An NHS beyond the market

June 2010

STANDING UP FOR DOCTORS

BMA

An NHS Beyond the Market

A round-table discussion on alternatives to the NHS market hosted by the British Medical Association in association with the NHS Support Federation, the NHS Consultants Association and Keep Our NHS Public.

The four organisations had been concerned at the cost, inadequacy and distortions imposed by the quasi market structure of the NHS and sought the assistance of a selection of participants in a round-table discussion to explore areas of common ground for a fresh direction of travel for the NHS in England, bearing in mind the possibility of a new political administration, challenging economic circumstances and even a new public-service philosophy. The starting point for the discussion, which took place on 14 April 2010, was a series of position statements addressing issues under the headings of...

- **Funding and efficiency;**
- **Cohesion and fragmentation;**
- **Planning and commissioning services;**
- **Improving quality and handling choice.**

Participants in the round-table were:

Mr Malcolm Alexander	Chairman, National Association of LINks Members
Dr Kate Bullen	Deputy Chairman, British Medical Association
Dr Brian Fisher	GP, London
Dr Peter Fisher	NHS Consultants Association
Mr Mike Jackson	Unison
Prof Harry Keen CBE	NHS Support Federation
Mr John Lipetz	Keep Our NHS Public
Ms Ann Lloyd CBE	past CEO, NHS Wales
Dr Hamish Meldrum	Chairman, British Medical Association
Ms Katherine Murphy	Director, Patients Association
Dr Sally Ruane	Health Policy Research Unit, De Montfort University
Prof Sir Richard Thompson	Royal College of Physicians
Dr Jonathon Tomlinson	GP, London

The event was chaired by **Nicholas Timmins**, the public policy editor of the *Financial Times* and author of *The Five Giants: a biography of the welfare state.*

Discussion

The chair first invited the participants to consider a number of questions centred on the theme of **'Why is health different?'** and thus unsuited to a market approach. These questions included:

- Why is profit from health care provision wrong?
- Are GPs not private providers?
- Why now?
- What are the alternatives to a market?

Why is health different?

Participants considered that health care provision was indeed different from other goods and services being founded on principles of risk pooling, free access and comprehensive care based on need alone and, more recently, continuous quality improvement and the involvement of patients and the public in the development of NHS services. The programme of market-based NHS restructuring currently being pursued by government threatens to erode these principles and thereby drastically change the face of the NHS. The timing of any questioning of the direction of travel was important. The healthcare market in England was still relatively poorly established but in the current climate it was critical that service reconfigurations, including more general moves to 'care closer to home' and any specific proposals for hospital or accident and emergency closures, are driven by coherent, evidence-based planning to meet manifest need rather than the exigencies of competition. Patients and the public must be actively involved in formulating and reviewing any plans to reconfigure hospitals. The outcomes of a health care system should be measured by health gains and cost-effectiveness rather than financial profit. Profit-related drivers had the potential to undermine risk pooling and cross subsidy, the fundamental mechanisms of a rational service where health care is provided in response to need. A tax-funded health care system (and no party has currently dissented from this model) had an obligation to ensure that expenditure was aimed at providing and improving the quality of equitably provided health care and was not diluted by providing profit to shareholders. Participants agreed that cooperation and integration were wholly desirable alternatives to a competitive market and should be the key building blocks in the proposals which would emerge from the round-table discussions.

Funding and efficiency

The starting point was an NHS which should continue to be available on the basis of need, free at the point of use and funded from tax revenues. Participants endorsed distributional arrangements based on equality of access to those in equal need and hence weighted capitation funding for health economies, however they were defined. Thus funding should be allocated on the basis of need and not activity. The present allocation formulae were not wholly fit for purpose and should be re-examined. They did not for example encourage the identification and pursuit of unmet need. Furthermore, the present funding arrangements had to accommodate high transaction costs.

The cost of the market

Participants were conscious of the financial position in which the NHS was likely to find itself during the next few years. It was agreed that experience elsewhere had demonstrated that abandoning the competitive market and purchaser-provider split would not require costly and disruptive reorganisations. Indeed it was likely to generate substantial savings. Such a change could initially involve modifying existing structures. Pro tem, the commissioning function of the PCT would be seen as locality planning function on the basis of more inclusive and collaborative relationships, and in the context of a more democratically accountable structure.

One of the more costly consequences of the introduction of competition into the NHS has been the arrival and growth of transaction costs. An alternative formulation would seek their dramatic reduction. The replacement of contracts with service level agreements would be the basis for service integration. These agreements could involve block funding with some adjustment for volume, incentives, particularly quality enhancement (see below) and cross-boundary activity or could be payments per specialty/care path way to ensure that there is effectiveness in care delivery and that incentives are built in to modernise the services. Either way, it would obviate the need for the current volume of transactions. Such agreements would also reduce management costs although the participants were agreed that management as such was undeserving of the pariah status it currently enjoyed. It is the management functions associated with the competitive market which represent unnecessary costs and sometimes introduce perverse clinical pressures. Properly used, the management function could drive improved efficiency and quality. The leading involvement of clinicians in management was essential in this context as was the participation of patients and the public in the assessment of effectiveness of services and as partners in service development. Investment in the education and development of the staff required to deliver effective modern health care cannot be ignored.

Cohesion and fragmentation

Cohesion was identified as critical to the future success of the NHS and to health economies within it, involving reassessment and new regard for:

- **Integration of services at various levels within and outside the health economy with a focus on the individual patient;**
- **Collaboration between providers across disciplinary and administrative boundaries;**
- **The development of clinical pathways and partnerships designed to maximise health gain; and,**
- **Incentivising all the above by the creative use of policy and financial levers.**
- **The involvement of patients and the public in helping to maintain and build confidence in the NHS during times when it is a risk of fragmentation.**

Cooperation not competition

Some participants had practical experience of integrated clinical programmes involving cooperation between secondary and primary care providers. They spoke about the benefits of such working and the need for the health service to facilitate greater collaborative working and innovation and to explore new health care initiatives. The present arrangements discouraged these programmes since the national tariff was based upon narrowly defined episodes of care with a common price attached in the interests of stimulating competition. Fee for service (Payment by Results) can impede patient pathways and generate perverse incentives in patient referrals.

Management of future demand for NHS services and the effective promotion of healthy living requires a greater emphasis upon wider social policies aimed at preventing illness. This should include some kind of "health in all policies" approach.

Planning and funding services

Planning of service provision and provider configuration should be at the most local level consistent with quality, economies of scale and principles of good governance and would as appropriate align with other services such as social care. Localism would, of necessity, involve some variation in the configuration and supply of services and this would need to be carefully managed to avoid gaming as well as to prevent the emergence of postcode lotteries.
A significant degree of autonomy should be granted to local health economies to determine the priority to be attached to services and these priorities must be determined through partnerships between patients, the public, and service planners. Patients, however, would expect that the vast majority of services currently on offer to be provided in all areas to the same specification and quality.

A responsive NHS

Improving quality and handling choice

Patients are sometimes a vulnerable sub set of the population, but because of their experience of front-line services can be very effective at making healthcare choices. To date, 'patient choice' has been insufficiently informed by adequate data and consequently has only operated on a limited basis. There is a distinction between patient choice as a lever to make providers more responsive and as the developed capacity of individuals to make informed decisions for their own care. Unfettered patient choice is inconsistent with localism, social solidarity, particularly when localism is combined with democratic accountability, and the efficient use of resources. Indeed, patient choice, as it has so far been conceived, is not what most patients want. Collective choice around patient pathways and local configurations should replace aggregated consumer choice. Policies should aim to deepen patient-professional trust and effective co-production and shared decision making, not undermine them. Policy advice should be evidence-based and its sources transparent.

Patients, populations and health professionals should be actively involved in decision-making processes involving changes and reconfigurations in the NHS. This should be achieved by making the NHS more transparent and democratic at every level and providing the educational resources to permit this. There should be further genuine devolution of decision making to the local level but in the context of local arrangements which permit effective democratic engagement, including an elected element. The market turns citizens into consumers whereas the NHS is a model where risk is shared in an effort to address society's health needs. The precise form of this involvement needs to be determined but the preference is for using the existing structures where possible to avoid costly and demoralising reorganisations.

What are the alternatives to a market?

Conclusion

The model for an improved and responsive NHS which emerges from this **'Beyond the Market'** discussion is one where nationally agreed levels of funding and standards and professionally formulated policies on prevention, diagnosis and treatment sit alongside a democratically accountable *local* approach to healthcare delivery; one in which local priorities are determined within a national framework and with input from local populations; one in which necessarily limited funds are distributed in accordance with population need and where these funds are used to encourage providers to cooperate with one another and with the public and to integrate services in the interest of both efficiency and better individual and community health.

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