportion of their income from private patients: but if a Foundation Trust's income increases, this means it can also increase the level of its private work.

Some first-wave Foundations have already made clear that they will seek deals with private sector hospitals and companies that would also result in increased volume of private work.

Others will no doubt seek to

Freedom to choose auditors

While all other NHS bodies have their auditors appointed by the Audit Commission, the bill would allow Foundation hospitals to appoint their own auditors. This is inconsistent with the principles of public sector audit, the first of which clearly requires that public sector auditors should be independent from the organisations being audited. After Enron, WorldCom and other scandals it should be all too obvious that there can be a conflict of interest if companies appoint their own auditors. Why have ministers not learned the lesson?

Freedom for private sector bodies to apply

Private firms like BUPA, Boots, or multinational healthcare providers may apply and be approved as a foundation Trust delivering NHS services. Such private companies acquiring foundation status would not be subject to the cap on private work, as this applies only to former NHS hospitals. However, in common with other NHS hospitals, they would be exempt from corporation tax.

Now the legislation has been drafted to allow it, it remains to be seen if any private sector companies will show an interest in foundation status.

Drafted by November 2003 by John Lister, London Health Emergency, .
Phone 07774 264112,
health.emergency@virgin.net