

A Successful National Health Service

From aspiration to delivery

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by

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Executive Summary

The case for managed pluralism

The NHS should be evaluated on the basis of its actual performance for patients with the greatest need, not through opinion surveys. Rationing is concentrated on services for people with severe illnesses and especially on new therapies which involve high cost and/or a greater volume. There are signs of a serious effectiveness gap which means that preventive action, access to care and quality of care are inadequate for many serious illnesses, including cancer, heart disease, stroke and severe mental illness. Day-to-day budgetary and political incentives give priority to immediate access services and to waiting lists rather than to the needs of less visible minorities with severe illnesses.

The NHS faces a major challenge in funding and managing better services in the prevention and care of severe illness — a challenge that is bound to grow with rising expectations, population ageing and opportunities for investment in integrated care. If the NHS is to meet its moral aspiration it should explore all feasible ways of reaching its goal. There has been little serious consideration of the possible roles of new kinds of private/public partnership in helping the NHS to achieve this goal.

This report develops the case for managed pluralism. This could bring in more resources for the development stage of new therapies, encourage international co-operation and reduce the delays which are likely to affect innovation under the current state of triple nationalisation (funding, decision-making and provision). It would also promote more competition and the development of clusters of excellence. The NHS could enter into a range of partnerships and agreements including the commissioning of services from private and voluntary providers and joint partnerships. This wider range of options would maximise access to low-cost innovation and assist with the very severe problem of cost containment at the local level. Managed pluralism would be particularly relevant to the problem of funding investment in a coming round of innovations in therapy and in more home-based care.

These wider options would be a part of a process of change over a period of years. The current modernisation of the NHS sets an ambitious agenda which is likely to create deep tensions between rising aspirations and funding constraints. The government has set in place a series of mechanisms for defining standards while at the same time blocking access to an important process that could potentially improve standards. If the NHS is to put the interests of patients first it should reassess the strong evidence in favour of managed pluralism as a way of promoting access to services and patient choice. Health Authorities and Primary Care Groups (PCGs) should be able to buy in services from a wider range of voluntary and private providers.

Government should see its role in terms of setting a framework for maximising the access to services, whatever their source. There is a strong patient interest in

supporting excellence in services, whether they come from the public or the private sector. The private and voluntary sectors should be encouraged to deliver more services for less severe illnesses, and for patients on waiting lists where that could lead to better patient access and value for money. There must also be a new partnership by which people take more responsibility for their own routine care.

The past record of healthcare access and quality in the UK is not such as to give grounds for complacency. Rather, it should stimulate the urgent search for alternatives to improve results. The NHS cannot continue to resist the pluralisation of provision and meet its moral aspiration of serving those in most need.

1. Introduction

Aspirations

The NHS represents an aspiration – that of ensuring access for all, irrespective of income, to healthcare of the highest feasible quality. This is an aspiration both widely accepted and likely to be difficult to achieve in practice, given the inevitable differences in human nature, motivation, location and chance. However, the actual attempt over the last fifty years, to achieve the aspiration by means of a super-nationalized industry has ensured a fluctuating but perpetual state of frustration.

The NHS has been held in place mainly by negatives and by hope. The alternatives of insurance-based funding and private provision have been deeply unattractive, with likely problems of access and cost. International experience has not been encouraging for reformers. The aspiration in itself has generated strong citizen loyalty. For the last twenty years, 75 per cent or more of the public have supported a continuing service which would be open to all, irrespective of income. More positively, the NHS has commanded the loyalty and commitment of many people of great professional dedication who have made the system work better than has usually been the case with government monopolies.

Complacency and poor service

The fact that healthcare is a distant issue for most people, until they need it, has created a quite unjustified complacency, not only about the record of the Service but, even more importantly, about its potential and whether it could ever deliver on its aspiration. The key test for NHS performance should be the quality of prevention and treatment of serious illnesses, not survey opinion from people who are in health. The focus must be on the quality and standard of care received by people with serious illnesses, whether acute or chronic and longer term.

The logistics of running a huge service and the time commitments involved in an open-access service for minor health problems combine to obscure the evidence about the quality of care in cases of serious illness. The 'forgotten 400' on the GP's list have to fight for time and resources with the 1500 who call out the doctor quite often for trivial reasons. Within the hospital service, people with serious illnesses have to take their place in the queues with less critical appointments. The problems of treating severe illness are usually approached as local or diagnosis-specific, as with current efforts for reorganising treatment for cancer. But there is evidence of a much more general 'effectiveness gap' affecting quality of care across the main areas of serious ill-health, including cancer, heart disease, stroke and severe mental illness. This report discusses not just the symptoms in evidence about care, but the likelihood that the causes are inherent in the structure of the NHS.

The potential of pluralism in provision

We turn then to alternatives. These have usually been presented in terms of the crude polar opposites of keeping the NHS or turning to privatisation. In Section 3 we explore the practical issues of how to maximise changes across society so that the aspiration will actually be delivered to patients.

In this report, we consider not just the performance of the NHS in itself, but its wider effects on decisions made by households and by enterprise. The NHS has direct effects, but also powerful unexplored indirect effects on private and voluntary activity and on society's general approach to the problems of health.

We see government's role as that of creating conditions in which there is the greatest potential for the aspiration to be realised. There are neglected options for moving towards a more pluralistic system. The NHS of today represents an extreme form of nationalisation where government has a direct and overwhelming role in:

- funding;
- decisions on investment and 'outputs'; and in
- actually providing the services.

As a practical alternative, we present a step by step approach, concentrating in the first stage on creating greater pluralism in provision. It is only when there is more availability in supply that more variety can develop in demand and payment.

Today's three-way nationalisation was a consensual and realistic adjustment to the circumstances of the mid 1940s, where it seemed a lesser evil compared with a return to the alleged bad old days of the poor law and inter-war services. But conditions have changed so much that the continued existence of the NHS in the same basic form may now be inhibiting society's progress towards a moving target.

2. The NHS ‘effectiveness gap’

The main focus for investment in health therapies is on innovation, which is often viewed in terms of a breakthrough or leap forward. Such innovation as genomics may produce results in a very long time, but in the short term (say, the next two years) quality of care depends mainly on the effective use of therapies which already exist or are close to launch. We are concerned here with the ‘effectiveness gap’ — the difference in outcomes and quality of care which could be achieved using existing therapies compared to what is being achieved at present.

The killer issues

Such problems are often described in terms of specific problems of quality or inequality of access, such as ‘postcode rationing’. New information on access and quality is now much more available than it was even a decade ago. It shows that there are serious problems across many types of severe illness. This can be illustrated first in terms of the diseases which are the main causes of death in the UK – cancer, heart disease and strokes.

For **cancer** there are already well documented policy concerns:

- survival rates for lung, breast and intestinal cancer are lower in the UK than in the US (Sikora 1998). Such differences may in part be due to genetic, environmental or even statistical factors, but they are probably related in part to differences in the intensity of treatment (ABPI 1998). Between 1991-5, US cancer mortality fell by 2.59 per cent per year: the first sustained decline since records began in the 1930s. Five-year survival rates are now much better in the US — 80 per cent for breast cancer, compared to 70 in the UK; and 59 per cent for colorectal cancer, compared to 40 per cent in the UK (National Institute of Health 1996);
- the process of cancer care involves low access to specialist oncologists and a high workload for those specialists who are available;
- total expenditure on chemotherapy is low at 5 per cent of prescribing and there are local differences in access to therapy involving postcode rationing [See tables 1 and 2] (IMS 1998). The UK is spending far less on drugs than other developed countries — 0.95 per head in 1996, compared to £2.79 in France and £17.05 in the US. In fact the NHS spends less on chemotherapy than on laxatives — £68m compared to £77m in 1997 (IMS 1998).

The NHS has reacted to some of these concerns, for example through setting a maximum waiting time of two weeks for out-patient appointments in suspected breast cancer. It has also set aside special funding for improving the treatment of intestinal cancer. But such measures target some defects while leaving numerous others untouched.

Table 1: Comparative investment in cancer services (1996):

	France	Germany	USA	UK
1996 population	58M	82M	263M	58.5M
Cancer deaths/100,000 population	236	206	194	275
No. of oncologists/100,000 population	1.72	0.24	2.28	0.14
Cytotoxic spend (£)/100,000 population	£278,793	£205,172	£1,705,345	£95,551
Spend per capita	£2.79	£2.05	£17.05	£0.95

\$1 = £0.70 (Source: ABPI)

Table 2: UK NHS Spending on medicines in 1996, showing total and relative spend of each therapeutic sector:

Therapeutic area	1996 total (£m)	Therapeutic class as per cent of medicine spend
Alimentary tract and metabolism	1,061	20
Central nervous system	926	17
Cardiovascular system	866	16
Respiratory system	772	14
Systemic anti-infectives	598	11
Musculo-skeletal system	325	6
Genito-urinary system and sex hormones	310	6
Dermatologicals	294	5
All cancer products:	240	4
<i>Cytostatic hormones</i>	88	2
<i>Cytotoxic chemotherapy</i>	59	1
<i>Immunosuppressive agents</i>	67	1
<i>Immunostimulating agents</i>	26	<1
Total annual medicine spend, these therapeutic areas	5,392	

(Source: IMS)

Heart disease is a diffuse and potentially vast area of care, causing problems for a national service framework. However, there is reasonable evidence on the treatment of heart disease when it is serious enough to need hospital treatment.

A survey carried out by the Audit Commission in 1992-3 showed that access to treatment was variable (Audit Commission 1995). In one out of four of the 41 districts surveyed, treatment rates were 400 per million or less. In eight of the

districts, treatment rates were 600 or more per million. In effect some patients had a 50% better chance of getting treatment than others. These differences are thought to persist, even though the average may have risen. As well as variability in access there were also differences in waiting time. While some people on waiting lists may be affected simply in terms of their quality of life, in other cases the condition is fatal.

Problems in cardiac care extend beyond treatment to rehabilitation. There is uneven access to relatively inexpensive, low-tech care. As the review concluded:

“Cardiac rehabilitation and high quality discharge support are relatively inexpensive forms of care. They can improve significantly the quality of patients’ lives (and in some cases reduce mortality) and can also reduce demand for hospital treatment. But in the past they have been neglected areas and are still not uniformly available at an adequate standard.” (Audit commission 1995).

Stroke is an area of disease in which initial need is not showing a strong rise; indeed, the numbers of first strokes have declined in the UK as in other developed countries. There is, however, an increasing problem of longer-term support. Recent work has concentrated on the value of dedicated stroke units and on programmes to help improve patients' recovery.

In the last few years there have been a number of evaluations of stroke care in both hospital and community settings with random clinical trials comparing stroke units with general medical wards. The results have favoured the introduction of acute stroke units to deal with new cases of stroke. Dennis and Langhorne (1994) have reviewed the evidence from these trials, and using meta-analysis have shown a benefit in terms of improved mortality rates and reduced admission to residential care one year post-stroke, from 54% in the general wards down to 42% in the dedicated units. This is a clear and strong evidence base.

Despite the apparent benefit of these stroke units, however, a recent survey of UK hospital consultants found that only 5% had access to a specialised stroke unit, the majority of patients being treated either in general medical (29%) or geriatric (40%) wards. Indeed, only 1% were treated in specialist stroke units (Lindley 1995). There were also major problems in providing continuing integrated care for patients with strokes including a rise in the levels of stress suffered by carers (Bosanquet and Franks 1998).

Other serious illnesses

The problems of the effectiveness gap can also be illustrated in other areas of serious illness beyond those which are the main causes of mortality.

Patients with renal disease

As in cardiac care there are considerable differences in access to care. In the South West of the UK the chances of a patient being accepted for dialysis are 50 per cent lower than in the South East (Bosanquet 1997). There are also major differences in access to different types and duration of dialysis.

Patients with hip fracture

The Audit Commission carried out a detailed study of care for patients with fractured hip or femur (Audit Commission 1995). The condition is one that causes great distress and may mean movement to a nursing home. The study found that a significant minority of patients were having an unacceptable standard of care:

- Some 41% of patients were waiting over three hours in Casualty and 18% were waiting over 5 hours. The Royal College of Physicians guidelines recommend that hip fracture patients should not spend more than one hour in Accident and Emergency (A&E). This recommendation is important because many elderly hip-fracture patients arriving in A&E have often already spent some time undiscovered on the floor at home. Because of the changes associated with ageing this leaves them vulnerable to pain, confusion and dehydration, all of which may result in longer stays and poorer outcomes;
- documentation on risk assessment was poor;
- many patients waited longer than one day for an operation. In four of the hospitals, a third or more of the patients were waiting more than two days;
- in four of the hospitals, operations were often carried out by junior surgeons in training (SHOs);
- there were “major problems in planning rehabilitation and discharge” and considerable variations in the proportions of patients asked to return home after treatment. “Some of this variation is no doubt explained by sample size and case mix, as the likelihood of a return home depends on the frailty and age of the person involved and the type and complexity of the fracture, but the size of the variation is such that it indicates that hospitals are adopting different approaches”;

Patients with schizophrenia

This is included because of the high long-term costs of the disease and the effects on disability. Patients with long-term mental illness can still have a level of independence and choice: an effective care programme could be defined to include the use of new drug therapies, an appropriate length of in-patient care, intensive home support and rehabilitation including help with access to employment and housing. This is the programme any of us would seek on behalf of a relative. But the evidence suggests that at most 20 per cent of patients are receiving a care programme of this type and that many are not even getting a minimum level of support. For example, a survey of hospital wards showed that on the census day in 1996 there was no contact at all between patients and staff on a third of the wards (Mental Health Commission/Sainsbury Foundation 1997). In half of London there were no intensive support services in the community for people with severe mental illness and only 20 per cent of providers had employment rehabilitation. Use of new drug therapies was limited, with at most 50 per cent of those who might have benefited receiving treatment.

Palliative care

Low-cost therapies are available for palliative care, using morphine, programmes for non-pain symptoms and carer support programmes. A recent survey showed that many people were not getting satisfactory treatment (Addington Hall and

McCarthy 1995). These findings are particularly significant because of the very high quality of the study involved.

The main objective was to describe the quality of care received in the last year of life by people who die from cancer, focusing particularly on symptom control, communication with health professionals, and care in the community. The design of the study was an interview survey of family members or others who knew about the last year of life of a random sample of people who died in the UK in 1990.

Twenty district health authorities from a range of inner city, outer urban and rural settings were surveyed. They were nationally representative in terms of social characteristics and several indicators of health service provision and usage. Interviews were obtained for 2074 cancer deaths out of a random sample of 2915, a 71% response rate.

At some stage in the last year of life, 88% were reported to have been in pain, 66% were said to have found the pain 'very distressing' and 61% to have experienced pain in their last week. Treatment that only partially controlled the pain, if at all, was said to have been received by 47% of those treated for pain by their GP and by 35% of hospital patients. Other common symptoms experienced by more than half the sample in their last year were loss of appetite, constipation, dry mouth or thirst, vomiting or nausea, breathlessness, low mood and sleeplessness. Half of the respondents (51%) were unable to get all the information they wanted about the patient's medical condition when they sought it.

Such differences in access to treatment have not gone unnoticed, but they are usually attributed to problems highly specific to each area of care. The National Institute for Clinical Excellence will now be attempting to increase the spread of innovation and success through producing reports on new or effective therapies.

Yet the general nature of the problem across almost all the main types of serious illness has hardly received any attention, in spite of its consequences for the central NHS aims of equity and access in a world in which serious illness is unevenly distributed across society. Rationing is a process which affects a whole range of (usually) high-cost care for severe illness and so will be encountered by many of those suffering from such ill-health.

NHS poorly placed to solve the problem

In searching for an explanation it is worth defining an 'ideal' situation in which the chances of all patients receiving best-practice effective care would be maximised. Healthcare resources would not be unlimited, of course: the practical question is how close we can get to the ideal on the basis of a professionally acceptable level of resources. Whatever the resources available, they would have to be managed to **deliver high quality in both process and outcome**. For this there would be three more key conditions:

- **a driving, effective management** setting clear aims and getting results. The Service would have to answer the 'Griffiths question' – if Florence Nightingale returned, she would walk around the wards and ask: "Who is in charge?";

- **development of specialisation** so that teams were able to achieve full potential. Recent research in surgery has shown that surgeons who do numerous operations of a given kind in a week have skill levels which are three times greater than those who do such operations infrequently;
- **use of innovation** in a controlled, effective way.

The NHS is not well placed to meet these conditions for the following reasons:

Funding

The first problem would be in the ‘professionally adequate’ level of funding. Budgets for care in severe illness are cash-limited, while budgets for some important areas of primary care have been demand-led. Thus spending on care for one serious illness has to compete with others for a limited budget. This will raise problems — particularly in funding innovation, which will be more costly and also more common in these areas of care.

Fragmentation

The management problems are significant in such a large and multi-purpose organisation as the NHS, with responsibility often being fragmented between and within sections of it. Specialisation will be inhibited by the multi-product nature of demand on the Service, which has to meet waiting-list targets as well as to provide emergency care, and it will often be difficult to focus adequate funds for investment in an optimal pattern of service.

Complexity

Many of these areas of care use complex treatments. They involve higher risks as well as organisational problems. Yet the returns to the effective use of innovation have usually been low. Perverse disincentives interfere in every kind of NHS activity: a successful programme will attract more workload and put more pressure on staff, so there is little reward in success. Such disincentives are even greater when programmes are innovative: they will be a scarcer resource and will attract more referrals, and will therefore cause greater uncertainties in staffing and funding. Against such constraints, it is a remarkable tribute to the personal dedication of staff that the NHS achieves as much high-quality innovation as it does.

An effectiveness gap is almost inevitable where the demand for high-quality care generates the biggest problems in staffing and management. Rationing will tend to affect more difficult, high-cost types of treatment, rather than routine care. Thus the existence of an effectiveness gap is hardly surprising. Rationing is not uniform in its effects — it has most impact on those kinds of care which need the most new resources.

At present the structure of the NHS is not succeeding in creating the conditions and incentives that are necessary for overcoming these problems. There is a structural bias against providing a high quality of care for those that have the most need. The NHS was built on the aspiration of ensuring access for all, irrespective of income, to healthcare of the highest feasible quality; but it has failed to deliver that aspiration. Surely now we have the moral duty to ensure that all options for moving closer to the aspiration are fully explored.

3. The case for a mixed economy of healthcare

In this section we examine the case for change, while the following sections will review how best to achieve it. We can summarise the case for change as follows:

- **The NHS is not currently delivering an acceptable standard of care for serious illness, and the situation is set to become worse because of demographic change.** The needs and requirements for effective service are likely to increase greatly over the next 20 years. Unless the NHS can make use of cost-reducing innovation it is going to face an even more intensive process of rationing;
- **There have already been gains in terms of better care and more choice for patients where a more pluralistic model of care has been tried: and there could be more gains in the future.**

The demographic challenge

The numbers of very elderly people are rising, and there is a major challenge in increasing people's chances for independent living (Fries 1980, Mills 1988). By 2030 one in ten of the population will be 75 or over. We can either maximise the potential for older people to live in good health and independence — or face an increasing burden of dependency and disability.

But this is not the only significant change affecting health services. The numbers of young people are set to be some 20 per cent lower than was the case two decades ago. This will reduce the pool of younger people available for Health Service staff: the nursing shortage is set to get very much worse, both short and long-term, under the present structure. Furthermore, the ability of this shrinking younger age group to pay for the health services of increasing numbers of elderly people will be much more limited than is presently the case, especially since they are expected to contribute more to the costs of their own pensions.

The benefits of a pluralistic model

Change in the wider economy will create new opportunities for health services. In 1948 the NHS was one of the few services for the majority of people. The service economy was confined to the high-income enclave of Metroland in London. Now 75 per cent of economic activity is based in the service sector, much of it directly reaching households. These involve customer choice based on instantaneous access to worldwide information. They demand high quality standards and rapid change in organisation to meet consumer requirements.

The impact of such change can be illustrated from the leisure pursuit of cinema-going. There is no National Cinema Service and there has not been any systematic government strategy for the cinema industry. Yet despite the challenge from cable and satellite TV, cinema attendances have risen from 50 million a year in 1985 to 150 million in 1997. The new cinemas in multiplex sites are more accessible and offer wider choice (for example, a multiplex in West London has 3 Bollywood screens for Asian cinemagoers). The customer is paying a lower price in real terms for a better quality of service. In turn, the growth in attendance has had a positive impact on film production. The net result has been gain in utility for customers and in employment: gains which have been widely diffused as the new services spread from Hartlepool to Feltham, from Windsor to York.

It will be argued of course that cinema-going is a frivolous pursuit and that health services are too important to be left to the marketplace. However, new market-based services are already beginning to develop in healthcare:

- **Community pharmacies** are offering a wider range of over-the-counter drugs, together with additional services to help people stop smoking and otherwise promote their personal healthcare.
- **Where the NHS has left room for other services to grow in the marketplace, such as podiatry, optical care and dentistry, they have developed rapidly.** Podiatry is a good example of a service which makes a significant contribution to reducing disability, as chiropody was only available with long delay from NHS and Social Services. The new services are more accessible and the private sector has furthermore been able to invest in specialised premises and equipment. In optical services, similarly, there is a more accessible service offering greater choice. The previous service was free, and customers could take any frame they liked – but it had to be an NHS frame.
- There is likely to be a new wave of innovative therapies from **pharmaceutical companies** over the next ten years. Companies have restructured and reorganised to raise the rate of innovation and the results from this fourth generation of therapies are likely to be highly positive. There is also likely to be increased innovation from companies in **medical devices and diagnostics**: and there is potential for joint developments so that funders will be able to boost therapeutic results through IT, diagnostics and therapies which help to define programmes, improve communication with patients and monitor outcomes.

Implications for health services

For a centralised system, the coming changes would present great difficulties in actually making choices and securing results quickly and effectively. Results are more likely to come by concentrating resources and power in decision-making at the local level. The role of central government in such an environment would be to set a framework of values and define total budgets: the job of securing value for patients would depend on the effectiveness of choices made much closer to patients and local communities.

The impact of future change points to a pluralistic system in which there is freedom to experiment with different models of care until the evidence begins to support one model over others: and it points to a system in which there is freedom to co-operate

with innovators all over the world. The UK has good opportunities to improve further its position as a key centre for healthcare development and to attract development resources into health services.

The future ability of the NHS to meet its challenges is usually discussed in terms of aggregate spending, considering variables attracting demand such as changing demography and professional desire for new technology. Such debate usually reaches the agnostic conclusion that there is no objective standard of adequacy for health spending. A recent review concludes: “none of the approaches to funding discussed provided a satisfactory answer to the question of how much should be spent on the NHS and that the level of spending had to be based on broad political judgement” (Harrison et al, BMJ 1997).

Yet such discussions seem to accept the existing NHS framework as it is. Rightly they conclude that health resources are going to be limited: but surely in the light of that conclusion they should consider urgently whether there could be ways of increasing the amount of effective care delivered for a given amount of funding.

To meet the needs of those with serious illness there has to be an increased willingness for people to seek a diversity of solutions other than the NHS. The aim has to be a society in which the NHS has helped to bring about a greater range of contributors to the broad goal of health. The NHS aspiration is much more likely to be achieved through a pluralistic approach than through public sector monopoly. Greater pluralism would contribute to professional achievement and better public service rather than producing the detrimental effect so widely predicted.

4. Pluralism in practice

The case for pluralism rests in part on the actual experience of improvement in services where this approach has been tried. Most of these improvements have occurred on the borderline with social care, where Social Services have more experience with a mixed economy in care.

Pluralism can be defined primarily in terms of the existence of a range of providers who provide services specified in contracts. They could include public sector, voluntary or private providers. There are usually strong incentives for providers to develop direct sales on a self-pay basis, in order not to be completely dependent on one public buyer. This pluralism in supply is usually associated with greater pluralism in demand and the development of market access.

There are three main areas in which pluralism has developed:

- **services for people with learning difficulties;**
- **long term care services for elderly people; and**
- **home care services.**

We shall examine in each case whether the results achieved over a prolonged period of time are better than had been or would have been achieved by a continuing public sector monopoly in supply.

Services for people with learning difficulties

The NHS inherited about fifty large subnormality hospitals/institutions from local government. There was little improvement in conditions over the next quarter century: a series of scandals and enquiries in the late 1960s led to greater demand for reform, but it would be another ten years before there was much progress towards new models of care.

These new approaches were based on social models of care or philosophies of normalisation which were almost entirely drawn from US rather than UK experience. People lived as normal citizens in a community setting. Staff developed strong caring relationships with patients and helped them with day-to-day living. They also organised activity programmes at local colleges where possible.

These services are a major challenge to organise. They involve partnership with housing associations, winning support from local residents and motivating staff to take responsibility on a 24-hour basis. But the programme has been highly successful in creating a range of opportunities for people, even when their learning difficulties were great. New staff groups have developed, with skills based on social rather than medical models.

The services which are available are now much better than they were, but it is

highly unlikely that the NHS could have made as much progress if it had remained the direct and sole provider.

One important reason for that is **cost**. These services often need one-to-one staffing on a 24-hour basis. Private-sector and voluntary providers were able to do this at or even below the cost of a place in the hospital. It is highly unlikely that this would have been possible within the NHS – the budget for resettlement would have funded many fewer places. A second reason is **flexibility**. The NHS would have had great difficulty in moving from a medical to a social model. Finally, there were gains from **specialisation**. Many of the organisations involved were committed to this one activity. They needed to carry through particular projects and they had the special techniques and incentive to do so. In fact they were working to a double incentive of meeting contracts and facing professional scrutiny from within the NHS and Social Services.

As a result of these changes, the UK has become certainly the European, if not the world, leader in the quality of services available to people with learning difficulties. Pluralism has made a practical and indispensable contribution to meeting the needs of one of the most deprived groups in society.

Services in long-term care

There has been much debate on how far the continuing care of elderly people should be a responsibility of the NHS. There has been much less discussion of the continuing and fundamental problems which the NHS has faced in actually providing such care. After Townsend's survey of 1960, there was little progress for the following two decades in finding better solutions. Indeed, the poignant testimony of a relative in *Sans Everything* in the late 1960s, and the enquiry into deaths of elderly people from food poisoning at a hospital near Leeds in the late 1970s, showed a picture of serious neglect; and as late as 1998 an enquiry into conditions at St Pancras Hospital in London showed that there was continuing disquiet.

Since 1979, private and voluntary nursing and residential homes have expanded from 64,000 places to 442,000 places in England (Laing & Buisson 1998). These represent a close substitute for a service which was formerly provided by the NHS and by Social Services. We lack direct national data on their quality of service, but there are some significant indicators:

- the accommodation standards are such that by 1997, 60 per cent of clients had single rooms and many had *en suite* bathrooms;
- the market for 'self-pay' accommodation had developed to the point that by 1998, some 20 per cent of residents were paying for themselves in whole or part. These self-pay residents share homes under the same standards as residents funded by the public sector;
- there are constraints on the public funding of places: but there is no waiting for places once funding is available and in most areas the client has choice;

- private nursing and residential homes are subject to independent inspection, including unannounced visits. Public-sector homes and NHS places have not in the past been subject to independent review.

In summary, it is highly likely that pluralism is providing more choice and a better average standard than the NHS and Social Services could have done on their own. The private framework, with a variety of providers and local choice, allows for more continuous scrutiny and checks on abuse than occurred within the former public sector monopoly.

In addition, the funders have derived certain practical advantages. They have been able to buy places in nursing homes at under half the weekly cost of places in long stay NHS hospitals (£350 a week against £800). These places have been available flexibly and any under-occupation has been at the risk of the providers. They have reduced bed-blocking of acute beds in NHS hospitals, which was becoming a very serious problem in the late 1970s. Without the nursing home contribution the NHS would have experienced even longer queues.

Certainly, there could be legitimate questions about whether open-ended public funding through the social security allowance led to over-expansion in the numbers of nursing home places: but this is already changing as the public sector funds fewer places, with the costs of readjustment borne by the industry and not the taxpayer. The main lesson for the longer term is that of the need to improve contracting and secure an effective public/private partnership (Nazarko 1998/9).

Home care services

Home care services provide support with day-to-day living at home for people who might otherwise have to move into residential and nursing homes. Since 1993, Social Services have had to seek tenders for such services. The result has been the development of a new industry in privately provided home care.

The number of hours from private and voluntary providers has risen from 32,000 (3 per cent of the total) to 1 m (40 per cent) between 1993 and 1998 (Laing & Buisson 1998). These hours cost less than public sector home help hours - £7 an hour compared to £12: and by some indicators the private supply offers higher quality, with the help being available earlier in the morning and later in the evening, and also being guaranteed against sickness and holiday. At least one provider is able to provide 14 attendances a week, including morning and evening, for just £50.

As a result of the expansion of private services, many frail elderly people have received a service which would simply not have been available before. If all hours had been available at the private sector cost of £7 an hour, some one million more hours would have been available for the same budget. This expansion also led to an increasing self-pay market as the hours became more affordable and accessible.

Tragically, however, the new service has been least available in inner-city deprived areas, where councils have been most resistant to contracting out to the private sector. The new services are also mainly limited to social care and the NHS has generally not been able to develop an intensive home care service.

5. Pluralism: the opportunities in the future

Much of the success in providing improved services through pluralism has been in social care. Are there special factors which mean that the approach is not applicable to healthcare? In fact the challenges are different, but it is certainly clear that there could also be advantages derived from pluralism within healthcare. The nature of the partnership would be different, and the need to measure and promote quality even greater: but there could be scope for considerable gains.

Cancer treatment

For improving access and results for patients, investment is urgently needed in staffing, IT and in new therapies. The opportunities abound: for example, Salick Cancer Care, a subsidiary of Zeneca, has developed new systems for improving information about cancer care; and there are numbers of new drug therapies which offer scope for much more intensive treatment (Piro and Doctor 1998).

True, there are already close relations between NHS managers and suppliers: but these exist around particular therapies or pieces of equipment. The PFI scheme accelerated capital spending but not partnership with the private sector to facilitate the actual provision of services or to secure them on more favourable terms.

There could be a much more constructive and far-reaching partnership to develop better services for patients.

There are particularly strong reasons for thinking that there could be enormous gains from pluralistic partnership in the field of oncology:

- successful development in the UK market would be particularly positive for the credibility and international reputation of suppliers. **The NHS would therefore be able to secure favourable terms** from private-sector partners;
- longer-term partnership would **maximise incentives to reduce prices during the initial development phase**. At present there is every incentive to keep prices highest during the early use phase of the drug when the uncertainties and costs faced by the purchaser are greatest;
- cancer treatment is a highly international field, and partnership with the private sector could **promote international co-operation and international transfer of information**, especially during the service development phase. There is already close international contact during the research and pre-launch phase, but there is much less in the actual use of drugs. There could also be more flexible international co-operation in staffing, with more use of experienced oncologists from outside the UK;

- private/public partnerships would **encourage the development of new suppliers** in cancer services and of **innovation** in this field.

The current private financing approach allows the NHS to contract for buildings and support services, but not for clinical skills and services. It is not clear whether this is based on anything more than the fear of how healthcare professionals might react to new entrants: certainly Whitehall has provided remarkably little explanation of this rather important and far-reaching stance. Surely the issue should be decided by evidence, not by ideology. The key question is whether public/private partnership is going to provide quicker and better results for patients than anything delivered by the NHS with its triple nationalization.

Heart disease

There is clearly a major challenge in bringing about further reductions in mortality due to heart disease. In mid-life the incidence is now falling among men, but increasing among women. There are opportunities for creating new programmes for high-risk groups and for developing partnership in using new therapies.

The gains from such partnerships can be illustrated from the area of smoking cessation. A recent study in the UK has shown the very high effectiveness of short-term interventions designed to reduce smoking (Raw, McNeill, West 1998). Cost per life-year saved for a combination of brief advice and nicotine replacement therapy was £226.

In 1996 the nicotine patch became available over-the-counter in the US. As a result of active marketing 257,000 more people made successful quit attempts in the next two years.

There is likely to be a large world-wide expansion both in OTC methods of smoking cessation and in methods involving prescription drugs. Scope for partnership is great given the international interest in successful programmes, yet the UK approach so far has stressed central control in a very tightly specified programme in selected health action zones (HAZs) which involve a week's free supply of NRT. This is likely to have quite slow results: an alternative approach would have been through partnership to increase the spread of innovative therapies.

Severe mental illness

It is widely recognised that poor standards of care in severe mental illness impose high costs on patients and on society. Sporadic heavy use of older anti-psychotic drugs and lengths of stay running into months and even years create large groups of career patients who are likely to need high levels of support and are unable to work.

In a recent survey, 41 percent of hospital patients felt a severe lack of social support (Meltzer et al 1996). Living conditions are poor: patients share wards with little privacy, and 25% of women patients have no access to separate toilet or washing facilities. Services have many staffing problems: in England, some 20 per cent of posts for psychiatrists are vacant and many nursing posts are filled by agency staff.

Currently, some patients are transferred to the private sector when there are no beds for admission in the NHS. The quality of care provided by private-sector providers is high. Patients have their own room, newer anti-psychotic drugs and high levels of staff support. Many patients are discharged quicker. One private provider is achieving an average length of stay of 23 days for patients allocated on a non-selective basis from the NHS, compared to 60-80 days for NHS admissions. Cost per day is similar between the private sector and the NHS, meaning that the cost per admission turns out to be much less.

The NHS currently uses the private sector as an overflow, or safety valve, on a very short-term basis. This relationship is not in the best interests of patients who may be switching back to the NHS if the occupancy position improves. It is certainly no encouragement to the private sector to invest in the area, since there is no assurance of continuity. And it means that the NHS continues to face considerable stress within its own services.

There could be a much more constructive partnership if the NHS were to contract on a longer-term basis for places of clearly defined quality. There is no doubt that within this context the response from the private and voluntary sector would be a strong one. Within 12-18 months there could be a substantial number of places of high quality. The private sector would be able to attract staff to work in the new centres, without draining people from the NHS, because of its greater flexibility and wider area of search both within the UK and abroad.

The NHS faces great problems in improving its services for severe mental illness. It is highly likely that they could be improved faster through the use of new forms of public/private partnership.

Waiting lists

Greater use of partnership would also offer new approaches to the intractable problem of waiting lists. If government were to ask afresh the question of how resources could be mobilised to minimise waiting times, especially for the most deprived, it would not set up a system such as the NHS. Virtually no information is available on the characteristics of people on waiting lists, but it seems highly likely that those with higher incomes or a better ability to work the system are less likely to be on waiting lists than others (at a recent conference on waiting lists attended by 100 NHS managers/professionals, I took a show of hands on the delegates' experience of waiting lists. Only one out of the 100 had even been on one). The better-off often have private insurance and they are probably more mobile and vocal in search of treatment within the NHS.

Patients would benefit in the short term if the NHS bought more spare capacity in the private sector. At present there is under-occupation in private hospitals, with occupancy rates at 50 per cent or less. The NHS would be able to buy treatment quickly for at least another 100,000 patients a year. In the longer term there would be even greater gains if the NHS interacted with the private sector in a way which maximises the joint availability of services from both. At present the NHS is in the contradictory position of expanding the supply of private-sector services through the greatly increased role of NHS paybeds while refusing to fund improved access to these new services. The private finance arrangements work to increase the

inconsistency by encouraging more private-sector development on NHS sites. The losers are thousands of patients on waiting lists, many in pain and with conditions (such as cataracts) which show significant deterioration the longer they wait.

Summing up

In the past the relationship between the NHS and the private sector has been one of great suspicion and barely suppressed hostility. The private sector has sought to live off the defects of the NHS: and the NHS has sought to minimise these defects and to run its own services in ways which reduce the flow of business to the private sector. The result has been a fairly weak private sector with little entry from new producers, a static level of coverage (around 11 per cent of the population throughout the 1990s) and continuing problems in containing cost.

The covert competition with the private sector has disturbed NHS priorities and made it more difficult to achieve its goal of concentrating resources on people in health need. The political focus on waiting lists has meant that people with the need for elective treatment will be prioritized over people with serious illness. Under successive governments the NHS has shown greater speed and commitment to expanding day surgery than almost any other area of treatment. This priority can hardly be explained in terms of health need.

The NHS actually performs best when it comes closest to the pluralistic model, with specific targets and clear personal responsibility for achieving them. This is how the screening programme for cervical cancer has been developed over the last decade, for example. Family doctors are paid for achieving targets in population coverage and have staffing in primary care teams to give a service which maintains dignity and privacy for clients. Laboratories have been set standards for quality. In spite of some specific problems, coverage has been greatly increased, leading to more early detection of cancer. The Imperial Cancer Research Fund calculated that the programme has saved 3000 cases of invasive disease in 1992, while mortality rates have been declining by 7 per cent a year since the early 1990s (National Audit Office 1998).

There should be a strategic partnership which would allow the private sector to make a much larger contribution. The strengths of the private sector, seen so strikingly in the examples above, could be drawn upon by the NHS to improve national healthcare. In particular, a more pluralistic arrangement would lead to greater specialisation, increased capital, better management and more staff.

6. Conclusions

The founding aspiration of the NHS has been to ensure access to high-quality healthcare for all those in need. The means that were chosen to pursue this ideal involved a triple nationalization in funding, the allocation of resources and the provision of services. By now, the ideal and the means are hard to separate. When UK health policy is discussed, the power of the ideal often swamps any objective assessment of the means.

The NHS ideal does indeed have great ethical appeal and represents an important human commitment: but surely such an aspiration will be devalued, even hopelessly compromised, if we are not prepared to assess the actual results that are achieved in practice. To make a moral commitment and then not to consider alternative ways of reaching it is paradoxical and irresponsible. Yet there is much evidence that the present structure of the NHS cannot in fact turn the aspiration into reality.

Deep structural shortcomings

The shortcomings arise from deep within the structure of the NHS. They are not the result of local or chance differences in the availability of services, but of fundamental problems in concentrating and using resources effectively to achieve the stated goal. The NHS has many dedicated people working for it, but they have an uphill task because of the problems inherent in the structure. Key indicators of performance problems include:

1. **Rationing**, which is particularly concentrated on care for people with severe illness. Within a politically-supported universal healthcare system, free at the point of use, visible day-to-day services at low unit cost have been freely available and demand-led. Services for the small, less attractive, less politically visible groups of people with severe illness have had the full impact of the cost constraint. This has led to problems of quality and access across many kinds of severe illness.
2. There has been **inherent difficulty in funding and using innovation**. This is not just because of underfunding, but because the structure produces a series of management and professional risks which inevitably slow down decision-making. Under triple nationalisation, the same managers have to manage risks in funding, in procurement, and in actual performance. The separation between purchasers and providers could in principle have improved things by segregating procurement and performance risks: but it is doubtful whether the separation was ever robust enough to make much difference. The continuing concentration of risks means that the aim of speeding up decision-making and reducing bureaucracy will be very difficult to achieve. Unable to make clear decisions of its own, the NHS will continue to be pulled this way and that by the changeable views of the politicians.

3. **Defects in services produce increased calls for inspection** and add to the pull towards centralisation, weakening the rule of local innovators and product champions. This structure does not allow for many happy surprises in terms of problems being solved through local initiative, and makes it harder to exploit new service opportunities during a period of rapid change.

These problems might seem insoluble and certainly there is no easy and quick solution through administrative change at the centre. It is impossible to overcome the defects of centralisation with yet more centralisation. We set out here a process for moving beyond triple nationalization towards a new NHS which opens up the system to greater pluralism in provision as a first step towards actually attaining the moral aspiration.

The key structural changes

The key steps in this process towards a real NHS which could deliver on its own aspiration would be as follows:

1. The **government** role should be redefined. It should be concerned with creating the conditions and structures necessary to achieve the NHS goal of access to services.
2. The **purchaser** role should be widened to attract service from a greater variety of providers. This would have potential advantages in flexibility, innovation, access to capital and skills, and in reducing the direct risk for health service managers (since the risk in providing quality services would be directly carried by the provider).

In effect the NHS would be using the purchaser/provider split much more fully. The aim would be to harness a range of innovative providers, making the force of competition work for better services. This will mean that the interest of clients and patients could be kept much more clearly in focus – where, in the current NHS, they inevitably take second place to the huge practical problems of organising staff and managing services.

Defining the new partnerships

It will take time to secure gains from pluralism and for a range of new providers to emerge: but as the example of home care shows, considerable progress could be made over three to five years. Nor will success always be guaranteed; there will be some projects that do not work out. It will be important to allow time for the new approach to develop. To help the process along, we must:

- **focus the NHS on serious/long-term high-cost illness** with a much clearer guarantee of quality of care.
- **encourage a constructive partnership with the private sector to maximise total supply of high-quality service.** This could involve decisions on specialisation in certain areas of care, and could have particular implications for dealing with the problem of waiting lists where there has been little specialisation. The more

open partnership structure would also encourage new providers to step in, and would unleash new capital and other resources that could be drawn upon by existing NHS providers.

This partnership approach would have a particularly positive effect on the development of new therapies by companies in the pharmaceutical and medical equipment industry. At present there is close collaboration during the clinical trial stage, but much less close collaboration during the development stage in the first year or two when a new therapy is introduced. Yet clinical trials are a very special situation in which most effort is put into data collection. Teams are not allowed to know about progress with therapy nor to change protocols, and with a new therapy they are near the bottom of the learning curve. In the development phase, health teams have a longer-term commitment to work with the therapy. They are working with larger groups of people and so may be able to identify the sub-groups who could benefit most: they may also be able to identify changes in therapy or associated programmes which may raise its effectiveness. Thus partnership during this phase might induce greater contribution and investment from the private sector, because the returns would be higher in the longer term; and a willingness to invest in this development phase in the UK could produce gains in markets world-wide. Partnership makes sense in a world where innovation is being produced outside the NHS for use inside.

It could be argued that it would be morally wrong for the NHS to enter into contracts for development with pharmaceutical companies: but the NHS is already entering into commercial contracts in buying particular drug therapies. Why is there such a difference in principle in buying support systems which might ensure better results for patients? In fact, partnerships in development would subject companies to more competitive pressure in delivering results.

Encouraging new sources of supply

When the NHS began there was a great confidence in public-sector monopoly as an optimal way of achieving low cost and high quality. There was a very deep consensus in the UK that such an approach would have a remarkable combination of humanity and efficiency. Since then, doubts about this form of production have increased. Health economists have concentrated on the possible gains to the public that are possible through the purchasing power of an NHS monopoly; but they have not registered the certain losses due to the relative inefficiency of monopoly provision.

Pluralism retains the concentration of public-sector buying power while introducing the advantages of greater competition in supply. A further valuable step, therefore, is actually to encourage the development of new private and voluntary services.

At present, new services in the private sector are seen as a threat to the NHS goal of equality, but again the NHS role needs to be seen more widely in terms of its total effects on society. If the development of new services allows more concentration of public funding on those in most need with severe illness, it could certainly contribute to equality. Similarly, if the private sector developed attractive services which were accessible to people at moderate cost, and increased the pressure on the NHS to provide better services, this would also be positive.

There are some strong reasons for encouraging greater pluralism in services. The private sector has more flexibility in terms of innovation. An NHS monopoly implies a potential loss in terms of new or innovative services. This is particularly so today, when the scope for such services is much greater than in the post-war conditions in the 1940s, not least because of increased globalisation. Such services can also provide alternatives to direct access to the NHS which can allow more focus on priority. A mixed economy of care would reduce the NHS direct role, but increase the chances of reaching the NHS aspiration.

Moving towards the New NHS

This new agenda could be developed in an evolutionary way without the need for another centralized control structure in which local professionals simply carry out protocols from the centre. The centre would set broad values and total budgets, but there would then be considerable discretion in carrying them out. There would be an emphasis on innovation and initiative at the local level.

The key freedom would be to encourage Primary Care Groups to enter into service agreements with a range of providers, which would stimulate the growth of local services. At the moment, Primary Care Groups are likely to deepen the conflict of priorities between serious illness and other services. Freedom for PCGs to contract outside the NHS would raise the chances of improving quality quickly in severe illness, but would also increase the development of new and attractive services in home support and primary care.

It would also challenge the private healthcare sector to develop in ways which complemented the core NHS mission. The argument for tax relief for private insurance premiums would be much stronger if the private sector were developing services that reduced overload on the NHS.

In the long term the NHS would serve us all better if it did less and encouraged substantial new sources of funding and service supply. This would create an environment in which there would be a much better chance of using low-cost innovation and improving access.

It could be argued that any such approach would create inequality and lead to a two-tier service; but public monopoly carries a greater danger of uniformly poor performance and decline. Within a pluralistic system there would be clearer standards of care and more open scrutiny. The system would also allow a more rapid development of high-quality services.

Meeting the concerns

It could also be argued that more private payment would weaken political support for the NHS; but an NHS system that was clearly better in delivering on its aspiration would command more political support rather than less.

It is time that the interests of the patient came first. Do we have the courage to challenge the structures which block access to better services? If we duck the challenge, and fail to consider the alternative means by which we might achieve the

NHS aspiration, then we will surely fail to deliver the best and most innovative healthcare services to people with severe illness.

Economists have concentrated on the issues of funding and allocation. They have sometimes cautioned that “the arguments ... justify extensive government intervention in health care financing but not necessarily in its provision” (Donaldson 1998). But they have not had much to say about the supply side of health care, leaving the mix of mechanisms which work best as a question for another day. Our argument here is that the day can no longer be postponed. The balance of evidence on the key criterion of the quality of care for severe illness points towards the need for change, and the actual performance of pluralism suggests that this is the right direction for such change.

Some may believe that the current round of reforms in the NHS will address these problems and that no further action is required than waiting for the improvements to arrive. After all, the reformed structures include new kinds of central agency which will define good practice. The National Institute for Clinical Excellence will set standards and reference groups will install national service frameworks. There are new local organizations of Primary Care Groups to carry out health improvement, and there will be a Commission on Health Improvement to encourage better local performance.

But the most serious problem is likely to be with conflicts of priorities at the local level. Integration of budgets across all forms of care raises even sharper conflicts between day-to-day access programmes and less visible services for severe illness. The effects of triple nationalization are still there: while the more complex decision-making that will be required at local level may in fact slow up the process of change even further. Service agreements as currently defined actually entrench local monopoly. The reforms keep the purchaser/provider split but have greatly weakened the role of purchasers; they are likely to lead to an even greater divide between aspiration and performance. Tensions are likely to increase as more active central agencies define good practice, while local Primary Care Groups or Trusts face the reality of local funding constraints. The NHS faces a stark choice between using pluralism to promote lower-cost innovation – or facing the problems of rationing which would mean more denial of treatment, and lower staff morale.

Access to healthcare

A new phase in health care is opening up which holds out the promise of more international co-operation and a new wave of innovation in therapies. Against this background the key issue is how government can use its power to increase access to high quality health care, especially for those in most need.

Until now, we have sought to deliver healthcare services through an NHS with triple nationalization. There has been much discussion of health inequalities and a recognition that they have continued and even worsened: but these are usually seen as remediable through better funding and organisation. There is an assumption that ‘one more heave’ will bring about the new situation in which the NHS reduces health inequalities, and a reluctance to face the evidence that the NHS in its traditional form may not even be able to deliver on its core aspiration. But the traditional system slows down the pace of innovation, concentrates rationing on

minorities with severe illness and blocks access to privately funded services by the less well off.

The real interest of patients lies in maximising access to high quality services. If we focus on today's patients and ask how we could improve access to services so as to promote survival and quality of life for the individual, the pragmatic answer must be that we should try to increase access to treatment from existing sources, whether public or private.

The key issue about structure is whether it maximises the supply of innovative and effective services. A pluralistic NHS would be able to draw on a wider range of private and public providers in order to do this. There would be particular opportunities in the UK for more international investment and for strengthening the UK contribution to innovation.

A successful NHS

This paper has set out a process for widening the contribution to health services, and it is now incumbent upon supporters of the old NHS to explain why they oppose this approach. Rightly the World Health Organisation is stressing the potential gains from public/private partnerships (WHO 1998). A more pluralistic NHS would enhance the chances for innovation and service development, and would increase patient access. Such pluralism would not detract from professional status and opportunity: in fact it could increase the sense of control and responsibility for results at the local level.

It could reduce the intense frustration often felt by professionals working in a large bureaucratic organisation; and it could give new opportunities for nursing professionals to take a leading role. Such a change also builds on the successful introduction of general management in the NHS giving managers a greater range of options in improving services.

The first years of the new millenium could be a time of great progress in healthcare, if only we are bold enough to grasp new opportunities in a changing world. We must distinguish between the moral idealism of the NHS aspiration and its practical results, and be prepared to make changes where they are necessary. Through greater pluralism we can indeed improve the access to high-quality health-care as a whole. The naive identification of the aspiration for social justice with the tool of triple nationalisation represents the triumph of political illusion over the real interests of today's patients.

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