
The Impact of NHS Re-Organisation on Service Commissioning Costs: A Welsh Case Study

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Abstract

During recent years the NHS in Wales has undergone major structural change in relation to the commissioning of services. In a speech to the Welsh Assembly in February 2001 which outlined the planned changes, the then Welsh Health Minister stated that the restructuring of NHS Wales would "produce a health service in Wales in which bureaucracy is reduced, accountability is clearer and the system is made easier to understand."

On the 1st April 2003 the five Welsh Health Authorities were abolished and their role in commissioning services transferred to twenty two Local Health Boards. These Local Health Boards share geographical boundaries with the twenty two Welsh Local Authorities. The key functions of the Local Health Boards are to prepare strategies and plans to meet the health needs of their population, commission services from health care providers and make payments to primary care contractors.

Since 2003 NHS Wales has suffered increasing cost pressures and has struggled to meet a number of performance targets, including those relating to waiting list reductions.

In November 2005 a Welsh Assembly Government member publicly raised concerns about the level of spending by commenting that the creation of twenty two Local Health Boards had 'involved recruiting a high number of senior managers and executives for each local health board' leading to a significant increase in administration costs, and was 'another example of the Labour Assembly Government spending on bureaucracy, rather than front line services where it is most needed.'

Using information extracted from NHS Wales Summarised Financial Statements 1999/00 to 2004/05 (www.wales.gov.uk), this paper presents a review of commissioning costs within NHS Wales over the last five years and concludes that structural re-organisation has led to a significant increase in administrative costs, particularly executive and non-executive directors remunerations.

Key Words: NHS Wales, Structural Re-Organisation, Service Commissioning Costs

Introduction

Although the NHS in the United Kingdom is managed at the top level by the Department of Health, which takes political responsibility for the service, there is significant variation in the organizational and management structures operating within the service in England, Scotland, Northern Ireland and Wales.

In England, the NHS management structure is centered around ten Strategic Health Authorities (SHAs), recently reduced from twenty eight, each of which oversees all NHS operations in a particular geographical area. SHAs hold responsibility for the commissioning of health services for their resident populations and exercise a supervisory role over Primary Care Trusts (PCTs), which administer primary care and public health. Prior to October 1st 2006 there were 302 PCTs, following a major re-organisation there are now 152. Their primary role is to oversee England's GPs, NHS dentists and such matters as primary and secondary prevention, vaccination administration and control of epidemics. PCTs also act as hosts to some 290 NHS Hospital Trusts who administer hospital treatment centres and specialist care on approximately 1,600 hospital sites.

In Scotland healthcare policy and funding is the responsibility of the Scottish Executive. The chief civil servant in the Scottish Executive Health Department is also Chief Executive of NHS Scotland. The provision of healthcare is the responsibility of 14 geographically-based NHS Boards and a number of Special Health Boards. There are no NHS Trusts in Scotland, instead, those hospitals not managed by Special Health Boards are run by the local NHS Board who contract in the services of GPs. Provision of community and mental health care is also the responsibility of each local Board.

Healthcare in Northern Ireland is administered by the Northern Ireland Department of Health, Social Services and Public Safety and is currently undergoing major reorganisation. In November 2005, it was announced that a Health and Social Services Authority (HSSA) will be set up in place of the existing four Health and Social Service Boards. Seven primary-care led Local Commissioning Groups will also be established as local offices of the HSSA. Five new integrated Health and Social Service Trusts will replace the 18 existing Trusts supported by the existing Ambulance Service Trust. The Department of Health, Social Services and Public Safety will therefore become smaller (<http://www.dhsspsni.gov.uk/index/hss/rpa-home.htm>).

In Wales NHS services are operated and managed by the Health and Social Care Department of the Welsh Assembly Government. There are no Strategic Health Authorities or Primary Care Trusts in Wales, instead their service commissioning role is undertaken by Local Health Boards (LHBs). There are currently twenty two LHB's in the principality, operating within local authority boundaries, supported by Health Commission Wales, an Executive Agency of the Welsh Assembly Government with specific responsibility for the commissioning of specialist health services. Hospital services are provided by 13 NHS Trusts which cover groups of local authority areas. In addition there are two further Trusts covering the whole of the country, namely the Welsh Ambulance Service and Nationwide Agencies and Services.

Across the United Kingdom the NHS remains a system of healthcare intended to be "free at the point of delivery" and paid for by taxes. The structures outlined above have evolved over the last ten years as the current Labour government has pushed ahead with its plans to devolve responsibility for the management and provision of healthcare to a more local level (Department of Health 1997; Department of Health 1999; Department of Health 2000).

NHS Wales

Prior to 1st April 1996 the management structure of NHS Wales consisted of eight District Health Authorities and Family Health Service Authorities. District Health Authorities were responsible for buying health care for the population living within their geographical area. In some cases they also managed a proportion of the hospital and community health services, where these had not become NHS Trusts. District Health Authorities were accountable to the Secretary of State for Wales. Family Health Service Authorities managed the services provided by general medical practitioners (GPs), general dental practitioners, pharmacists and opticians. These practitioners were independent contractors and not NHS employees.

From 1st April 1996 five new Health Authorities took over most of the responsibilities of the former District Health Authorities and the former Family Health Service authorities. The primary functions of the new Health Authorities was to prepare strategies and plans to meet the healthcare needs of their population, the commissioning of health services from healthcare providers (NHS Trusts) and to make payments to primary care contractors.

However, further structural re-organisation was not far away. "Improving Health in Wales - A Plan for the NHS with its Partners" (Welsh Assembly Government, 2001) proposed new structures and organisational change for NHS Wales. The structure was developed to meet the following principles:

- Simpler for patients to understand;
- Accountable for the actions it takes and the service it delivers;
- Stronger democratic voice in the way it is governed;

The plan led to the establishment of Local Health Groups as sub-committees of the five Health Authorities. The primary responsibilities of which were:

- To provide advice to the Health Authorities on the development of general medical services and community health services;
- The commissioning of services under part 1 of the NHS Act 1977;
- The management of prescribing in the community including the administration of Prescribing Incentive Schemes;
- The development and improvement of the health of their populations;

The plan stated that 'All this removes the necessity for Health Authorities in Wales, abolishing a tier in the current hierarchy between the Assembly and the patient' (Welsh Assembly Government, 2001, P.77). Subsequently, on 1st April 2003 the five Health Authorities were replaced by 22 Local Health Boards. These are responsible for commissioning, securing and delivering health care in partnership with local authorities and the voluntary sector. Their boundaries coincide with Welsh Unitary Authorities.

The new structure also led to the establishment of the Health and Social Care Department within the Welsh Assembly Government on the 1st March 2004 to oversee healthcare in the principality. This is supported by three Regional Offices, led by Regional Directors who act as the agents of the Director of NHS Wales on a day to day basis in holding to account the Chief Executives of the 36 statutory NHS bodies and managing their performance. In addition Health Commission Wales (HCW) was created as an "arms length" agency to provide advice on specialised secondary and regional service commissioning. HCW also provides guidance and support for the commissioning of acute services. It is intended to be the first source of independent advice and guidance on commissioning issues that require determination. (www.wales.nhs.uk)

This new structure, has not however, been without its critics. Since 2003 NHS Wales has suffered increasing cost pressures and has struggled to meet a number of performance targets, both financial and non-financial.

In November 2005 one member of the Welsh Assembly Government raised concerns publicly, commenting that the creation of 22 Local Health Boards had 'involved recruiting a high number of senior managers and executives for each local health board' leading to a significant increase in administration costs, and was 'another example of the Labour Assembly Government spending on bureaucracy, rather than front line services where it is most needed.' (<http://www.medicalnewstoday.com/medicalnews.php?newsid=33148>)

The primary aim of this paper is to evaluate the true extent of any increase in the cost of commissioning health services for the population of Wales as a result of major structural re-organization over the last five years, with particular reference to the Board costs referred to by the Auditor General for Wales ('The Finances of NHS Wales 2005', Wales Audit Office). The findings will then be evaluated in the context of the key issues highlighted in the Auditor General Report of April 2006.

Devolved Responsibility & The Cost of Managing Health Services

The cost of management and administration within the National Health Service has been the subject of much debate over recent years.

Appleby (2001) comments on the perspective that in the NHS there is always a demand for more doctors and more nurses whereas, "Managers are not seen by most of the public as adding any value to the NHS or patient welfare". Indeed, he indicates that the Labour government set out a target for the reduction in "bureaucracy" over five years from May 1997; £1 billion was to be saved by reducing the costs of management, despite the agenda for change in the NHS. The NHS Plan for England (Cm 4818, 2000) set out the government's intention to devolve power to the front line of the NHS and to reduce management costs. Baggott (2005) reports that this has led to the abolition of NHS regional offices and health authorities.

Appleby (2001) goes on to identify the difficulty of defining management costs in the NHS and states, "Currently, the DOH identifies health authorities, primary care groups, NHS trusts and primary care trusts as the organisational entities that incur costs due to management", but the DOH excludes the management costs of piloting new developments.

Appleby goes on to refer to two pieces of research touching on the question of how many managers are needed within the NHS in the UK. The first study was by Soderlund (1999); this considered data over the period 1991-1994 and concluded that "overall management input across and within hospitals does not appear to be associated with improved productivity as measured by average cost per adjusted inpatient episode." This suggests that there is little relationship between increases in management expenditure and increases in efficiency.

A second study by Fulop et al (2002) involved a cross-sectional study of all nine trust mergers and reconfigurations in London in 1998/1999. It examined inter-alia, the financial consequences of mergers, indicating that areas with few providers (due to the greater integration of services) tended not to show lower proportionate expenditure on management than in those with many providers. The following quotation from Fulop is quite striking within the context of this paper. "Interviews with finance managers indicated that the clearest source of potential savings from the merger was the £500,000-£750,000 that was associated with reduced numbers of members of management boards in the merged trusts."

Deeming (2001) discusses the problems of devolving health spending to local areas. He identifies two problems. The first is the hypothecation of health spending as so much of it is related to prior year expenditure and unavoidable commitments. The second concerns the threat of regional variation in health care. He comments "However, too much devolution for the NHS may not chime with the expectations of voters who have witnessed 50 years of effort to achieve national standards of access and equity within the NHS. It is doubtful how far the public are likely to accept a significant re-emergence of local differences emerging from devolution."

Ezzamel et al (2004) researched the development of democratic accountability in the devolved assemblies/ parliaments of Wales, Northern Ireland and Scotland. With regard to understanding financial issues, they comment "Ordinary members of the national assemblies/parliament ...are, however, seldom able to understand accounting and budgetary issues." They also refer to the presence of information overload among both civil servants and elected members. However, they also observed more scrutiny of budgets and questioning of executives in the newly devolved bodies. They state that their findings suggest that post-devolution budgeting and accounting processes are much more open and transparent than before devolution.

Another area of debate in healthcare reorganisation is the optimum size for primary care organisations (Bojke et al 2001). Whilst it was originally suggested that primary care groups in England would serve average populations of around 100,000 (Department of Health 2000), the

transition to Primary Care Trusts resulted in mergers which saw the average population size increase to around 200,000 (Bojke et al 2001). Further mergers in October 2006 saw the number of PCTs reduced from 302 to 152 resulting in a significant increase in the average resident population.

The Wanless Report (2002) concluded that the UK must devote a larger share of its national income to health care over the following 20 years. Following publication of the report, the Chancellor of the Exchequer announced real terms increases in NHS funding of 7.4% annually over five years beginning in 2003-04. Bailey and Fitzgerald (2004) comment that this increase in NHS funding is on the back of a 59% real terms increase in NHS expenditure between 1984/85 and 1999/2000 compared with real terms increases of 35% in Education and of 17% in total public expenditure over the period. Wanless (2002) observed that managing the increase in resources effectively is a key challenge for managers in the NHS and comments "The challenge to ensure that the additional resources are spent wisely, delivering greater activity and more capacity rather than driving up prices is huge". He advocates rigorous independent audit to ensure that all resources are being used efficiently and effectively.

Dickson (2005) reports that a major success of the increased funding has been a steep reduction in waiting times in England. However, work by the King's Fund (2005) on the destination of extra NHS funding in England found that a substantial proportion of increased funding was spent on inflationary increases in pay and non-pay costs. For 2006/07 a further study by the Kings Fund (2006a) estimated that almost 40% of the £4.5 billions increase for English hospitals and community health services will be absorbed by pay rises. Another study by the King's Fund (2006b) reveals significant variations on how much different primary care trusts spend on different diseases, although the figures do show that funding is reaching the government's three clinical priority areas of mental health, coronary heart disease and cancer.

"An Independent Audit of the NHS Under Labour (1997-2005)", by the Kings Fund (2005) outlines government growth targets for NHS staff in England over the period and observes (ibid, p.62) "Unsurprisingly the Government did not set targets for increasing the number of NHS managers. However, NHS management has increased significantly since Labour came to power". The study established that managers as a percentage of total NHS staff in England increased from 2.5% in 1997 to 3.35% in 2003, an increase in excess of 30%. However, it also observes that the NHS is considered by some to be under-managed. Managed care organisations in the USA (regarded as comparable to the NHS), spend 12%-15% of their budget on administrative support.

NHS Wales Restructuring - Cost implications for the Commissioning of Healthcare

Every year, the Auditor General for Wales publishes a report on the finances of NHS Wales. In 'The Finances of NHS Wales 2003'(Welsh Audit Office, 2003), the Auditor General stated that

'In May 2002, the Director of NHS Wales asked me to review the transitional and running cost budgets of the new NHS structures that will come into effect on 1st April 2003.....The Minister for Health and Social Services has stated that the running costs of the new structure will not exceed those of the existing structure.....The terms of reference of my review were to comment on the assumption that the running costs of the new structure would not exceed the running costs of the existing structure. The review did not involve a detailed examination of the costs but focused instead on whether the estimates used by the NHS Wales Department were robust and could be adequately supported.'
(p.13,Paragraphs 3.9-3.11)

In reporting the results of the review the Auditor General concluded that the basis on which the NHS Wales Department had calculated the existing running cost figure of £71.1 million was sound, but that the planning budget for the running costs of the new structure was £79.6 million, which meant that savings of £8.5 million would be needed in order for the new structure to achieve cost neutrality.(Paragraph 3.12,p.13) He also commented that 'there were major uncertainties with many of these costs, and that estimates would need to be revised as staffing structures and accommodation requirements became clearer'.(Paragraph 3.12, p.13)

The following year it was also stated that 'The NHS Department have informed me that they expect the running costs of the new structure to remain within £71.1 million'('The Finances of NHS Wales 2004' Welsh Audit Office, p.19). By the time the 2005 report was published, the estimated running costs budget had been increased to £71.3 million, but the Auditor General noted that

'Additional running costs associated with the new structures, such as additional Board and accommodation costs, have meant that savings have been necessary from the running costs associated with the former health authorities.

(*'The Finances of NHS Wales 2005'*, Welsh Audit Office, Paragraph 3.10, p.21)

The comments of the Auditor General above clearly allude to the fact that additional Board and accommodation costs have necessitated savings to be made elsewhere within the service in order to maintain cost neutrality in running the new NHS service commissioning structure in Wales. The elements of cost to which he refers can be broadly classified as administrative costs.

One of the major criticisms associated with public sector structural reform in recent years is that administrative costs have increased, diverting resources away from service provision. In Wales, this type of criticism has been directed at the Welsh Assembly Government in respect of the NHS re-organization.

Opposition parties within the Welsh Assembly Government (WAG) have expressed their concern regarding the rising cost of a Labour Assembly Government restructuring programme of the Welsh NHS.

Comments from a WAG member in November 2005 stated, "New Labour's restructuring created a costly bureaucratic nightmare. New Labour created 22 Local Health Boards to replace the five Health Authorities. This involved recruiting a high number of senior managers and executives for each local health board. Furthermore Plaid Cymru have learnt that the administration cost of Local Health Boards exceeds the administration costs of Health Authorities by £5 million. Another example of the Labour Assembly Government spending on bureaucracy, rather than front line services where it is most needed."

(<http://www.medicalnewstoday.com/medicalnews.php?newsid=33148>)

The financial pressure facing the NHS across the whole of the United Kingdom is a subject which has been at the forefront of debate in the national press and television in recent years. Increasing financial deficits have been widely reported and many NHS organisations are facing sustained pressure to reduce costs whilst at the same time improving service provision. In Wales, the pressure being faced by the NHS ,both financial and in terms of improving service planning and provision, was recently highlighted in a report by the Auditor General for Wales entitled 'Is the NHS in Wales managing within its available financial resources?' (Wales Audit Office, 2006).

The primary aim of this paper is to evaluate the true extent of any increase in the cost of commissioning health services as a result of major structural re-organization over the last five years, with particular reference to key issues highlighted in the Auditor General Report of April 2006 (Wales Audit Office, 2006).

Analysis of changes in the administration and management costs associated with the commissioning of health services in Wales 1999 - 2005

In order to ascertain the true cost of commissioning healthcare within the principality pre and post re-organisation on 1st April 2003, the NHS Wales Summarised Financial Statements (www.wales.gov.uk) were analysed from 1999/2000 through to the end of the 2004/5 financial year. At the time of writing data for 2005/6 was not yet in the public domain.

A number of key cost elements relating to Board and other administrative salary costs were then extracted from the published data for comparative purposes. Where possible, figures were taken directly from the summarised accounts. However in view of the fact that the presentation of some information in the notes to the accounts varied from the old Health Authority format to the new Local Health Board format some manipulation of the original data was necessary in order to ensure accurate comparative data. This primarily related to the assessment of the cost of staff involved in the service commissioning function and the cost of Local Health Group Board members within the summarised Health Authority Accounts pre April 2003. The detail of specific cost calculations is outlined along with the findings below.

The Total Administrative Costs of Service Commissioning

As previously discussed, the five Welsh Health Authorities were abolished on 31st March 2003 and replaced by 22 Local Health Boards supported by Health Commission Wales, who took over the service commissioning role of the old Health Authorities.

Using the NHS Wales Summarised Accounts 2002/3 to 2004/5 (www.wales.gov.uk), the total administrative staff costs associated with the commissioning of health services were collated and are presented in Table 1 below.

	Health Authorities	Local Health Boards	Local Health Boards
	2002/03 ¹	2003/04 ²	2004/5 ³
	£000	£000	£000
Other salaries and wages	15094	16313	19008
Non-executive directors remuneration	261	1779	1891
Total	15355	18092	20899
% Increase in year		18%	15.5%

Table 1 - Administration Costs - Commissioning

1 Source Summarised Account of Health Authorities in Wales 2002/3 Note 6, adjusted to include only those staff identified as involved in the commissioning of services (note 9) assuming an average salary per staff member. Average salary calculation based on other salaries and wages figure included in note 6, less executive Directors remuneration (note 8) less estimated cost of LHG Board members remuneration. Executive directors remuneration and estimated LHG Board members remuneration then added back to give a total staff cost.

2 Summarised Account of Local Health Boards in Wales 2003/4, Notes 6 and 9.

3 Summarised Account of Local Health Boards in Wales 2004/5, Notes 6 and 9.

The costs identified in Table 1 relate only to LHB commissioning staff costs and exclude the staff costs of Health Commission Wales (HCW). By adding the administration costs reported in the Health Commission Wales Accounts 2003/4 and 2004/5 (www.wales.gov.uk) total costs would increase further (Table 2).

	Health Authorities	Local Health Boards	Local Health Boards
	2002/03	2003/04	2004/5
	£000	£000	£000
Total (Table 1)	15355	18092	20899
HCW staff costs		907	1450
Total	15355	18999	22349
% Increase in year		24%	18%

Table 2 : Administration Costs - LHB plus HCW

Although the above table shows an increase in administration costs of 24% following structural re-organisation of the healthcare commissioning function within Wales, and a further increase of 18% in the year following re-organisation, a proportion of this additional expenditure can be accounted for by inflationary increases in pay costs. In order to provide a more accurate assessment of the real increase in costs the figures for previous years have been brought up to a 2004/05 price base using the inflation factors for Hospital and Community Health Services (HCHS) published by the Department of Health (www.dh.gov.uk). The indices used was that for non-review body pay inflation⁴ as the vast majority of administrative staff costs would fall within this category. The adjusted figures are presented in Table 3.

	Health Authorities	Local Health Boards	Local Health Boards
	2002/03	2003/04	2004/5
	£000	£000	£000
Total Administration Cost (Table 2)	15355		
2003/04	15985	18999	
Total Cost at 2004/05 Price Base	16976	20177	22349
% Increase in year		18.9%	10.8%

Table 3 : Administration Costs - LHB and HCW at 2004/05 Price Base

The inflation adjusted figures above show that in real terms, the increase in total administration costs remains significant. It is reasonable to assume that this can only be as a result of an increase in the number of administrative staff employed within the commissioning function following re-organisation for Health Authorities to Local Health Boards.

This increase in recurring administration costs is not consistent with the on-going management cost of devolved responsibility in the NHS in England. When service restructuring came into force during 2006, NHS Chief Executive David Nicholson re-iterated earlier comments that reducing the number of PCTs combined with the earlier reduction in the number of SHAs is expected to release £250 million savings annually from management and administration costs for re-investing in frontline services from 2008/09. (<http://www.medicalnewstoday.com/medicalnews.php?newsid=53173>)

4 HCHS Non Review Body Pay Inflation indices 2003/04 4.1%, 2004/05 6.2%.

Board Members Remuneration

Each of the twenty two Welsh Local Health Boards have a structure headed up by a number of Executive and Non-Executive Members.

The following costs extracted from the NHS Wales Summarised Accounts (www.wales.gov.uk) show the total Board Members Remuneration pre and post re-organisation. Table 4 shows actual costs, whilst Table 5 shows the increases after adjusting for pay inflation.

	1999/00 £000	2000/01 £000	2001/02 £000	2002/03 £000	2003/04 £000	2004/05 £000
Non -Executive Directors⁵	920	815	866	888	1779	1891
Increase in year £000		(105)	51	22	891	112
% Increase in year		(12%)	6%	3%	200%	6%
Executive Directors⁶	1985	2033	2116	2151	5862	6821
Increase in year £000		48	83	35	3711	929
% Increase in year		2%	4%	2%	272%	16%
Total Directors Remuneration	2905	2848	2982	3039	7641	8712
Total % Increase		(2%)	5%	2%	261%	14%

Table 4 : Executive and Non Executive Directors Remuneration 1999 - 2005

	1999/00 £000	2000/01 £000	2001/02 £000	2002/03 £000	2003/04 £000	2004/05 £000
Non-Executive Directors	1195	990	1003	982	1889	1891
Executive Directors	2579	2497	2452	2378	6225	6821
Total Directors Remuneration	3774	3487	3455	3360	8114	8712
% Increase		(8%)	(1%)	(3%)	241%	7%

Table 5: Total Board members Remuneration at 2004/05 Price Base⁷

Tables 4 and 5 show that between 1999/00 and 2002/3 Board Members Remuneration had shown a marginal decline in real terms. However, between 2002/03 and 2003/04 the trend is reversed, with salary costs increasing by £4.602 m which equates to an actual increase of 261%. After adjusting for inflation the percentage increase falls marginally to 241% but is larger in real terms at £4.754 million. The significant cost increases reported in 2003/4 and beyond reflect the additional salary costs of the Board members of the twenty two LHB's over the Board member cost of the five old Health Authorities.

The large increase in expenditure can be explained by firstly, an increase in the number of paid Board Members, and secondly a large increase in the number of Executive Directors earning salaries of between £25,000 and £50,000 (Table 6).

Between April 1999 and March 2005 the number of Board members involved in the commissioning of health services in Wales increased by 27% from 300 to 382. The majority of the increase occurred between 2002/03 and 2003/04 when Health Authorities were replaced by Local Health

5 Summarised Accounts of Health Authorities in Wales 1999/00, 2000/01, 2001/02, 2002/3 Note 6 adjusted to include 'Local health Groups Non Health Care Costs' included in Note 9. These are assumed to primarily relate to remuneration payments to LHG Board Members.

Summarised Accounts of Local Health Boards in Wales 2003/04 and 2004/05, Note 6.

6 Summarised Accounts of Health Authorities in Wales 1999/00 to 2002/3, Note 8.

Summarised Accounts of Local Health Boards in Wales 2003/4 to 2004/5, Note 9.

7 HCNS Non Review Body Pay inflation indices 2000/01 5.8%, 2001/02 6%, 2002/03 4.8%, 2003/04 4.1%, 2004/05 6.2%.

Boards. During the same period a clear increase can be seen in the number of directors with average salaries between £25,000 and £75,000. In the £25,000 to £50,000 salary banding the number of directors grew from 4 to 65, and in the £50,000 to £75,000 banding numbers increased from 3 to 45. During the same period the number of directors within the £0 to £25,000 salary banding fell by 36, indicating an upward shift in salary levels as a result of re-structuring. Whilst a gradual upward movement in salary due to pay inflation during the period might be expected, this does not adequately explain the significant changes identified. Applying the inflation uplifts previously noted to the mid point salary in each banding would not have resulted in a shift up to a higher banding between 2002/03 and 2003/04.

Year	Total	£0 - 25K	£25 -50K	£50-75K	£75-100K	£>100K
1999/00	300	272	3	18	6	1
2000/01	287	261	3	10	11	2
2001/02	299	272	2	5	14	6
2002/03	301	275	4	3	11	8
2003/04	357	239	65	45	7	1
2004/05	382	253	73	41	13	2

Table 6: Number of Executive and Non-Executive Board Members and Average Salary Bandings 1999 - 2005⁸

The above analysis shows that both the number and salary costs of Executive and Non-Executive Directors involved in service commissioning have risen sharply as a result of the re-structuring from Health Authorities to Local Health Boards.

In addition, there are significant variations in the number of salaried board members across the 22 Welsh LHB's. In 2003/04 the average number of paid members was 16. Whilst four boards had only 13 members, the majority (14) had a membership of between 14 and 17. Of the remaining four boards, one had 18 members, one 19, one 21, whilst one had a total of 30 paid members. In 2004/05 average membership rose to 17, with the lowest number of members being 14 and the highest remaining at 30. Although membership numbers on most boards increased only marginally, the number on one board increased from 21 to 28.

Whilst it might be reasonable to expect the LHBs with the highest levels of expenditure (reflecting for the most part, local population size) to have a proportionately greater number of paid board members, there appears to be little correlation between the two variables. In 2004/05, the LHB with the highest level of expenditure⁹ had only the average number of members (17), whilst the expenditure of the board with 30 members equated to barely half that of the highest spending board. This difference is even more pronounced for the board whose membership increased from 21 to 28 between 2003/04 and 2004/05. Here total expenditure was less than 25% of that of the highest spending LHB and barely 50% of the total expenditure of two of the boards with the lowest number of paid members.

8 Number of Directors taken from HA Summarised Accounts note 8, 1999/00 to 2002/03 adjusted to include the number of Local Health Group Members identified in note 9. Average salaries for LHG members are assumed to fall into the £0-25k based on remuneration levels from 2003/04 onwards identified in LHG Summarised Accounts. The LHB Summarised Accounts from 2003/04 onwards do not include summarised detail of salary bandings, this information is only available in note 4.10 of the accounts of each individual LHB. This information was therefore collated from the 22 LHB accounts 2003/04 and 2004/5 (Source; www.wales.gov.uk).

9 Expenditure figure taken from the Operating Cost Statement of each individual LHB for the year ended 31st March 2005.

Conclusions

The analysis presented in this study shows that the structural reorganisation of the health service commissioning function across the NHS in Wales has led to a significant increase in administration costs and the number of directors with overall responsibility for the purchasing of healthcare.

"An Independent Audit of the NHS Under Labour (1997-2005)", by the Kings Fund (2005) outlined government growth targets for NHS staff in England during this period but noted that 'the Government did not set targets for increasing the number of NHS managers' (p.62) This is consistent with the recent reduction in the number of Strategic Health Authorities and Primary Care Trusts in England which is expected to result in significant savings by reducing administrative staff costs.

At the start of the 2003/04 financial year, the five Welsh Health Authorities were replaced by twenty two Local Health Boards. This re-organisation, intended to reduce bureaucracy and increase local accountability, has led to an increase in the administration costs of the commissioning function of 32% in real terms (2002/03 to 2004/05).

One of the major contributory factors to this overall cost increase has been the significant increase in total directors' remuneration. In the first two years following re-organisation Executive Directors remuneration has increased in real terms by 287% when compared to the total cost pre re-organisation. In addition, the number of Directors earning a salary of between £25,000 and £50,000 has increased from four to seventy three, whilst the number earning salaries between £50-£75,000 has increased from three to forty one. The number of Non-Executive members has also increased. When combined with an increase in average remuneration, this has resulted in a increase in total cost of 193% after adjusting for the effects of inflation. It is also evident that the number of Local Health Board paid members varies significantly between the twenty two bodies, ranging in number from fourteen to thirty. This in turn does not appear to be a function of the total expenditure levels of the different LHBS

In 'The Finances of NHS Wales 2003'(Welsh Audit Office, May 2003), the Auditor General stated that 'In May 2002, the Director of NHS Wales asked me to review the transitional and running cost budgets of the new NHS structures that will come into effect on 1st April 2003.....The Minister for Health and Social Services has stated that the running costs of the new structure will not exceed those of the existing structure'(Paragraph 3.12,p.13).In reporting the results of his review the Auditor General concluded that the existing running cost figure of £71.1 million was sound, but that the planning budget for the running costs of the new structure was £79.6 million, which meant that savings of £8.5 million would be needed in order for the new structure to achieve cost neutrality. These comments clearly allude to the fact that additional Board and accommodation costs would necessitate savings to be made elsewhere within the service in order to maintain cost neutrality in running the new NHS service commissioning structure in Wales.

The analysis carried out in this study indicates that almost half of this additional cost can be accounted for by the increased salary costs of LHB members within the new structure, the vast majority of which relates to the increased cost of Executive and Non-Executive Directors remuneration. It would therefore appear, that in order to fund the increase in board level management costs of the revised structure, significant savings would need to be made elsewhere. Unfortunately these savings do not appear to have materialized.

In his report 'Is the NHS in Wales managing within its available financial resources' (Welsh Audit Office 2006), the Auditor General for Wales concluded that whilst LHBS met their resource limits in

2004/05 and are forecasted to do so again in 2005/06, 'as at the end of 2004/2005, commissioning bodies had received repayable resource brokerage¹⁰ of £32 million'(p.7) all of which is repayable by 2009. In addition a 'significant overall deficit position (for NHS Wales) is forecast for the end of 2005/06' (p.5) and 'current indications are that the situation will become significantly more difficult for NHS Wales in 2006/2007' (p.5).

In view of the analysis presented, it appears that there is significant evidence to suggest that in revising the structure of the health commissioning function within NHS Wales, the Welsh Assembly has failed to achieve at least one of its major aims, to reduce the level of bureaucracy. Re-organisation appears to have resulted in significant additional administration costs, a huge increase in the number of Executive and Non-Executive directors managing the commissioning function and an ever increasing financial deficit.

When viewed in the context of the debate about optimal organisation size in healthcare commissioning (Bojke et al 2001), combined with the recent reduction in the number of Strategic Health Authorities and Primary Care Trusts in the NHS in England, the effectiveness of the current NHS Wales structure in meeting its financial & non-financial objectives must be called into question. A review of the roles and responsibilities of Executive & Non-Executive Directors within the structure, and an evaluation of how performance is measured appear to be areas where further research may be warranted. This could include a comparative study encompassing both public and private sector organisations.

Furthermore, whilst a significant financial deficit within the NHS Wales is already apparent (Welsh Audit Office 2006) there is little direct evidence to suggest that re-organisation and the emphasis on devolved responsibility and local control has, as yet, led to any significant improvements in the quality and level of service provision. These also appear to be areas where further research would be warranted.

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¹⁰ Short term borrowing between one part of the public sector and another usually involving the transfer of a non-recurring revenue surplus to cover a deficit elsewhere in the service.

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