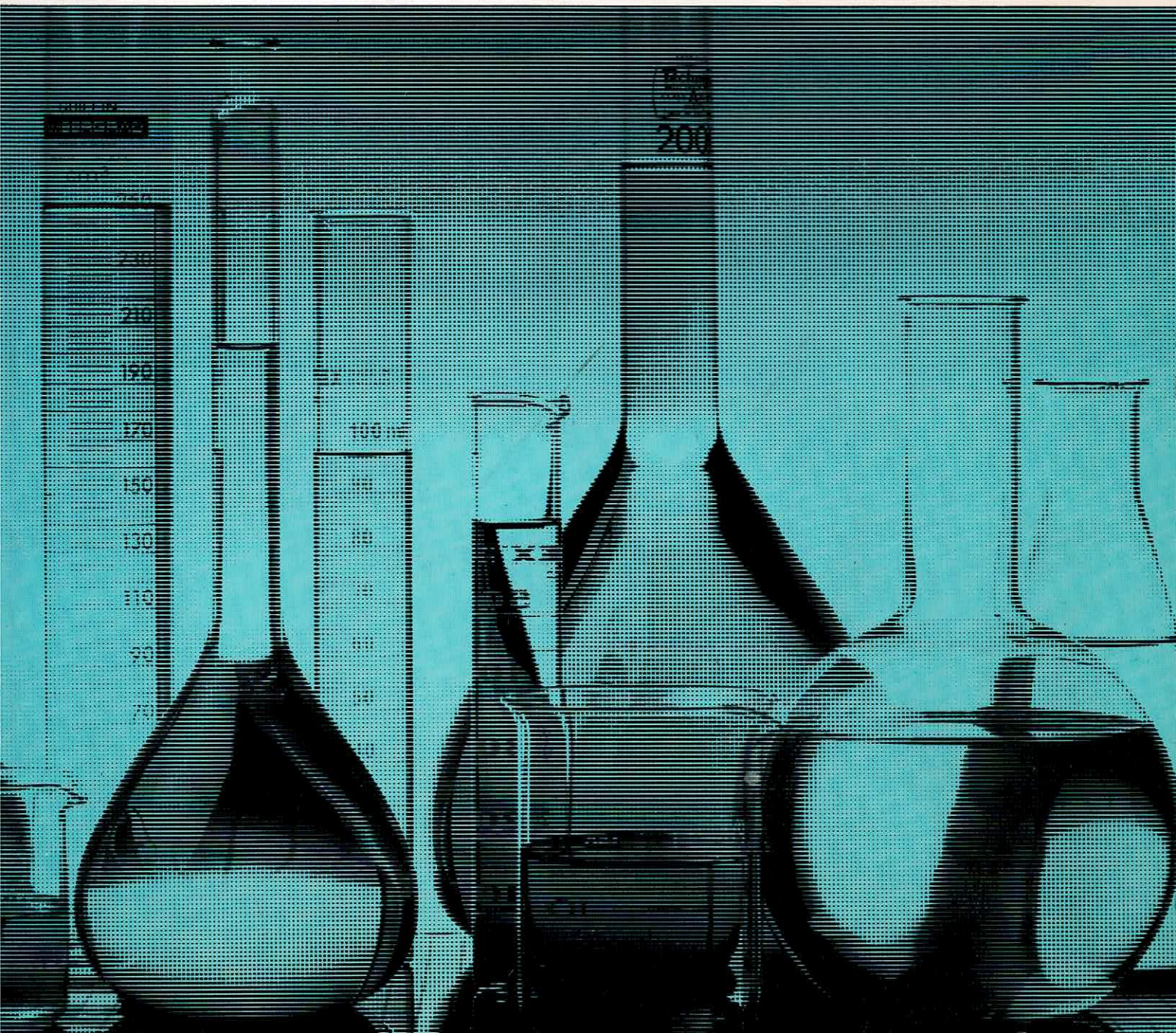


UNHEALTHY COMPETITION



THE PUBLIC-PRIVATE MIX FOR HEALTH

Edited by Dr Eamonn Butler



UNHEALTHY COMPETITION?
The Public-Private Mix for Health

UNHEALTHY COMPETITION?
The Public-Private Mix for Health

Adam Smith
London
1994

Contents

A market future for NHS purchasing and supply

Dr Eamonn Butler *Adam Smith Institute*

Competition and patient choice

Dr Clive Froggatt *Fundholding General Practitioner*

Competition and co-operation in healthcare provision

Peter Jacobs *Chief Executive, BUPA*

Patient power and the medical monopoly

Dr David Gladstone *University of Bristol*

Co-operation between the NHS and the independent sector

Dr Brian Mawhinney *Minister of Health*

Innovation and entrepreneurship in NHS service

Dr Martin McNicol *Chairman, NHS Trust Federation*

Changes in the health care market

William Laing *Laing & Buisson*

Quality improvement and the demand for NHS services

Elizabeth Hunter Johnson *Citizen's Charter Unit*

Bibliographical information

(c) ASI (Research) Ltd 1994 and individual authors

Published in 1994 by Adam Smith Research Trust. All rights reserved. Apart from the purposes of private research, criticism or review, no part of this report may be reproduced without the prior permission of the publishers.

The views herein are those of the authors and do not necessarily reflect any opinions of the publishers or copyright owners. They are presented as a contribution to public debate.

ISBN: 1-873712-36-7

Printed in the UK

"Wealth, as Mr Hobbes says, is power. But the person who either acquires, or succeeds to a great fortune, does not necessarily acquire or succeed to any political power... The power which that possession immediately and directly conveys to him, is the power of purchasing; a certain command over all the labour, or over all the produce of labour which is then in the market."

Adam Smith,
The Wealth of Nations
Book I, Chapter V

A market future for NHS purchasing

By Dr Eamonn Butler

Adam Smith Institute

A *market* is a mechanism which brings together buyers and sellers for the purpose of beneficial mutual exchange.

The *internal market* which has been set up within the National Health Service is the same -- though in its jargon, the buyers are called *purchasers* and its sellers *providers*, the principle is entirely similar.

Yet for any market to function, it needs both active purchasers and active providers. The NHS internal market is missing one of these key elements, and in consequence it cannot work. Further structural reform is needed before that will happen.

Purchasing deficiencies

The half of the market which is deficient is the *purchasing* function. While NHS providers have been very dynamic in responding to the new possibilities that the reforms have brought, the purchasing role is sadly underdeveloped.

Certainly, some GP fundholders have been highly active and innovative purchasers, though even they have been held back by regulations that restrict the range of things they can purchase and how they purchase them. Other purchasers, however, have been highly cautious in their purchasing and poor at seeking out the best value for money and ensuring that they get it.

Idea of the internal market

The idea of the internal market was that it would encourage those in charge of the public's funds to shop around for the best-quality and most cost-effective care.

Indeed, they would be free to shop around not just from NHS providers but from the private sector too. They could even look outside the UK if they thought it more cost-effective.

Thus, the money would follow the patient. Instead of being pushed by a central

political/bureaucratic decision-making structure, NHS providers would find themselves being pulled more and more by the decisions of patients, their family doctors, and their purchasing agents.

It was reckoned that innovative providers, including private-sector providers who have always had to gear themselves to the demands of their patients, would do very well out of this new and open structure. The fact that both are complaining so strongly about it confirms the suspicion that the internal market is not working as it should.

Rusty machinery

The internal market is creaking because too much rust has remained in the mechanism. Old relationships between purchasers and providers have been carried over. The personalities remain the same, the old DHA way of doing things carries on.

So there has been very little switching between old suppliers and new ones, as one might have expected if purchasers had been truly imaginative. Of course, experimentation means risk, and there is scant reward for risk-taking even in the reformed NHS. The old way of doing things might not be the most cost-effective, and might not even be what patients and their doctors really want: but it is certainly a safe strategy, for the moment.

The classic illustration is probably the block contract. Just purchasing the entire package of healthcare from the traditional provider is easy and straightforward. It saves having to investigate the market for each particular item of service -- all those different suppliers, different services, different prices, different service qualities. There is little point in trying to monitor the results in terms of value for money, because the block contract obscures the detail of what is happening and makes such measurement nigh impossible. The more the service is broken down into individual contracts, the more stark become the differences in cost-effectiveness, the more easily can quality be monitored, and the better will be the purchasing choices in the next round of tendering. Still, without an incentive structure to encourage such innovation and dynamism, why should any purchaser really bother?

Public-private partnerships

Because of this inherent conservatism among purchasers, the innovative providers, including those in the private sector, get a much lower share of NHS business than they probably deserve.

Some private-sector providers, in fact, now regard the NHS as more of an unfair competitor than a potential source of trade. NHS Trusts are developing new ventures that compete with private providers, but which (as William Laing points out) might not be properly costed in advance and (as Peter Jacobs fears) might even be cross-subsidized with taxpayers' money. Then, of course, the Citizen's Charter is pushing the Trusts to provide a higher-quality service (as Elizabeth Hunter Johnson describes below). Unless it is carefully

presented, however, this direct move by the NHS into the traditional territory of the private sector can generate an atmosphere of concern, if not distrust.

Another prediction made at the time of the NHS reforms, was that the new internal market would stimulate an active investment in joint ventures between public and private providers. Again, this has not really happened. The political obstacles still loom large; a web of committees, consultations, and referrals up and down to Richmond House tangles up anyone seeking to do anything bold and new. There is insufficient understanding of the needs of the private investors; of the importance of quick and clear decisions; of the need for reasonable certainty about future trading rules; or of the importance of matching reward to success.

Trusts themselves complain (as Martin McNicol does here) of the snowstorm of paper directing them what to do and how to do it. The idea of the internal-market reforms was to allow local managers to take important service decisions locally. It might be uncomfortable for ministers and officials when local managers exercise that freedom and do take difficult and unpalatable decisions. Yet to try to limit the political fall-out by a snowstorm of central direction runs quite counter to the direction and purpose of the reforms. There are few enough incentives for Trusts and providers to break with outdated service strategies anyway. To make the internal market work requires more scope for local agents, not more restrictions from central authorities.

NHS Supplies

The NHS Supplies Authority is a prime example of where centralism has resurfaced. Its purpose was to use the power of the NHS as a large purchaser to negotiate better deals from suppliers of hospital goods and non-medical services. In addition, it operates warehousing and transport facilities to store goods and distribute them to NHS hospitals.

Yet the Authority was an anachronism even before it became fully operational in October 1992. It was an answer to yesterday's problem. (Even its name seems more 1940s than 1990s.) Before the 1990 reforms, when all hospitals were directly managed as part of a centralized structure of provision, and local autonomy was limited, the attempt to keep costs down by purchasing supplies centrally might well have seemed logical.

Meanwhile, things have changed. Most hospitals are now self-governing Trusts; after April 1994, the overwhelming majority of provider units will enjoy Trust status; after April 1995 it could be all of them. The whole purpose of this change is to make the NHS driven from the bottom up, instead of from Whitehall down. Local autonomy, management, and diversity are not just more significant today -- they are the motive force of the new system.

If the new NHS is to be driven by the creative energies of local managers, it seems quite contradictory to set up a centralized purchasing system alongside. Trusts negotiate separately with a range of suppliers of their own choosing, and value this new flexibility and control. Yet they are also pulled in the opposite direction as customers of the NHSSA.

The whole thrust of the NHS reforms was to bid up service quality and cost-effectiveness by stimulating a certain competition between provider units. Indeed, Trusts have pioneered all sorts of new and more cost-effective delivery strategies. By using new day-case surgery techniques, for example, they have reduced the average time a patient stays in hospital by a third.

Such improvements are possible only if local managers and medical staff are free to seek out new advances in technology and innovations in supply. Central procurement, on the other hand, means that decisions about treatment strategies must be taken centrally so that the necessary supplies can be bought in bulk. Markets work through the competition between people who do things differently; central purchasing, by contrast, promotes uniformity. It cannot easily work with variety, nor make use of the dynamic power of innovation and incremental change at the local level. Central purchasers will look primarily at costs and will give much less weight to the after-sales service, technical assistance and educational support that local doctors might regard as vital if the market is judging their work by its quality as well as its cost.

Centralism versus market testing

The idea of a tax-funded NHS Supplies Authority is also in stark contradiction to the principle of market testing which has been extended progressively throughout the public sector since 1979. While we might all agree that it is the duty of the government to ensure that certain essential services *are provided*, there is no reason why the government itself should actually *provide* them if other suppliers can do the job more cost-effectively.

Application of this principle began when local authorities were obliged to invite competing tenders for some of their more mundane services; then NHS support services such as cleaning, laundry and catering were put out to tender. More recently the White Paper *Competing for Quality* proposed that core Whitehall services should face exactly the same test of cost-effectiveness.

In-house providers scorned contractors as being more expensive because of their need to charge a profit; but the practical savings, including £100m from contracting-out NHS support services alone, have long made that argument untenable.

Nobody expected Whitehall to rush enthusiastically into market testing when its own turn came. In the event, only £40m worth of Department of Health business is earmarked for 1993/94. What remains most remarkable is that, for NHS supplies, the whole direction of policy should be reversed, with a new in-house supplies agency being set up where a competitive wholesale and distribution sector already existed!

Governments since 1979 have not generally favoured this sort of nationalization. They have seen nationalized industries as unlikely to be very responsive to customer pressures, and very likely to use their market dominance to squeeze out other sources of supply. Given the criticism that the Trusts have subjected it to, and the enormous make-or-break

power over suppliers which it wields, the performance of the NHSSA seems to confirm that these concerns are still quite justified.

This latest nationalized industry must be privatized or closed down. If privatization is chosen, its current management should be helped to mount an employee buy-out that would turn it into a large private-sector wholesaler. Then it would face competition, and the public could be more confident that Trusts and taxpayers were really getting the best value for the money they spend.

Concerns about costs

Though the Authority stands by its record by pointing to savings of £27m in its first year of operation alone, it is still not clear whether its net effect is positive or negative. The savings figure cited is less than 1.5% of NHSSA turnover, at a time when Trusts face efficiency targets of up to 2.5% per year. In view of the very tough market conditions now prevailing, it is at least arguable that individual Trusts could have negotiated even larger price cuts on their own. To illustrate the point, some critics point out that Regional Health Authorities already seem able to undercut the nationally-agreed price of some products. If national agreements were truly minimizing costs, this should not be possible.

By doing it themselves, Trusts might certainly have saved themselves the 11% on-costs charged by the Authority. Some argue that whatever price benefits the NHSSA achieves through its bulk-buying power are more than offset by grossly wasteful storage, inept order assembly, and inefficient transport systems.

Indeed, it is a fair question why the NHS feels the need to have its own stores and distribution systems, organized centrally, when highly advanced and cost-effective storage and distribution networks are already available within the private sector. With private-sector wholesalers already internalizing such costs, and given the obvious costs and weaknesses of the present central procurement system, it should even be possible for Trusts to purchase their supplies on a call-off basis (of regular or weekly deliveries) at the same price or even lower prices than the bulk deal, without the need for the NHS to own a single warehouse or operate a single lorry.

Reduced competition

The enormous market power of the NHSSA may well be working to reduce competition rather than to take advantage of it. The Authority has already been accused of using three-year contracts to make annual market testing impossible; of resisting trading across regional boundaries; of trying to prevent Trusts seeking their supplies from elsewhere; and of imposing penalties if its chosen suppliers also trade directly with Trusts.

The process of tender evaluation is not transparent. For example, companies are not told why they failed to win a contract. Consequently, they have no rational way of adjusting

their service so as to improve their prospects of success in the next round of tendering. They might well decide not even to bother, resulting in a loss of competition in future years.

In a specialist market, the concentration of purchasing power can produce particularly deep distortions. There are comparatively few suppliers of some hospital-specific products, and the private hospital sector is relatively small. So if the NHSSA awards a three-year contract for a particular item to a single supplier, for example, there may not be enough customers elsewhere to allow other suppliers to continue their own production. The result would be a loss of competition once again.

The loss may be permanent. The development of many hospital-specific products requires large and long-term investments of capital and expertise. If there is no sales revenue coming in, investment on new products must be diminished. If the tendering process is regarded as unfair, opaque, or arbitrary, some suppliers may prefer to withdraw from the UK market entirely. Monopsony purchasing induces monopoly supply.

The effect is even stronger when the monopsonist controls not just the purchasing, but the physical handling and distribution of supplies. For then the supply chain becomes a seamless whole, and it is impossible for private-sector wholesalers to break in. Manufacturers may be contractually dissuaded from dealing with other wholesalers, or unable to quote the prices offered to the NHSSA; so private wholesalers are unable to quote for a direct supply service to the point of use (that is, to the individual Trust hospital or even to the individual wards, theatres and kitchens), and the centralized handling costs remain.

All of this indicates that the present supplies operation should be swept away and replaced by contracts with specialist private wholesalers and distributors, whose technology and expertise would enable them to provide a significantly better service at lower or equal cost. Through a management-led buy-out, the NHSSA could become a specialist private-sector wholesaler.

Policy implications

To make the internal market work, some structural changes are necessary. It is no good simply exhorting purchasers to be more innovative in their decisions; they need to be given the freedom and the incentives to do the job more effectively.

Ministers and officials might worry about the political risks of devolving further control to local managers, who might well make controversial decisions. While the apparatus of central control remains in place, that is a real concern, because the train of accountability leads straight up to them. Yet purchasers are supposed to be the agents of their local public; if their accountability could be shifted more clearly in that direction, the political risk of decontrol would be reduced, and the gains from local innovation and improvement would be great.

Extending some present policies could achieve much in this regard. GP fundholders are among the most imaginative purchasers. They already care for nearly one-third of the population, and others are set to follow. After that round, it may be possible to make it easier for other GPs to become fundholders, providing assistance where practical circumstances make this difficult.

Certainly there is every reason to allow GP fundholders to purchase a much wider range of healthcare services on behalf of their patients. Many fundholders have shown how innovative they could be if given this extra latitude. When it becomes possible for trained specialists to practice independently, the GPs could well lead a major structural change in the delivery of healthcare services, away from the overblown district hospitals of the 1970s and into the community poly-clinics of the 1990s. By removing the restrictions, GP fundholders could in effect become full Health Maintenance Organizations.

Such structural change will require capital investment, and much of that capital will have to come from the private sector. While the present rules on public-private partnerships are more liberal than before, they are still a very large bureaucratic barrier against private investment. With a decade of experience behind us, it is time to acknowledge that the savings (in time and money) derived from employing private-sector management skills on infrastructure projects far outweigh any derived from the idea that the government can always borrow more cheaply. Fundholders have to be allowed full access to private-sector capital.

A number of modest changes would improve the transparency of purchasing decisions, and so produce a more open and competitive market. Block contracts conceal the detail of what goes on within them, and can have no place in such a market. Purchasers should be aware of the cost and quality of all they buy, so that they have the option of moving to another provider for any part of the service. They may not always exercise that option; but the mere threat of it will further concentrate the minds of providers on the quality and price of everything they do.

Likewise, there needs to be better monitoring of results, so that purchasers do actually get the service they pay for. To achieve this, one could set up quangos or send down more directives. For example, one try to encourage shopping around by requiring that a certain percentage of the budget should be spent outside the traditional NHS provider network. Yet a far better way is to make success in purchasing -- raising service standards and value-for-money targets, and then making sure they are achieved -- the basis of reward for the purchasers.

The NHS Trusts have demonstrated how dynamic and innovative service providers can be. With less central restraint, their achievements could be truly astonishing. Perhaps it is time to give the same sort of freedom to the purchasers too. Just as "social landlords" like the housing associations help to depoliticize the provision of social housing, some new trust structure could help to depoliticize the healthcare purchasing function.

The District Health Authorities should be allowed and encouraged to opt for independent

status as Local Provident Trusts. They would purchase healthcare on a non-profit basis, but would be locally self-controlled and empowered to break free of the present bureaucratic shackles. They would become, like fund-holding GPs, full Health Maintenance Organizations. Patients would have the luxury of choice.

Going further, many parts of the purchasing function, including the assessment of local needs, could in fact be provided by non-public agencies under contract.

The snowstorm of circulars that inhibits NHS providers must be ended too. It dampens local innovation and keeps the whole Service overtly political. Even if politicians felt unable to dismantle this apparatus overnight, they could at least define entire areas in which the Trusts would have complete local management control. There needs to be more advance scrutiny of whether particular central directives are either necessary or worth the cost of compliance.

The newly-privatized NHS Supplies Authority would fit in with this more open market. Trusts could still come together to exercise their market muscle in bulk-buying arrangements, but there would probably be a number and variety of such arrangements, so that purchasing power did not threaten to become so concentrated as to end in monopsony.

By transforming the NHSSA, through a buy-out, into a competitive private-sector wholesaler, the market would judge its effectiveness and decide its future.

For the immediate term, greater transparency in the tendering process is as important for NHS supplies as it is for the purchase of medical services. The long experience of local-government tendering, and now of market testing in Whitehall, is sufficient testament to how the very idea can be thwarted by inept implementation or deliberate obstruction. Tender documents need to be clearer, the widest range of potential suppliers must be investigated, adequate time must be given for them to bid, the cost of making a bid must be reasonable, there must be a genuine intention to consider new suppliers, and so on.

Perhaps most important, a clear explanation must be published of why particular bids were accepted and others rejected, so that service providers know how to improve their product for the next round. There must be a more open system of appeal and redress for suppliers who feel themselves discriminated against. The activities of NHS buyers must be reported annually, and open to public scrutiny from the Audit Commission, the National Audit Office, or Parliament.

Picking from this menu of changes, some radical, some simply extending what has been achieved so far, it should be possible to restore the functioning of the internal market, by helping to make the market whole again.

Competition and patient choice

By Dr Clive Froggatt

Fundholding General Practitioner

I have warned myself mentally to be careful not to be drawn by the title of these proceedings into a wholly sterile debate on whether the so-called private sector has any future in the National Health Service -- or alternatively, and quite differently, whether *competition* will be lost on the sacrificial altar of preserving the status quo (a religion, or should I say a self-interest, to which those working in Richmond House seem sometimes to be completely dedicated).

However, my arrows are not aimed exclusively at the Department of Health, since I have yet to be convinced of the motives of the Adam Smith Institute itself! What exactly does it mean by *Unhealthy Competition*? This seems to be a challenge of the most fundamental kind. And what does one infer from the juxtaposition of the subsidiary title *The Public-Private Mix in Health*? Just where does the Institute think it is taking us?

Of course, I should not be contributing here if I felt uneasy about the provocative title. In many ways the title makes explicit the challenges facing purchasers, particularly those in the reformed NHS: challenges which have always been implicit (and perhaps as a result of their being so, have been ignored for far too long by the 'old' system of health care management).

So let us consider thoughtfully the challenge that has been presented to us. Can the Adam Smith Institute seriously suggest that competition is *ever* unhealthy? Moreover, in a sense, so far as health is concerned, for *competition* you can read *choice*. So in effect, what is being debated today is whether this is good for purchasers and providers from both the public and private sectors.

The challenge defined

Last year Brian Mawhinney made a trilogy of speeches on purchasing in the new National Health Service, intending to concentrate minds on the central relationship between purchasers and providers.

In the first speech, the Minister presented his *vision for purchasing*, in which he expounded the virtue of competition designed to 'seek out the best care for patients' and 'to raise standards to those of the best'. He emphasised the responsibility of purchasers to force the pace of change. Furthermore, he wanted to see shared purchasing between DHAs and GP

Fundholders -- cooperation *and* competition.

The Minister's second speech dealt with the mechanism of *purchasing and contracting*. The trilogy concluded with his *yardsticks for success*.

Thus the challenge facing us has been defined. In the immediate aftermath of the reforms, the development of Trusts was at the forefront of our minds -- that and the role of GP fundholders.

Three years later the scene is evolving. With over 90% of providers functioning as Trusts, the development of *purchasing* is now of prime importance. This has happened as the number of fundholders has risen with the third wave to nearly 1200, catering for 25% of the patient population. This I anticipate will rise again by 500 to 1700 in the fourth wave, with fundholders then catering for over a third of the nation's population.

But all this is happening at the same time as the government faces a £50 billion deficit. With the PSBR dramatically high, no government in the foreseeable future will be in a position to provide the resources demanded by public and profession alike.

With the reforms in place, public demand for more services will continue to grow along with the professional frustration at being denied the resources to provide them. With no prospect at all of public money being sufficient, it follows as day follows night that the private sector will have unparalleled opportunities in future to provide services to NHS patients in a wide variety of ways.

I know, of course, that the title was really raising the age-old problem of public-sector monopolies having a supposed 'unfair' advantage over the private sector -- an advantage that was enhanced by the loosening of financial controls. But I believe that this was necessary simply to ensure that the private sector did not run away with all the opportunities for development to which I have just referred.

With their new financial potential, NHS managers will be encouraged to develop skills which enable them to respond to the challenges of the private sector. Thus we can expect improvements in NHS facilities which enable them to compete effectively with commercial healthcare providers.

New approaches

I envisage, therefore, that over the next few years we shall see the line between public and private sector provision blurred progressively.

NHS facilities will be used more often by patients covered by health insurance, and NHS patients will be treated on *privately-owned premises* at NHS expense. The guiding principle which will determine whether this is proper will be the patients' best interest.

It will be necessary also for the purchaser to justify the use of public resources in such a way. Examples of this are occurring now. Thus the principle to which I refer has been tested already, and not found wanting.

Private investment in *joint ventures* with the NHS will be seen more regularly. An example is the much quoted waste incinerator scheme at Oldham where local health authorities have joined with an independent company to fund the building of a new incinerator, which will be used over a number of years to the advantage of both parties.

For investors, the safety of such a commitment holds considerable attraction. For the NHS, it may be the only way to raise much-needed capital.

The provision of *shared facilities* at NHS hospitals holds equal advantages. The Newcastle Royal Victoria Infirmary NHS Trust has been able to upgrade its equipment with the support of the private sector; something which they could not have contemplated without co-operation with their 'competitors'.

Similarly, *private investment in GP polyclinics* will enable premises to be built to a much higher specification than would be possible if they had to rely solely on NHS funds.

None of these present examples mean very much taken on their own, but together they represent a sea-change in the government's attitude which has profound implications for the future of both the NHS and the independent sector.

However, the significance of the government's financial predicament cannot be overemphasised.

In the 1992 *Conservative Manifesto*, the government pledged to continue funding the NHS, raising in real terms each year its investment in healthcare. It has promised to ensure that healthcare will be provided regardless of ability to pay and mainly free at the point of delivery. With these pledges and regular restatements of the continued commitment to them, the options on funding are few and far between. Thus it seems to me the private sector can rest easy: with rising expectations and increased demographic demand, the opportunities for investment have never been better.

Let me conclude by sounding a note of caution. The government may be short of money but it is not short of ideas, particularly where the NHS is concerned. And here the Citizen's Charter, or its health equivalent, the *Patient's Charter*, comes in.

In essence, in the *Patient's Charter*, the government has reaffirmed its commitment to:

- * patient-centred services
- * services of the highest quality;
- * choice for individuals; and

* good value for money.

Furthermore, Brian Mawhinney's *yardsticks for success* were nothing less than standards that he intends should be set for the NHS.

The outcome for patients will be the critical determinant of good care. But with money being tight the government is more determined than ever to obtain the maximum value for its budget. With this in mind purchasers will be demanding value for money and cost-effectiveness in every contract they let, in the certain knowledge that the ultimate beneficiary will be the patient -- without whom (let us not forget) there would be nothing for us to discuss.

Competition and co-operation in healthcare provision

By Peter Jacobs

Chief Executive, BUPA

At the moment there is a will within government to harness more effectively the resources of the public and private sectors in the field of healthcare. We must not allow this to pass without taking action.

Joint capital ventures, providing services for both public and private sector patients would bring long-lasting improvements to the delivery and quality of health care in this country.

The potential for private providers

The health reforms of 1991 were designed to deliver three key benefits for patients.

1. Local assessment of health needs and purchasing by health authorities of services which most closely matched those needs.
2. An emphasis on the quality of care, with NHS contracts specifying the quality as well as the quantity and cost of services to be delivered.
3. Contracts would go to providers offering the best quality and value for money.

To achieve the objectives of enhanced services for patients and a better return on the taxpayers' massive investment in the NHS, the government introduced competition into the *provision* of public health care. But for this to be effective, there must be *genuine* competition; and that means some services should be provided by the private sector.

As Britain's leading independent healthcare company, and the only one spanning both the provision and funding of health care, BUPA welcomes the opportunities this presents. We are already structured on a purchaser-provider basis, and have worked with a number of district health authorities on joint ventures and waiting list initiatives.

Let me give you some examples. BUPA has:

- * provided a Magnetic Resonance Image scanner for the National Hospital for Nervous Diseases;

* pioneered the use of mobile health technology (our mobile lithotripter and mobile prostatron treat both private and NHS patients); and

* treated thousands of patients in our hospitals under the government's waiting list initiative.

These modest incremental services show how the delivery of health care can be substantially improved by the augmentation of public health care facilities with private services.

The private sector is already a significant force in healthcare provision. Last year it performed over half a million operations, compared with about three million in the NHS. Some 15% of all elective surgery is carried out in the private sector -- and not (as is sometimes thought) only the straightforward operations. For example, about 20 per cent of all heart surgery and about 30 per cent of all hip replacements are carried out in the private sector. Therefore it already makes a valuable contribution and is well placed to give the providers within the NHS the stimulus of competition in key areas of healthcare.

Given the great pressure on public funding, the private sector should be encouraged to play a larger role and therefore increase the total available resources. I am delighted to see that this is now the government's position.

Unintended outcomes

Clearly, using the market mechanism, we have to move to a position where the resources of the private sector efficiently augment those of the NHS. There are many opportunities for private-sector services to be purchased for NHS patients, such as physiotherapy, dialysis, pathology and day care centres.

But strangely, this has not been the area of development attracting most interest. Instead, what we have seen is NHS Trust hospitals investing in building private wings to compete with the independent hospitals servicing private patients.

A report last year from Laing and Buisson revealed a doubling in the dedicated private units in NHS hospitals from 25 to over 50.

So rather than competition to supply health care to the *public* sector, the reforms have meant that the *private hospital sector* will face increasing competition from the Trusts. That's fine if it is on the basis of reasonably accurate NHS costings. But because of the lack of good costing systems within the NHS, this is unlikely to be so in at least a significant number of cases. The result is likely to be that the very existence of some independent hospitals will be threatened by NHS private activity subsidised by the public sector. That would be unfair competition, and I am sure is not what is intended by the government when it talks about a free market.

Block contracts

Furthermore, a competitive market in healthcare provision to the NHS will not develop so long as District Health Authorities are intent on sustaining their local general hospitals by awarding block contracts to them on a basis which does not fully take into consideration the real costs of providing the treatments being purchased. This move by-passes the GP fundholding process which I would argue is the most effective means of establishing a true marketplace.

Interestingly, the Laing and Buisson report also points out that there was no indication of either health authorities or GP fundholders placing sizable contracts with the independent sector.

Restrictive practices

Another development which the private sector is watching with interest is the pressure from Trusts on consultants to sign contracts restricting them to carrying out all their private work in the Trust's private wing. Many consultants are against these contracts, which could also be very damaging to the private sector. We would have to fight back with the only weapon we have and employ our own consultants full-time. A knock-on effect would be that, on a local basis, there could be a serious disruption of the referral patterns from GPs to consultants. In the interests of maintaining their reciprocal arrangements with consultants and Trusts, some GPs would stop referring patients to consultants who were contracted to private hospitals. Consequently, in the private sector we might have some excellent consultants contracted to us, but with patients losing out because they were only being referred to the NHS Trust.

Again this contractual restriction on consultants is not what most people would see as an expansion of competition in the supply of healthcare provision to the NHS. It would be aimed at enabling the NHS Trusts to use their local power to supply the private-funded sector and possibly a challengeable restrictive practice. Independent operators, particularly if their existence was threatened, might well refer the matter to the OFT and, I suspect, be successful.

I strongly advise those going down the path of restrictive contracts for consultants to seek legal advice before going much further. If you want to be part of a market then you have to play by the market rules and, happily, fair competition is supported and enforced by statute.

Capital co-operation

The NHS reforms should be introducing healthy competition, but there are also opportunities for collaboration between the private sector and the NHS. Principal among these should be joint capital ventures.

Until a year or so ago the development of joint capital ventures was discouraged by a restrictive Treasury rule on unconventional funding. Subsequently this rule was dropped, and the promise was that these ventures would be encouraged.

Another important step forward was taken when the health minister Tom Sackville MP announced a change in the limit for capital projects above which health authorities must seek approval from the government, to £10 million instead of the previous £250,000.

This is all very welcome. However, I still do not feel at all confident that the energy and business acumen of the private sector is about to be unleashed to fulfil those high ideals of the NHS reforms. Although the value of projects which must have government approval has been increased forty-fold, there is also the caveat that a 'sample' of these projects will be reviewed by the Department of Health and the Treasury. Now this sounds a reasonable and prudent check on the use of public funds. But let me tell you how this 'sampling' for review is planned in practice. Those projects below £1 million will escape any sampling, but very few of the projects tackling the new frontiers of medicine will fall into this category. Of the projects between £1 million and £10 million, one in two will be sampled by the Department of Health; and of those sampled above £4 million, all will be referred to the Treasury for scrutiny and approval.

This is where the liberalisation programme has gone off the rails a bit. This level of sampling for review is stricter than for projects funded purely by the NHS. Where we are asking NHS managers to be innovative and work with the private sector, a sample rate of one in two, with Treasury approval required for all those above £4 million, is likely to be a big disincentive.

Managers are already busy with setting up Trusts. They are not going to add to their workload the preparation of projects which stand a considerable chance of bureaucratic delay and possibly rejection.

I invite the government to think again. Set the rate for sampling at about one in six and tighten up if it proves necessary. Start by showing some confidence in local management. That in itself might produce results.

Tendering rules

We also need the answer to another outstanding question which is influenced by EC rules. Are all joint projects to go out to tender? If so, there is little incentive for one private operator to identify and draw up a project, only for it to be offered to others and then lose out if the innovator's price is not the absolute lowest. The issue, to which there is no easy answer, is about the ownership of intellectual property. Compensation for the work put in is no answer. A mechanism will have to be found to protect the position of a partner who brings innovation and originality to a project. After all, if everything has to go out to tender, everybody will just sit back and wait for the tenders. There will be no motivation

to originate and lead. Again I am sure this is not what is intended.

The private sector will require that projects be undertaken on a realistic commercial basis, with an equitable sharing of risk and reward. There is also a need for opportunities to enter into long-term relationships where major investment is involved. This is normal and good commercial practice, and should form the basis of joint projects within the NHS.

Attitudes

In many NHS districts, there is still a feeling that there is something wrong in involving the private sector in the delivery of health care to NHS patients. This is the 'creeping privatisation' syndrome. It is outdated and illogical, but it exists, and is a powerful inhibitor. The Secretary of State for Health has helped point the way to a new vision, telling the NHS to regard the private sector as a partner, not pariah, and I believe the way round the barrier of attitudes is to notch up a few successes with progressive NHS managers to prove that everyone gains as a result.

Nothing succeeds like success and when the advantages to all parties become apparent, these anachronistic attitudes will decline, though they will probably not disappear. They will always be there in some shape or form and will have to be managed.

Meanwhile, let us pull down the barriers so that the private sector can work with those enterprising NHS partners. The contribution which we can bring includes experience, expertise of commercial business development, and access to capital which is not available to the NHS. The benefits to the country as a whole will include significant cost savings, improved efficiency, increased throughput of patients, and improved quality of care.

And there are other opportunities for collaboration between the private sector and the NHS. For example, BUPA is already collaborating with the NHS in establishing:

- * clinical consensus panels;
- * clinical quality standards;
- * consistent measurements of outcomes; standard costing procedures; and
- * electronic data interchange.

We have access to people in their workplace, something that has eluded the NHS. We see opportunities to help regional health authorities achieve the government's *Health of the Nation* targets on occupational health. Our health management services could help GPs to develop and market Well Person clinics.

In the medium and long term we could develop some hospitals as centres of excellence, specialising in specific procedures for both public and private sector patients. We could

also undertake joint initiatives in primary care facilities such as health centres, clinics and pharmacies.

Conclusion

These are some of the possibilities. To ensure a positive outcome, the government, the NHS and the private sector must work together to identify the opportunities and fulfil the potential which exists to harness the resources of the public and private sectors.

If common sense prevails, there will be a true mix of competition and collaboration between the public and private sectors.

I stress the urgency needed for this action because it is now two years since the reforms were implemented. Although from the outset there appeared to be tremendous scope for private sector resources to be co-ordinated with those of the NHS, very little has happened. Some of the obstacles have been cleared away. Others need to be resolved. I believe we are at a stage where we can make progress. We must do so and quickly: because meanwhile it is the patient who is kept waiting unnecessarily.

Patient power and the medical monopoly

By Dr David Gladstone

University of Bristol

The power of the monopoly

No system of health care can function without the cooperation of the medical profession. For that reason, they are in a position of considerable power *vis a vis* suppliers, whether public or private. And it is power that exists because the status of the medical profession is underwritten by law -- specifically in the Medical Act of 1858. As Nicky Hart expresses it:

The power of the medical profession lies in its success in having secured by political means a legal monopoly over the practice of healing in contemporary society. This made the doctor *the* official expert on health and illness in modern society -- a title enshrined in written law. This is the legal-rational basis of medical power. It consists of a monopoly given by the state, giving the profession exclusive occupational rights, freedom to control the process of recruitment, training and practice, and control over the conduct of individual members who each enjoy the rights of clinical autonomy.

Secondly, the issues with which the medical profession deal (potentially matters of life and death), their role as gatekeepers to resources for treatment, and their specialised education, training and experience -- all place them in a considerable position of power *vis a vis* patients and consumers.

This raises issues that range from the constitutional position of the General Medical Council to the system of redress and complaints by dissatisfied or aggrieved patients.

Thirdly, no group which holds power will voluntarily surrender it. Historical experience provides much evidence of that statement but a quote from Machiavelli sums it all up:

The innovator makes enemies of all those who prospered under the old order and only lukewarm support is forthcoming from those who would prosper under the new. Their support is lukewarm ... because men are generally incredulous, never really trusting new things, unless they have tested them by experience.

Changing circumstances

Yet the situation is changing in relation to medical monopoly power in the UK healthcare system. Let me suggest four directions of change, especially in relation to hospital-based medicine.

Managerial change in the NHS: The introduction of general managers, internal markets, trust hospitals, and budget-holding GPs have created a new world for professional practice with increasing surveillance of each activity (aided by developments in information technology), assessment of spending and outcome measures (expressed in league tables), medical audit, and indicative drugs budgets.

The *Patient's Charter*: The *Patient's Charter* initiative highlights the challenge to professional power from the consumer voice in all its diverse forms: concern with ineffective or even harmful drug supply; a positive commitment to greater individual responsibility in health; the challenge from dissatisfied patients (represented by the marked increase in the number of complaints about the quality of medical care); as well as the *Patient's Charter* itself with its emphasis on quality of service and its provision of yardsticks and guarantees.

Price fixing and private fees: Then there is the Monopolies and Mergers Commission's enquiry into the fees charged for private medical treatment. The point of departure for this was the guideline published by the British Medical Association, setting out recommended fee rates for medical and surgical procedures. While the BMA insists they offer only guidance and not recommendations, the Office of Fair Trading has pointed out that:

If these are adhered to by a significant number of consultant doctors, they may effect the nature of competition and the level of fees in the market for the supply of private medical services.

The Calman report: Implementation of the Calman recommendations on specialist education and training could bring about substantial changes in the pattern of senior hospital medicine. The Report recommended shorter, better-supervised and more structured training programmes, ending with the award of a Certificate of Completion of Specialist Training as the formal indication that an individual is capable of independent practice.

Shorter training programmes mean that today's medical students could expect to complete their training in their early 30s instead of waiting until they are on the brink of middle age before being considered for a consultant appointment. Furthermore, the award of the CCST at the end of a formal training period will serve to highlight the numbers of those judged capable of independent practice who are 'in waiting' for consultant specialist appointments, instead of being concealed in what are euphemistically described as 'training grades' as at present.

The Calman proposals hold a significant implication for both the private and public sector of hospital medicine. Private fees were initially set at a premium to attract consultants when skills were scarce. By the simple law of supply and demand it would be expected

that any significant increase in the supply of specialists would reduce the price levels to private insurers, assuming that no impediment existed to free-market conditions. Increasing the number of specialists could thus have considerable implications for the private sector and for Trust hospitals in the negotiation of consultant contracts.

Meanwhile in the public sector, increasing numbers of specialists could speed the process of referral between GPs and the hospital sector and shorten the hospital waiting times for surgical procedures. A report published last year by the Royal College of General Practitioners pointed out that, while British GPs refer relatively fewer patients to hospital than their European counterparts, British patients at present wait longer to see a specialist than in any other European country.

Areas of practice

I have already begun to suggest how recent and proposed changes may affect the delivery of services. What, then, are the issues which need to be confronted in moving towards a more responsive relationship between professionals and users? Let me briefly suggest three.

The tension between quality and choice: At present, patients seeking treatment are in a straight-jacket imposed by the established referral pattern between GPs and specialists: their choice is restricted. But on the other hand, they have the security of knowing that they are dealing with legally qualified practitioners who can be held accountable for the treatment and services they prescribe.

This raises the issue of redress for those with grievances or complaints. Margaret Stacey's recent study *Regulating British Medicine* highlights the bewildering complexity of the complaints procedure: an array she considers confusing to members of the profession as well as to the public:

To the public because they are unclear where to go for what purpose, to practitioners because they may be arraigned for an alleged offence by a variety of authorities and for the same offence before more than one.

NHS doctors, for example, are subject to more regulation than those in private practice.

But Stacey's other point is that not only at law but in any circumstances in which medical practitioners may be called to account, the profession has insisted that it should judge its own. Professional self-regulation, she concludes, 'is clearly implicit in every form of medical accountability. It is *the* principle of essence.'

The supply of information about specialist services: This specifically impinges upon the current debate about the Medical Register itself and the designations contained within it.

My point, however, is more general. It is to set the attitude of the GMC towards advertis-

ing of specialist services in the context of what is now accepted for GPs. While supporting the wide availability to the general public of lists of local GPs and factual information available in practice leaflets, the GMC has been much more circumspect in its approach to information about specialist services. That type of information, the GMC argued, should be distributed chiefly within the medical profession. To do otherwise, the GMC argued:

would be to dismantle the present arrangements for medical care. The Council has therefore had to balance the advantages for patients of being better informed about the specialist services available to them with the consequences of dismantling the present arrangements for medical care.

The issue here is how far the GMC is acting in this regard, as it is required by law to do, in the public interest -- and how far in the interests of *preserving the status quo*, from which its own members derive considerable benefit?

The interface of scientific and complementary therapies: The Medical Act of 1858 united those parts of the medical profession engaged in the application of the principles of scientific medicine -- 'curing individuals of episodic bouts of organic disorder in a clinical environment'. Practitioners of other methods of treatment were not suppressed but were progressively assigned to the fringe, unable to certify any statutory documents or to practice in any public setting. They were excluded from the 'panel' system set up under the 1911 National Health Insurance Act, and their activities were further restricted with the advent of the NHS in 1948. For the past century and a half, the bio-mechanical model has constructed our understanding of the nature of health and illness. And furthermore, it has also created the specialisms within medical practice based on the divisions in the system of the human body as biologically defined.

Yet published evidence confirms the rising trends in herbal and homeopathic remedies to treat a range of self limiting conditions. Boots, the High Street pharmacy chain, plans to provide in-house training to deal with a growing number of queries and to designate counters specifically for herbal medicines.

And the BMA which, in its report on alternative medicine in 1986 was unequivocal in its opposition is now much more positive about the appropriate use of complementary therapies.

While the legal exclusion of other treatments to fringe status made the medical profession virtually immune to outside interference and criticism, the sorts of new developments I have just described may yet offer a new position to the patient and consumer in the medical relationship.

Co-operation between the NHS and the independent sector

By Dr Brian Mawhinney

Minister of Health

The key mechanism for harnessing the power of the NHS reforms to benefit patients and the public -- and securing the principles of the *Patients' Charter* -- is NHS purchasing.

For forty years the NHS has been provider driven. As a result of our reforms, in the future it will be purchaser driven. That is the fundamental change brought about by the legislation.

Having concentrated on providing for forty years we have become internationally renowned in those terms. But, having paid much less attention to purchasing, we find ourselves short of experience in developing the purchasing role. As a country, we have a reputation for being timid as a purchaser of services.

We need to change this for the sake of patients. That is why the government has been focusing people's attention on the whole concept of purchasing, and putting it at the top of our agenda. That is why I made a number of major speeches last year, encapsulating the objectives and direction of our policy in purchasing terms.

Changing circumstances

It is fair to ask why government started to focus on purchasing only in the third year of the reforms; but I believe that there are good answers to that question.

The first is that, given the radical nature of the reforms, we would have been thanked by no one had we tried to build up the purchasing role without first consolidating our provider base. We would have faced serious criticism and it would have been counter-productive in terms of service delivery.

Secondly, from April 1994 approximately 95% of all hospitals and community units in this country will be in Trust form. We took a view, I think rightly, that it did not make great sense to focus on purchasing when the purchasers were themselves still running half the hospitals in the country; but that purchaser/provider split will become a reality now.

Thirdly, there is the whole new development of GP fundholding. As GP fundholders increasingly become a serious part of the purchasing process, there are much greater

opportunities to develop the purchasing function.

So for all of these reasons we decided that the time had come to move into the next stage of the reforms, and to do it with commitment, putting purchasing at the top of our agenda.

Purchaser freedom

Having made the provider base much more secure, we are now ready to move on to allow purchasers greater freedom to do the job that they are expected to do on behalf of patients. So we see purchasing as an engine for change.

We see it also as the means by which a whole new series of relationships in the NHS will be developed. If GPs are increasingly influencing provider budgets, for example, then we must expect a whole new set of relationships between GPs (and other purchasers) and hospitals or community units.

And there must also be new thinking from the district health authorities. If they are to be purchasers on behalf of people in their community, then new sets of relationships must be developed around the concept of the DHA as an agent and an advocate. We expect purchasers to force the pace of change, to improve health and health services, to be active as agents for people, committed to reshape health services to reflect the needs and preferences of local people rather than those of providers.

Every district health authority in the country should be able to demonstrate that it is taking systematic action:

- to seek and act on views of Community Health Councils, voluntary bodies and the wider public; and

- to improve their awareness of local health and health service issues.

Contractual relationships

Perhaps most change will occur in the area of contracting. In the health service we are seeing purchasers becoming more assertive and more canny about what they want for their patients.

There is a growing awareness that simplistic block contracts will not deliver what we are looking for in the NHS. We need much more sophisticated contracts, rolling contracts, multi-year contracts, cost and volume contracts, a whole range of concepts aimed at meeting the needs of the patients for whom the services are provided.

It should not be a macho fight between purchasers and providers. Successful private companies develop deeper relationships out of which both their customers and their sup-

pliers maximally benefit. In the NHS we are not writing contracts to buy the cheapest. We are writing contracts to form relationships that will deliver cost effective and higher-quality patient care; and new measures of service quality must be part of the purchasing process.

And it is the responsibility of the purchaser to ensure that healthcare is delivered throughout the period of the contract. In this country there are hospitals which believe that there are twelve months in a calendar year and those which seem to believe that there are only nine months in a calendar year.

The hospitals which believe there are twelve months in a calendar year are generally those hospitals where the medical staff have been involved from the beginning in the contracting process and in the monitoring of that process. Those who suppose there are only nine months in a calendar year tend to be hospitals where the medical staff are not involved in the contracting and monitoring process.

So I have made it quite clear that we expect purchasers to assume responsibility for health-care delivery throughout the year, in conjunction with their providers; and that both the medical staff and the nursing staff must also be involved in the contracting and monitoring process. It is hard to defend a situation where the nurses, who are delivering 80% of the face-to-face care in the NHS, have no role to play in the development and monitoring of service contracts.

Primary and secondary care

The new focus on purchasing is likely to re-define the boundaries between primary care and secondary care. It is understandable that a health service tends to focus its attention on the hospital sector. But of course the NHS is much more than hospitals, and has increasingly become so.

Medical practitioners, along with patients and their families, increasingly wish to see services provided close to the patient's home where possible, and in hospital only where necessary. That in turn must produce a major change in terms of service structure and manpower requirements in both primary and secondary sectors. It will require greater co-operation across the primary/secondary border, which in itself will become more and more blurred over the passage of time.

For example, GP fundholders increasingly invite consultants to come and hold clinics in the GP's surgery. Is that a primary activity? Or is that a secondary activity? And does it actually matter? One could provide numerous examples of changes which are challenging the old stereotypes as the NHS starts to focus on what the patient wants and needs rather than on its historical provider structures.

Patients' needs

Indeed, purchasers will be expected to focus more much on the needs of patients. Patients need, for example, to have confidence in the fact that their hospital treatment is actually clinically effective. That raises a whole series of issues.

The first is the issue of monitoring the quality of the services that are bought. Purchasers have a legal and moral obligation to deliver maximum, efficient, effective healthcare from their resources. Those conditions are not being met if they are carelessly buying in treatments which the medical literature suggests are of dubious clinical benefit.

The next issue is patient empowerment. Of course patients are being empowered in new ways -- not least through the *Patients' Charter*. Of course, practitioners who are clinically qualified have to make the clinical decisions. But that does not mean to say that patients can be kept in the dark and their views ignored.

As a new MP in Peterborough I argued that my constituents should be given the same information about consultants' waiting lists that was available to GPs. I was told that this information could only be entrusted to the doctors. Just recently, though, the situation changed. The health authority grasped the nettle and published the waiting times for every consultant in East Anglia.

The roof did not fall in, there were no riots in the hospitals, doctors did not walk out in disgust. All that happened was that my constituents had more information for a sensible conversation with their GPs, so that they could start to talk about whether they wanted to wait to have their operation locally, or travel a little further to have it more quickly.

So you can ultimately empower patients to make some of their own clinical decisions. And I am looking for purchasers who devise ways that give patients more and more power to decide what should happen to them.

Public and private sectors

While we are committed to a mixed economy of care, in which public and private provision operate side by side, we have no wish to enter into argument about the respective merits of public and private healthcare. We are determined that individual patients should have available to them services of a high quality at a cost effective price.

My responsibility is to see that patients get the best quality treatment in a way which is most convenient to them. It is for purchasers to decide whether that can be achieved most effectively by making some local arrangement with an independent sector provider alongside the NHS provision.

Indeed, co-operation between the NHS and the independent sector is actually a great deal bigger than people seem to understand. In 1991/2 alone, the NHS received £141 million

for treatment given to private patients in their hospitals. This money was, of course, subsequently used to the benefit of NHS patients. Private treatment within the NHS is permitted when hospitals have excess capacity and provided it does not prejudice their commitments to NHS purchasers.

There is, of course, wide co-operation already in the provision of nursing-home and other care for the elderly. The NHS has a long history of purchasing into the independent sector. And in line with that we actually wrote into the Care in the Community policy a requirement that local authorities should spend 85% of their transitional grant in the independent sector.

Other opportunities will be available for independent sector providers, but only where they can offer the right service with guaranteed quality at a reasonable price. Neither public nor independent providers can expect any special favours; we look to and welcome competition to force prices down, in the interests of the patient.

Future changes

For the future I see change continuing. First there is the development of our current market testing programme. The competition provided by private treatment within the NHS is very important in forcing prices down and aiding the purchasers' quest for value for money.

Market testing of services to the NHS is part of the constant search for improved quality and value for money. It is not undertaken to satisfy some philosophical or political dogma. It is carried out to produce savings that can be fed back into direct patient services.

Last year we market tested about £2,500 million out of a total £5,000 million budget for non-clinical services. Cumulative savings since 1983 amount to nearly £1,000 million, and these savings have been accompanied by improvements in quality.

This initiative was driven from the centre, but market testing will increasingly become the responsibility of purchasers, and it will be for them to decide whether other non-clinical services should be added to the list.

Secondly I would expect to see a greater level of private sector investment in the NHS in the years to come. We are already exploring new ideas, such as permitting health authorities to co-operate with the private sector in the building of a patient hotel. A number of joint ventures are now being explored. We are looking at health authorities who are leasing equipment from the private sector, and so on. The new initiatives are coming forward -- something not unconnected to the decision to raise the financial barriers on private sector investment.

Once again, this is not being done in the name of some dogma. We will measure these sorts of future developments against three pragmatic measures:

Will they provide value for taxpayer's money?

Where do they place the risk? (A joint venture leaving the NHS carrying all the risk is not much of a joint venture.)

Will they improve NHS patient services?

If the answers to those questions are in the affirmative then we are interested. And the whole strategy might well lead us on to some quite large development concepts which are presently under discussion, but which will be measured against the same objectives.

Conclusion

As we move forward with the reforms so there are opportunities for us to deliver better care than we have in the past. More effective care and better quality care.

Because of our reforms, the NHS is at last getting away from forty years of talk about inputs, and is now starting to talk about outputs. It is a huge cultural change. We are all so conditioned to talk about inputs -- to talk, for example, about hospital budgets and the number of beds, almost as if the GP and care in the community did not even exist. In future we have got to talk about the number of patients treated, the quality of that treatment, the convenience of that treatment and the efficacy of that treatment.

I think it is an exciting prospect.

Innovation and entrepreneurship in NHS Services

By Dr Martin McNicol

Chairman, NHS Trust Federation

I want to start by putting forward some general concepts about NHS organisation. I should stress that these are purely my own views.

Hallmarks of the NHS

It is useful to ask what are the features that define our National Health Service.

The first is that the NHS is a mechanism for purchasing health care through a tax-funded system such that the care provided is free at the point of delivery. We use agencies to purchase health care on behalf of the patients, and now have a part of the organisation whose specific task is to purchase health care. Other parts of the system provide the services so purchased.

The second feature that makes our service unique is that we have a major and institutionalised role for primary care. Primary care is provided by general practitioners who are independent contractors working within the health service. They provide most of the care -- 90% of patient contacts with the NHS are with general practitioners. They have an additional, very powerful role as gatekeepers for entry into secondary care.

The health service has traditionally (but I believe erroneously) been identified with the management of secondary care providers. Much time has been spent and is being spent on the issues of managing secondary health care provision, but this is not the key feature of the NHS. The real action is in purchasing and primary care.

With the 1990 legislation we saw a considerable clarification of these principles. Purchasing and providing secondary health care were clearly separated for the first time through the creation of the internal market and the establishment of Trusts, a devolved management structure for providers. We have begun to see some explicit purchasing decisions being made, and purchasers are beginning to think about what is being purchased on behalf of the patients. The devolution of management of the provider function introduced for the first time competition between providers on the grounds of quality of service provision and cost. It was believed that the competitive stimulus would make the service more responsive to the public and would improve efficiency and value for money.

The foundations of the market

In a 1993 *Times Health Supplement* article, the former Director of the Audit Commission, Howard Davies, argued that a prerequisite for any market (even a social market like the NHS internal market) is a rational financial framework. It is not clear to what extent that is possible with a publicly funded service like the NHS.

But he also argued that it is important to talk about *outputs* rather than *inputs*, and to be clear about what you actually want to be provided. Purchasing and providing have to be clearly separated, and there has to be an explicit contracting process. Purchasers should disclose their contracts. The market should enhance customer choice, and appropriate information should be available to inform that choice – information about clinical outcome – as well as the financial information that is important to the purchasing agency. It is instructive to compare this description of the features of a social market with the features of the NHS as it takes shape in the 1990s.

Current state of the NHS internal market

The impact of the new structure on provider management has been remarkably beneficial. It has given us more responsive organisations and local decision-making capability. It has spurred innovation in all sorts of ways. It has delivered more patient care and has been cost-effective. On these measures it has clearly been a great success. But if you reflect on the basic concepts of the market, while provider development has been considerable, market development has been held in check.

Old features of the managed service persist. The number of circulars, guidance letters and suchlike that come into every Trust in this country is greater than the number that used to come into hospitals five years ago. There is a vast traffic in management coming from all directions -- the Secretary of State, the Management Executive, the Health Authorities. It has become a standing joke. To that extent one essential feature of the reforms -- devolution of decision-making to providers -- remains incomplete.

Some of this lingering centralism is understandable. It is very difficult for the Department of Health fully to devolve provider management so long as the Secretary of State is expected to stand up and answer questions in the House of Commons (or even from the popular press) about what providers are doing. But on that peg of "ministerial accountability" now hangs a vast layer of bureaucracy which is constricting the development of the market.

An additional, even more important failure, has been the failure to develop the purchasing function -- a crucial denial of what the internal market is about. It is only now being addressed: before this year, purchasing was given a low priority. But until the purchasing and provider functions have been developed and clearly separated, you cannot initiate the bargaining dialogue that makes the internal market work.

The failure to develop the purchasing function has inhibited the development of the market and the development of providers and has allowed many of the features of the old bureaucracy to persist. Although Trusts have been successful they have been successful largely within the limits of the old organisational structures. They are doing the old job, just doing it better, because as yet there is no reality of a competitive market.

Developing a competitive market

If we were really serious about making the social market operate a genuinely competitive market, what would we be trying to do?

We would have to have effective purchasing -- there is no doubt about that. Unless purchasers know what outputs they want and demand them, the market is not going to function. The purchasing structure would have to be simplified. We require fewer agencies -- RHAs, DHAs, FHSAs, Commissioning Agencies, whatever they are called.

We need to change our methods of contracting and to make our decision-making much more transparent. Contracting at the moment takes place in a very closed manner. Should we insist on open tendering for specific clinical services as indeed we do for many of the other functions in the NHS? Competitive tendering is already the norm for a number of basic day-to-day activities in the NHS -- should it perhaps be the rule rather than the exception that it is at present?

This change would fundamentally fracture the club-like atmosphere of NHS purchasing today. It would open up traditional arrangements to public scrutiny, and lead to a surge of innovation. Private sector providers would have equal opportunity to provide NHS case and could be expected to establish a significant share within the decade.

Block contracts, at present the commonest form of contracting, achieve none of this. When a contract deals with thousands of patients across all types of services, purchasing is very inefficient. Only if needs are clearly defined, and the contracting process is publicly opened up through some mechanism such as competitive tendering, are you really able to test the market and allow the independent sector to prove its ability to deliver the totality of health care.

The tendering route is not likely to be perfect, but it is more likely to provide the taxpayer with the best value for money in health care provision, to make purchasers clear about what they want, to make providers competitive and to produce a process which is open to public scrutiny. Such specificity and openness would begin to produce the reality of competition. It might be uncomfortable for those of us in Trusts, but no doubt it would be equally uncomfortable for those in the private sector. It would certainly open up the game.

New organisational models

The new social marketplace would give Trusts a much greater stimulus to aim for improved performance. They would have to be managed to maximise their output standards, to provide purchasers with high quality services at the lowest possible prices. It would help them to escape bureaucratic over-management from the centre which is still based on input measures and which imposes significant compliance costs upon them. They would be accountable to the purchasers and to the department of health for what they did -- no Trust seeks to escape that -- but the grounds of accountability would be clearly defined and no political or managerial superstructure would need to be built on top of it. Trusts facing real competition would rightly complain even more loudly about such bureaucracy.

We need to look for a new structure which will sharpen provider accountability and yet free us from bureaucratic, input-orientated central management. We might start by looking at models like the Housing Corporation and the Housing Associations. That may not provide all the answers but we need to look urgently at structures of that sort.

We also need to define the limits for a new regime of greater competition and open tendering. Clearly, a wide range of elective services currently undertaken by NHS providers could equally well be carried out either by NHS Trusts *or* by the private sector.

We also have to think about other possible providers of secondary care, including the primary care sector. There are now good examples of primary care managing the provision of secondary care within the community, and there is no doubt that this model could be extended to cover a considerable amount of elective and diagnostic work. Real competition between these different providers would show us who was best suited to manage these services, and I am sure it would demonstrate that there are many different ways in which a better-quality service could be delivered.

Purchasing structures

There remain major issues about the management of purchasing: of which the most urgent are who should be the purchasers and how they should be organised.

At present, purchasing is done on behalf of patients by official surrogates -- the health authorities who purchase services for the vast majority of the population. Is this the best structure, or should we be aiming for purchasing decisions to be made much closer to the real customer -- the patient? Should GPs purchase most of the care for their own patients? The primary care relationship is the most fundamental for most people, and purchasing at that level has considerable logic. If we do develop purchasing to the primary care sector, will that impair the gatekeeper function? Could such a mechanism of case-by-case purchasing decisions ever deliver national objectives like those expressed in *Health of the Nation*? Or would it produce an outcome that was neither better nor worse, but simply different?

These are difficult issues. But for my own part, I do not think that Health Authorities effectively represent their communities at the moment, and I believe that we must bring purchasing decisions closer to the real customer -- the patient.

The need to think about purchasing structures is crucial to the future development of the NHS. The NHS is all about purchasing priorities; it should be driven by the output requirements demanded by those it serves. It is not about the management of institutions or services, and it should not be driven by input rules. Only if we focus on outputs and remove the great swathe of central management interference will we free up providers to show what they can do in an open and competitive social marketplace.

The government budget is under strain. We face a situation in which there will have to be either a reduction in the quality and quantity of health services available to the public, or in the cost of those services to the taxpayer. The further development of the social market opens up the chance of cost containment through competition. But market management and intervention designed to blunt competition will deprive us of this possibility.

Changes in the healthcare market

By William Laing

Laing & Buisson

I would like to address three basic issues.

First, the private sector now has the capacity and the skills to deal with *all* elements of health care.

Secondly, little or no real competition yet exists between NHS and private providers in the delivery of NHS services. Whether it will exist in future is really a question of whether there will be the political will to carry through the NHS reforms to their logical conclusion.

Thirdly, there remains a major question mark over just how far NHS providers should be permitted to go in the supply of privately funded patient services.

Growth of independent healthcare

Up to the mid-1970s the private hospital sector was really very small and fragmented. Because of its vulnerability to the Labour Party's restrictive policy on private health care, it was quite difficult for the private health care companies to raise finance from the City. Apart from the charitable Nuffield chain and some large hospitals in metropolitan centres, the independent hospitals were mainly small and run by local charities or by religious institutions. Most of the work they did was confined to minor surgery.

The private hospital sector of that time met perhaps only half of the demand for private treatment -- the remaining half being provided in the NHS paybed sector. And most of the privately funded major surgery took place in NHS paybeds.

The late 1970s proved to be a watershed, with Barbara Castle attempting to eliminate private practice from the NHS during the labour administration of 1974-1979. Precisely because NHS paybed facilities were disappearing, capital from American and other sources was drawn into new investment in private hospital provision.

Investors were further encouraged by the increasing demand for private health care at the time, and the growing demand for private medical insurance, which continued into the Thatcher years. At the same time, the threat to the private healthcare sector was evaporating as the Tories won successive general elections.

By the election of 1992, investment and consolidation had transformed the private hospital section into what is now a mature industry in which the three largest chains now control about 51% of the market, which amounts to about £1100 million. As well as their bigger scale of operation, these independent hospital providers are now doing much more complex surgery than ever before. They have also reduced the NHS share of the private patient market to around 12% (though this trend may now be changing).

The net result is that private hospital operators are now serious players as potential providers of patient services for the NHS, either in competition with Trusts or indeed as partners in the establishment of new services. And the private sector is not confined to the hospital environment. It provides clinical diagnostic and pathology services, runs nursing agencies, and spreads into primary healthcare with GP deputising and other services at that level. Biggest of all, private involvement in the long term care sector is very large indeed, accounting for about £4000 million per year, two-thirds of which is publicly funded. The potential of the private sector as a competitor or a partner to NHS provision can no longer be ignored.

Competition with the NHS

Yet outside the long term care sector, the much-vaunted mixed economy in healthcare still does not really exist. As the NHS reforms were being put in place, there was a great sense of excitement among private healthcare providers, who were being told by everyone that a wide new market was about to open up. But in the event, the NHS market has proved to be just about as open to private providers as the Japanese market proved to be to western manufacturers. Apart from some specialist services like satellite communications, dialysis facilities and imaging services, a few extra-contractual referrals and a small amount of contracting-out by GP fundholders, private healthcare providers really have not yet managed to penetrate the market for NHS services in any significant way.

There have been three main reasons for this. First, the Treasury rules on capital projects have discouraged co-operation. Secondly, the purchasing function of the NHS remains underdeveloped.

Thirdly and most fundamental, clinical patient services are the core business of the NHS, but clinical services tend to be natural local monopolies. It would be a brave NHS management team which immediately contracted out these core services to private providers.

For this reason, the private sector's role in NHS clinical centres is unlikely to develop in the form of simple contracting out. It is more likely to develop gradually in the form of partnerships or joint ventures to provide new services or, or to replace existing services where the NHS is capital-poor or skill-poor and the private sector is capital-rich or skill-rich.

Falling barriers?

This is why the revision of the Treasury's rules on investment to private capital in this sector announced earlier this year is so important.

The first main change is an easing of the rules by which the use of private finance was rejected wherever the NHS could theoretically raise the money more cheaply. Since the government theoretically can always borrow more cheaply than the private sector, these rules blocked virtually every project, including those which never had any hope of actually being financed publicly.

The second big change is that the financial limit above which Treasury permission must be sought for capital projects has been raised considerably. This will considerably reduce the bureaucratic burden, although not entirely because there will still be quite an extensive sampling and monitoring procedure.

The changes to the Treasury rules may have removed at least some of the regulatory barriers to partnership initiatives; but the barriers posed by the fact that the purchasing function is underdeveloped still remain.

It is to be hoped that things will open up. NHS managers are still pretty wary about involving private providers in the delivery of core services; none of them ever lost his job by failing to do a deal with the private sector. Their nervousness may stay around for some time to come.

The provision of private services

For private providers, the NHS reforms are really a double-edged sword. It does raise the possibility of a massive new public sector market, but at the same time the new incentives for health authorities and Trusts to market their facilities to paying customers poses a real threat to private hospitals.

While the externalisation of the internal market has been proceeding rather slowly over the last couple of years, that is not true of the provision side. NHS investment in paybeds has gathered rapidly in pace, to the extent that we now have 54 NHS units designated for private patients.

There is no doubt at all that private patient services offer health authorities and Trusts much more scope for income generation than any other activity. Of course, the NHS share of private patient care is still much lower than in the 1970s, when it accounted for around 50% of the market. But it is going up. By 1991-1992, total NHS private patient care had reached £150 million, representing about 12.5% of the total market.

While it is hard to imagine the NHS recapturing half the private patient market, one can certainly foresee them taking quite a substantial chunk away from private hospitals.

Should we care about that? Certainly the private hospitals cannot complain about it in principle: they have to say that fair competition is a good thing, and to welcome it, albeit through gritted teeth.

But the worry is that few of us have any idea at all whether the NHS Trusts have taken sensible decisions about their investment in paybeds. Revenue figures of £150 million are really meaningless without knowing what the costs are and how much of a surplus, if any, is generated on the exercise.

The worry is underscored by the fact that the newly developed paybed units cluster in the range of 10-20 beds. Most people in the private hospital sector would say that private patient services could not run profitably on that scale, even if they are part of a larger hospital and can share overheads.

Investors in private hospitals need to be able to separate out the exact profitability of every part of their enterprise. You cannot extract anything like that at all from the accounts of NHS Trusts; without exception they are completely opaque on the matter. We are left totally ignorant about whether or not sensible investment decisions are being taken on the development of private patient services within the NHS.

It is not just a question of establishing a level playing field; or even of knowing which way the playing field slopes. It is a question of public and professional accountability over very large sums of taxpayers' money. At the very least, to quote the catchphrase of *Private Eye*, "We should be told."

Quality improvement and the demand for NHS services

By Elizabeth Hunter Johnston

Citizen's Charter Unit

The NHS has been through an enormous upheaval and I have great respect for what it has achieved. Within a very short period of time we have seen a massive organisation split into purchasers and providers, the establishment of self-governing Trusts, GPs managing their own budgets, and changes in the whole relationship between consultants and general practitioners.

Yet all that was done without patients noticing any real problems. NHS managers could teach a lot of people in private industry about how to manage change, and I respect their achievement.

But let us all remember that the object of all this change is to improve the quality of services for patients. I was involved in the assessment of three successive rounds of Trust applications, and one of the most important criteria we applied in deciding whether or not to recommend approval was the potential benefit to patients. In the first wave, there seemed to be little vision from the applicants on this point; more an assumption that patient benefits would, somehow, follow from the managerial changes that occupied so much of the applicants' attention at that stage.

By the time of the third wave, however, the prime focus had shifted. Now the applicants were emphasising how the proposed changes would actually affect patients, how new managerial freedoms could be used to benefit them. Instead of focusing on inputs, the NHS was at last beginning to focus on results -- on the quality of the service actually provided.

I want to examine five areas where, as a result of all the management changes, these quality issues are coming to the fore.

Purchasing

The development of purchasing lagged behind other areas of the NHS reforms. It was not given a high enough priority at first; the main concerns then were whether the new Trusts and the purchaser/provider split were going to work at all.

The assumption was that there was little difficulty in deciding what services needed to be

purchased, and from whom. Of course, that (as we now know) is not the case, and purchasing needs to develop. So it is very encouraging to hear the statements from the Department of Health that purchasing is to be given a much higher priority.

It was understandable that, with all the other changes they had to deal with, purchasers did not at first change their purchasing patterns very much. But circumstances have changed now, and today we do want to see people purchase more imaginatively.

A year or two ago it was dispiriting how little dynamic purchasing pressure was being put on the providers. Required standards were not being specified, little choice was being offered, purchasers were not shopping around very much.

One Trust I interviewed had a waiting list of about a year for prostate operations. Yet there was a large hospital a few miles away, offering the same quality of care, with no waiting list. I was told that patients would rather wait to have the operation locally; but actually I do not believe the choice was being presented to them in the right terms. I doubt that many well-informed patients would wait a year in discomfort, when by travelling a few miles to the nearest hospital they could have the necessary treatment at once.

How much are purchasers really monitoring what is provided in return for their expenditure? Again it is dispiriting when you see people waiting for long periods in outpatients' departments, for example. Patients and their relatives complain to each other about the poor service. But why is the purchaser not complaining to the provider? What kind of monitoring is going on? Who is setting down the acceptable standards and checking that they are actually achieved?

True, this sort of monitoring is beginning to happen and will happen more and more as purchasing becomes more dynamic, more choosy. As that happens the whole market will start to open up -- though it will bring with it some difficult decisions about the future of some providers.

Customer focus

We are also beginning to see a change to a more customer focused approach. The public services in this country have traditionally dealt with the recipients of their services in something of an adult-to-child relationship -- assuming that they know best what should be provided, rationing by queues, blaming their inadequacies on lack of taxpayer funds.

We have to change this into an adult-to-adult relationship. That can be quite painful for both sides: treating customers as adults sometimes involves exposing to them difficult decisions.

Take for example the argument last year about whether babies should be set to sleep on their backs or their fronts. For many years, we were told that putting babies on their fronts was safest; but then researchers into cot deaths began to suspect that the opposite was true.

Remarkably, there was much professional resistance against this suspicion being revealed to the public – on the grounds (a) that it would imply the NHS had got its advice wrong before, and (b) that no "official" view should be published until the outcome of the research was absolutely decided.

But this is not the way for a modern public service to treat its customers – as if only the experts could decide what was right for the rest of us because they alone understand the issues.

If we are to treat people as customers, then we have got to let them make up their own minds, and give them as much information as we can to help them do it. We have to tell people about their treatment, about the alternatives, about the comparative outcomes. We have to tell them about the waiting times, the different sorts of treatment, and the performance of different units. Of course the professionals must continue to deploy their professional skills, and to give patients the best advice. Of course we must not put out information which just confuses people. But we *must* provide more information.

Staff training

Of the principles of the Citizen's Charter -- standards, information, openness, choice, consultation, courtesy -- the one which often requires the greatest investment to achieve is that of courtesy and helpfulness. To ensure that staff have a courteous, helpful approach to customers can require an enormous investment in training and empowering the staff who actually deliver the service.

However much energy is expended on total quality management, it can be wasted if the face-to-face relationships of staff and customers are not right. One reason why many people go to private healthcare providers is that they are more certain of being treated as an individual rather than as a statistic; they are made to feel like a real person; they get respect and individual care from people who are also real, and whose names are given.

Most people who work in the NHS do so from idealistic motives; they do want to care for people. So it is a matter of harnessing that goodwill and giving the necessary training and encouragement and support to empower staff to take the decisions they need. We need to end the days of staff saying "It's not my job" and teach them instead how to say "I'll sort it out for you". That approach is much more rewarding for everyone. But it involves trusting staff and allowing them often to make decisions, even allowing them to take risks.

Accountability

There is a strong link between financial accountability and the improvement of service quality. If you get the delegation of financial responsibility right, then a lot of quality issues start to solve themselves.

I was in a hospital a while ago and I commented on how nice were the curtains between the beds. The Sister told me that she had been given a delegated budget and the first thing she did was go out and get some decent curtains. The cost was peanuts: but the effect on patient morale was enormous, as she knew it would be.

Yet I know of hospitals which want to spend millions on new capital projects, even though paint is peeling off the walls in the outpatients' department.

The secret lies in getting the money into the hands of those who are genuinely interested in the quality issues -- usually because they are nearest to the actual provision of services and nearest to the customers for those services. It was very exciting to see the development of Trusts because they had control of their own money, and started to use it more imaginatively and to delegate control right down to ward level. That is how to ensure that the budget starts to buy quality service.

Strong management

Much is said about the NHS being over-managed. It's a very strong perception: too many accountants and paper-pushers getting under the feet of our dedicated doctors.

The reality is quite opposite. I remember waiting to be discharged from a hospital because the doctor who was supposed to tell the patients they could go home spent most of the day on an ancient switchboard, trying to find out what had happened to an ultrasound scan that had gone missing because the filing system was unable to keep track of what was going on. So about ten people were going to be kept in overnight.

The unnecessary cost of all that was phenomenal; and it was the result of poor management and insufficient management.

So we need to develop a much crisper management if we are to improve the quality of services -- a management which is more demanding in its purchasing, more customer-orientated in its focus, which trains all staff to the highest levels of customer courtesy and helpfulness, and which is prepared to devolve financial control right down to those who are most concerned with the delivery of a quality service to the public.

