

Fatally flawed

Yes to the NHS Internal Market – No to the External Market

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Introduction

Prior to the 2010 General Election David Cameron, who was to become the new Prime Minister in the Conservative-Liberal Democrat Coalition, had brilliantly defused the NHS as an issue which traditionally had won votes for Labour and lost votes for the Conservatives.

No-one could have been under any illusion that David Cameron had deliberately foresworn the top-down NHS reforms associated with Tony Blair's second and third terms, which crucially had been accompanied by a substantial increase in expenditure on the NHS, which had oiled the wheels of change and softened the impact of reform. Many NHS workers were wooed by Cameron's obvious emotional commitment to the NHS care his son had received. They felt their work would be recognised. Also, the Liberal Democrats who had all through the 1980s and 1990s been very reluctant to even endorse the internal market would, it was felt, act as protectors of the NHS in the Coalition. Yet, despite this, the Coalition unexpectedly and inexplicably, forged ahead with legislation for NHS reforms of staggering ineptitude. The Health and Social Care Bill rushed forward is not just massive, running to 353 pages, but challenges vital aspects and principles of the NHS. It is necessary to clarify those principles and make a distinction of an internal market in the NHS, which is essential, and an external market, which is destructive.

History

It is important to state at the outset that the NHS, like most institutions in the United Kingdom, evolved. In 1911 David Lloyd George, as Chancellor of the Exchequer, brought forward the legislation to introduce national insurance, and for the next 35 years the issues surrounding insurance-based health care dominated public and parliamentary debate on welfare reform. The exclusions from insurance cover, the two classes of patients: those on the “panel” and those who paid for private health dominated the debate until 1920, when the Minister of Health’s Consultative Council on Medical and Allied Services produced the Dawson Report which, against conventional wisdom, asserted that *“the best means of maintaining health and curing disease should be made available to all citizens”*. In 1926 the Royal Commission on National Health Insurance argued for *“divorcing the medical service entirely from the insurance system”* and supporting it from *“the general public funds”*.

In March 1943 Ernest Brown, then Minister of Health in the wartime coalition, presented proposals to Parliament for a unified health care system based on large local government areas, which was opposed by many in the medical profession. In February 1944 the new Minister of Health, Sir Henry Willink, presented a somewhat different White Paper, which he then modified before the General Election in 1945. In March 1946 *“The National Health Service Bill; Summary of the Proposed New Service”* was presented to Parliament, and after a long battle, including a British Medical Association (BMA) revolt, and after some crucial compromises, on 5th July 1948 the NHS came into existence.

In 2010, sixty-two years later, because of a steady process of evolution and despite many changes, the NHS is still recognisably the same entity as that introduced by the Attlee government, having survived the Thatcher government relatively unscathed, and also the pay bed controversy from 1974-76 under Barbara Castle as Secretary of State for Health and Social Security.

In 1976 after two years as Minister of Health under Barbara Castle I published a book: *"In Sickness and in Health"* which argued: *"the medical profession clearly does make economic decisions. It is not only this that should be more openly recognised, but also the considerable size of the resources influenced by doctors' decisions"* (Owen, 1976: 81). We also sought to try and reduce inequalities in the allocation of resources to Regional Health Authorities; introduced the Resource Allocation Working Party (RAWP) and focused on "Cinderella" areas like mental illness. But the really significant change was that I began to openly talk about a rationed health service. Firstly because I believed then and believe even more today that it is a fact and also inevitable. But secondly I believed that unless politicians admitted this to the health professions, who knew this, they would find it hard to accept political reforms of the NHS, in that they would suspect the reforms were merely attempts to disguise this reality.

The professions have become, not unreasonably, a little tired of politicians boasting about the NHS being the best in the world while not recognising areas in which it was falling down and the financial pressure working against maintaining high standards of care and striving for excellence.

What I hoped for was continued evolution in the NHS for I was, and remain, a believer in reform to keep pace with the radical changes in the provision of health care, and the ageing population which is in large part due to these advances.

Starting an NHS Internal Market

The concept of an internal market in the NHS started in the early 1980s with the writings of Professor Alain Enthoven of the Stanford School of Business in California, which I described in *“Our NHS”* (1988:102-108). His ideas were adopted by the Social Democratic Party, (SDP), and were then criticised from within the government during 1986 by the Health Service Management Board. An exchange in December 1987 of minutes between officials had one writing: *“I am still doubtful whether an Enthoven-style model would give sufficient voice to the consumer – the patient”*. (Edwards and Fall, 2005:57)

The SDP saw the Enthoven model as a means to improve quality in the NHS, and ensure that the whole population benefitted from more efficient and cost-effective NHS care. Under later SDP proposals District Health Authorities (DHAs) were to be *“free to contract with other DHAs and with the private and voluntary sectors”* (SDP, 1988:14-15) in order to meet their obligations, but it was implicit in this that the NHS would be the main provider of care, with contestability where NHS provision was failing patients.

On 28 January 1988 after winning a third General Election, during which the NHS had largely escaped from the Conservatives’ radical reform programme elsewhere, the Prime Minister Margaret Thatcher set up a small ministerial group under her chairmanship to review the NHS. The members were the Chancellor of the Exchequer, Nigel Lawson, and his number two, John Major, and the Secretary of State for Health and Social Security, John Moore, and his number two Tony Newton. Moore and Newton were both later replaced by Ken Clarke and David Mellor when Health was split off from Social Security. The five met every week and more frequently just before the publication of the January 1989 White Paper *“Working for Patients”*. This paper marked the official start of the internal market within the NHS.

in his autobiography Nigel Lawson describes the discussions on the ministerial committee and makes clear why their conclusions did not embrace privatisation. Coming from a self-confessed 'arch promoter of privatisation' he writes *"the provision of medical care is sui generis, and should not be assimilated to other activities where full-blooded privatization is entirely appropriate."* (Lawson, 1992:615)

Lawson here established a clear demarcation line. He went on to develop some guidelines about the economics of health care. *"Simply stated, the demand for health care exceeds the supply; and that is inevitable in the public sector with a free service financed out of general taxation, which means that demand is virtually unlimited-hence the persistence of waiting lists"*. (ibid:616). He also tried to draw another clear demarcation, arguing against making all personal subscriptions to BUPA and similar private health insurance schemes tax deductible. If we simply boost demand, he claimed, for example by tax concessions to the private sector, without improving supply, the result would not be so much a growth in private health care, but higher prices. The key for him was in the supply side. His concession of providing tax relief on personal private medical insurance premiums, but limiting this to the over-sixties, had been wrung out of him by Thatcher, but was abolished by Labour in 1997. It seems now to have become an established demarcation line across all the political parties.

I believe the internal market has been an essential reform for the NHS. Following on from the introduction of general management during the 1980s under Norman Fowler, a sense was created that a degree of separation between purchasers and providers was an effective way of bringing into the NHS more market disciplines and was seen rightly as fully compatible with its founding principles.

The idea that GPs might hold budgets for patient care emerged during the 1980s, led in the UK by academics including Alan Maynard and Marshall Marinker, and was taken up by Kenneth Clarke during the 1989 NHS review that led to *“Working for Patients”*. GP fundholding was rolled out by John Major’s government. It had the value of making those GPs who chose to involve themselves far more aware of the costs associated with the allocation of resources, but it blurred the line between purchasers and providers, particularly as fundholding practices undertook an increasing range of services in-house during the 1990s. But this was not always a bad thing, and was an inevitable consequence of involving GPs.

The continued popularity across the political spectrum of systems of GP budget-holding suggests that it is a worthwhile strategy, and if well-conceived, compatible with a pragmatic internal market. It does present a model of integrated health management that bears some resemblance to successful health maintenance organisation (HMO) setups elsewhere, not least the oft-cited model embodied in Kaiser Permanente, America’s largest not-for-profit healthcare organisation, which combines both the commissioning and provision of care for more than 8 million subscribers.(Feecham, 19 Jan 2002).

The agglomeration of large groups of GP practices into multifunds, usually in the major cities, bringing many small GP practices together into fundholding, and the later development of Total Purchasing Pilots for the largest fundholding groups to commission the full range of care, rather than the limited range available to most fundholding GPs, never really came to prove their worth as they came very late in the Conservatives’ final term of office. Following Labour’s election in 1997, despite a commitment to destroy the internal market in general, it survived, but GP fundholding did not. Nevertheless, Labour’s system of “Practice-Based Commissioning” bore some similarities with the earlier system.

In the 1990s the NHS was unwilling or unable to invest in information systems, and the practice of adjusting prices for the different intensities of care within a single diagnosis, known as “casemix”, was in its infancy. This made quality measurement difficult, except for the crude mortality and waiting time statistics incorporated into the Patient’s Charter.

Building an Internal Market: Labour

Having won the General Election in 1997, the incoming Labour Government kept their promise and accepted the previous Conservative Government's public expenditure forward plans. The new Government only in its second term, after the 2001 General Election, turned to the very necessary policy of increased spending, following Chancellor Gordon Brown's review of health spending conducted by Derek Wanless. It also began to develop a more market-based agenda.

In opposition Labour had attacked the Conservative Private Finance Initiative (PFI) for hospital redevelopment, but went on to adopt the approach with extraordinary vigour for capital projects, even though they would place significant financial burdens on local health systems in order to meet the long-run operating costs and interest payments of the new facilities (Pollock, 2011).

Labour created more than 300 primary care trusts (PCTs), reverting to a smaller number as problems arose, with PCTs merging in order to confront budget deficits. Eventually there were 151 PCTs, similar to the number of health authorities that existed prior to Labour coming to power in 1997. Central control remained strong, with a steady flow of instructions to PCTs from the NHS Executive.

In a friendly, but critical, assessment of Labour's health spending record a recent book *"The Verdict: Did Labour change Britain?"* says:

"The 2001 increase in National Insurance pegged explicitly to increased health spending said: better services cost more. The increase was popular".

"NHS spending was a Labour triumph, but with it came a fixation on the minutiae of healthcare, not just organizations and management, but operations, clinical practice and recovery rates

“As in schooling, Labour ministers sitting in Whitehall could not stop themselves tinkering. Plans, reforms, edicts and reorganisations spewed out. In Scotland and Wales their absence showed how little Labour meddling mattered to patients. What mattered was more money.” (Toynbee and Walker, 2010:44-45)

A 2008 Nuffield Trust study said that:

“no-one could justifiably deny the past decade has seen an improvement in quality in the NHS”, but added that:

“given the generous increase in resources dedicated to healthcare there are many who question whether progress has been as marked, as rapid, or as predictable as might have been expected”. (Leatherman and Sutherland, 2008:3)

“The Verdict” blames the fact that the rate of progress fell behind the rate of spending upon the endless cycle of reform under Tony Blair and his pro-market health ministers:

“They spent so much time and goodwill chopping and churning, refusing to admit a redoubtable truth. The NHS, big, baggy and shot through with anomalies, worked pretty well. What the anorexic patient they inherited in 1997 needed most was fattening up. Force-feeding was the wrong therapy”

quoting the former social services chief and former Labour health minister, Lord Norman Warner, as saying that the NHS probably received too much, too quickly (op cit, 2010:45).

Using the NHS budget alone to tackle inequalities is a strategy that is doomed to fail given that the causes of health disparities range well beyond the scope of just health services. It also has damaging consequences for NHS patient care, because of the diversion of funds that is not justified by results.

Nevertheless *“The Verdict”* concludes that:

“After thirteen years the UK was in better health, even if the exact part played by government policies was debatable. The death rate fell by 17 per cent. Life expectancy continued its remarkable ascent. For every 100,000 of those aged under seventy-five, circulatory disease accounted for 129 deaths in 1998, but only 74 in 2007, exceeding the target Labour set themselves. Wonder drugs, such as statins, played their part, but how people ate, drank and exercised was critical”...“But the gap in life expectancy between men in poorest areas and the average grew by 2 per cent. For women the gap was worse; it widened by 11 per cent from 1997. Death rates remained lowest in the better-off South East, worst in the North West.”(op cit:49)

The Independent Sector Treatment Centres (ISTCs), which were brought in on a standard national contract from 2003 to tackle NHS waiting lists appear to have achieved their short-term goals, albeit at considerable expense. Some commentators have argued that the ISTCs were brought in also to serve a strategic role as: *“a crucial step in the replacement of the NHS as an integrated public service by a healthcare market, in which private providers will play a steadily increasing role.”(Player and Leys, 2008:71)*

Recent questioning by a Liberal Democrat MP, however, revealed that the use of pre-paid contracts for private providers meant that many were overpaid when treatment volumes were lower than expected(Martin, 10 Mar 2011), as a result of Patricia Hewitt’s determination that ISTCs should not bear all of the risk if NHS patients should choose not to use them to the expected extent.

Another problem is that there is evidence to suggest that healthcare lends itself to large-scale provision at the local level. More competition and patient choice do not of themselves deliver high quality and efficient services, compared to policies that provide payors with choices between

providers, rather than providing these choices directly to patients (Propper, 2010:22). The truth is that there is a trade-off which necessitates experienced managers making difficult decisions.

A problem with Labour's record and NHS policy lies in confused ambitions on the achievement of equity. The pursuit of more equal outcomes, through a range of expensive initiatives and changes to the NHS resource allocation system took place while health inequalities widened.

Near the end of Labour's period Andy Burnham, the Secretary of State for Health, rejected the "Any Willing Provider" model for NHS care, saying that for Labour the NHS was "*the preferred provider*" and the consequences of that decision were to check the previous inevitability of EU competition policy intruding on the NHS.

The External Market:

Conservative-Liberal Democrat Coalition

The 2010 Coalition Agreement on health decided to change Labour's caveat of the preferred provider being the NHS and said they would reinstate *"the power to choose any willing provider that meets NHS standards, within NHS prices"*. (HMG, May 2010)

The Health and Social Care Bill in 2011 also makes major changes to PCTs. Dr Sarah Wollaston, a newly-elected Conservative MP and herself a GP, suggested it; *"looks like someone has tossed a grenade into the PCTs"* (Beckford, 17 Jan 2011). **In addition to the active promotion and enforcement of an NHS free-market in the supply of healthcare, the Bill actually suggests that providers would be able to undercut applicable NHS Tariff prices, thus bringing price competition into the core of our health system.**

This wording in the Bill on price competition will have to be clearly amended, at Report Stage either in the House of Commons or in the Lords, to guarantee that the reprieve from price competition announced first in January by the NHS Chief Executive, and future Chief Executive of the new NHS Commissioning Board, is firmly established. Only subsequently was the decision reinforced by Ministers. There must be no equivocation on this matter.

Prior to the General Election the Conservatives had earned support in the NHS community for their promises to abolish the "target culture" and to avoid further disruptive "top down restructuring". Targets had been used very widely as a control mechanism under Labour, and a shift to a more advisory use for them would better balance clinical responsibility with transparency in NHS performance,

The 2010 Coalition Agreement also stated categorically that: *“We will stop the top-down reorganizations of the NHS that have got in the way of patient care”* (HMG, May 2010). The small print, however, suggested otherwise. When the coalition talks of cutting quangos, centrally-dictated closures, and developing Monitor into an economic regulator it is, in fact, promising a dramatic reorganisation of NHS structures. But the Coalition Agreement envisages a continued role for PCTs, whilst GPs would take on commissioning, with direct elections to their boards.

Within months the Government set out plans for PCTs to be abolished (DoH, July 2010). As a consequence the NHS was immediately destabilised and PCT managers, particularly the good ones, began to leave. The incoherence of the proposals also shocked many fair-minded people in the NHS, sensing that integration was going out through the window, with fragmentation and discontinuity of care coming in. They began to look for the exit door. By February 2011 some 25 per cent of PCTs had been disbanded, and a shadow National NHS Commissioning Board is to be in place by April, before the Bill has reached the Report Stage in the House of Commons.

For all its length the Bill offers few insights into the purpose of the future NHS. The size of so-called GP commissioning consortia, which is a crucial question, looks set to vary widely, at least in the early stages before the NHS tendency to recentralise in difficult times next takes effect. Amongst the initial “pathfinder consortia” sizes range from 3 practices to 105 and from patient populations of 19,000 to more than 600,000 (DoH, 9 December 2010). Some seem far too small to allow rational decisions to be taken, to produce an effective pattern of healthcare. Such commissioning decisions need to be taken in quite large units, for decisionmaking on facilities such as maternity, A&E units, and stroke units. For many GPs the responsibilities being thrust upon them will be entirely new, and for a large number they will also be unwelcome.

Some will lack the skills, knowledge and experience to fulfill their new roles effectively.

In current discussions of the new system a large proportion of GPs are reported to be silent and, perhaps, bewildered, by the changes. A small number of activists are very vocal: Some driven by concerns for the future of local health needs, others by the opportunities for their own managerial autonomy and authority, and others for the financial advantage that they might gain. One GP, for example, reportedly told an NHS provider: *“I’ll commission as little as possible from you, as every penny in your pocket is a penny out of mine”*, He was told that this was: *“not a great basis for commissioning health care”*.

Many in the NHS already expect the smaller consortia to be combined into bigger units, although this may take some time and involve ongoing disruption. Even Andrew Lansley, the Health Secretary, has now started to use the term *“clinical commissioning”* rather than GP commissioning; something which the Royal College of Physicians and the Academy of Medical Royal Colleges have been pressing for, and which will hopefully herald the appointment of hospital consultants as well, and public health doctors, not just GPs. The Academy argued that: *“This wider involvement will produce more informed and co-ordinated commissioning and better services for patients”* (AMRC, 2011). This could ensure that the new consortia do not simply inherit the weakness in clinical leadership and engagement that puts many current PCTs in a poor position relative to many NHS providers (Nuffield, 2011). For all the upheaval, however, most of the “GP” consortia will bear remarkable similarities to the old PCTs, with little real patient choice between local practices.

Throughout the Bill there is wording which allows for an abdication of the Secretary of State’s responsibilities for NHS money, with an appointed NHS Commissioning Board having the vital task of resource allocation.

We were promised by the Conservatives a “*bonfire of the quangos*”. In a recent article in the Daily Telegraph Sarah Wollaston MP wrote:

“It is one thing to rapidly dismantle the entire middle layer of NHS management but it is completely unrealistic to assume that this vast organisation can be managed by a Commissioning Board in London with nothing in between it and several hundred inexperienced commissioning consortia.”(Kite, 2011)

As far as hospitals are concerned, on the face of it, it seems to me to make sense to move more steadily towards all hospitals in the NHS becoming Foundation Trusts. This can only be done if there is a substantial reconfiguration of hospitals, and at a time of great financial stringency not all necessary reconfigurations, particularly those requiring rebuilding, can be undertaken. A sign of the incoherence of the present health ministers’ proposals was their refusal to give the go-ahead to the reconfiguration for three hospitals in North London: Barnet, Chase Farm, and North Middlesex. For years health ministers in all political parties have shown great reluctance to close any hospital in the face of local opposition. But over Chase Farm there has been strong and committed NHS leadership that deserved to be supported by Andrew Lansley. This decision does not give the sense of strong governance for the future; more reminiscent of ministerial buck-passing, but this time in a structural way.

The unlimited rise of competition and free choice will also make the task of achieving integrated care even more difficult. The Academy of Medical Royal Colleges has expressed: “*serious concerns about possible risks to coherent, equitable healthcare*” under the Any Willing Provider model (op cit, 2011). Whilst ministers and the NHS Commissioning Board might try to encourage co-operation, the demands of the marketplace and the threat of competition complaints will make the commissioners of care cautious in the discussions that might take place in GP conversations with hospital consultants and social care providers.

The Bill and its proponents fail to make clear the consequences of delegated decisionmaking, even within the broad confines of the NHS Constitution and continued funding from general taxation, the NHS in England as we currently know it will, under this Bill, no longer maintain or even expect to provide a uniform national service. Yet a uniform service looks set to remain in Scotland, Wales and Northern Ireland. Local services will become very visibly different, as commissioning consortia pursue different strategies and local provider markets develop.

The NHS Tariff now covers about 60 percent of NHS services, so that prices for the remainder are still subject to negotiation between purchasers and providers, providing flexibility for specialised and new services. The Tariff remains largely an activity-based payment system, however, so that the overarching policy of “Payment by Results” remains little more than an aspiration rather than description of the current system. Indeed, the Tariff has been used by ministers to manage activity levels. In 2010 the Department of Health introduced a punitive system of paying only a “marginal price” of 30 percent of the Tariff price to providers who exceed agreed levels of emergency admissions, which were set back at 2008 levels.

Sue Slipman, representing Foundation Trusts, argued that the Government was using the Tariff to put *“all the risks on providers”*.(Shifrin, 25 Feb 2010). Yet in 2011 the Department once again retained the 2008 baseline level for emergency admissions, introduced across-the-board price cuts, and introduced a *“new flexibility”* for providers to undercut the Tariff, which would therefore become a maximum price (DoH, 15 Dec 2010:54), paving the way for price competition, which they now deny they will introduce.

The Tariff provides a mechanism for command-and-control from Whitehall, whilst also subjecting the NHS locally to the rigours of the free

market. A combination that could put the NHS in the worst of all worlds. Despite assurances from the new Chairman of the NHS Commissioning Board, Sir David Nicholson, that the Bill does not herald price competition in the NHS, the new Chairman of Monitor, which is set to become the economic regulator for NHS-funded services, argues that *“over time there will be areas where it is useful”* and that it would slowly be introduced into the NHS (Ireland, 3 Mar 2011).

Just prior to the 2010 General Election the debate over the limits on the application of free-market practices in NHS-funded care came to the fore. Reported spending on NHS-funded care in the private sector had risen dramatically from less than £50m in 2007 to around £500m in 2010 (CCP, 24 Feb 2011: Fig1 p7). For some the boundary between a largely internal market and a full-blown external market had already been crossed. They were aware of, and indeed welcomed, the encroachment of competition law into NHS care, as the commercialisation of the health system progressed (Timmins, 16 Jan 2007).

The formation of an NHS European Office to deal, in part, with European competition law issues affecting NHS organisations should have been a warning sign. Labour’s Secretary of State for Health Andy Burnham’s 2009 rejection of “Any Willing Provider” brought at least one competition complaint to an abrupt end.

Putting the NHS under European Law*

The present Conservative parliamentary party has rejected practically every new intrusion of the EU into the domestic affairs of this country. Yet, amazingly, it seems happy for this to happen in the NHS. This is despite categoric assurances in the 1970s during the public debate about taking us into the “Common Market”, later called the “Single Market” that the NHS was exempt.

The Government’s plans include the imposition of a pro-competition regime similar to those applied to the privatised utilities, to support the policy of “any willing provider”. This should represent another defining limit for the NHS. The public are not content that the English NHS should become a commercial utility, and health care become a commodity subject to market forces and disciplines. Nor will they appreciate Monitor, becoming the sector’s economic regulator, charged with the promotion of competition while the Secretary of State for Health opts out.

Both the present Presidents of the Royal College of Surgeons and Physicians suggested limiting the powers of Monitor to encourage

Restrictive Agreements

- Treaty on Functioning of European Union Art 101
- Competition Act 1998

Agreements between undertakings... which have as their object or effect the prevention, restriction or distortion of competition are prohibited

competition, in their cases put before the Committee of the House of Lords chaired by Lord Bernie Ribeiro, a past President of the Royal College of Surgeons.

Simon Burns, the Minister responsible for the Bill, told the Commons Public Bill Committee that the GP commissioning consortia would not constitute economic “undertakings” (which would place them under

* The text in boxes is adapted from a presentation by Runella Reumerman to a House of Lords seminar on 17 March 2011

competition law) in their commissioning role, although they would continue to fall into this legal definition “*when competing for services as providers*”.(Commons, 15 Mar 2011:Col 766) . The Minister also claimed that competition law would not prevent vertical integration or an expansion in a provider’s range of services, and that competition and choice “*would strengthen incentives for providers to work together in integrating services. (ibid)*

The test of whether an entity is an “*undertaking*” for competition purposes is whether it is engaged in an “*economic activity*” and whether it performs an exclusively social function based on the principle of national solidarity. As commissioning consortia develop using the autonomy available to them under the Bill, it is by no means clear that they would benefit from exemption from competition law. In the 2002 *BetterCare* case¹ the UK Competition Appeal Tribunal rejected the argument that the local health and social services trust did not constitute an undertaking simply because it was carrying out a social function in purchasing care for the disadvantaged.

Restrictive Agreements in the NHS

Undertakings engaged in offering goods or services for sale on a market

- GPs and independent providers may undertakings
- Foundation Trusts probably already undertakings in some activities

Enforced by Office of Fair Trading and the Courts. NHS Cooperation and Competition Panel deploys similar powers in NHS. Monitor will have concurrent powers with OFT

The Tribunal argued that the trust was using “*business methods*” in its contracting. Academics claim that this decision:

“suggested that European competition law will apply to an

entity that participates in markets, even if the purpose is a social one, and even if the market is highly regulated.”(Mossialos, 2010:321-322) The situation was later complicated by the Office of Fair Trading (OFT) which then decided that competition law had not, in fact, been breached

¹ *BetterCare Ltd v Director General of Fair Trading* [2002]

because the discriminatory prices involved had been set by central government, which was not an undertaking given its exclusively social functions. This must heighten the importance of the new freedoms being offered to English commissioning consortia in terms of pricing outside of the NHS Tariff. Similarly, the mixed role of consortia as both purchasers and providers of services would fall foul of the OFT's 2004 clarification on the application of competition law to public bodies, in which it said that it would drop cases against such bodies engaged only in purchasing and not the provision of goods and services in a particular market.(OFT, 2004).

If commercial enterprises are involved in a health system this heightens

<p>NHS Procurement</p> <p>Rules apply to contracting authorities:</p> <ul style="list-style-type: none"> ▪ European directives ▪ Public Contracts Regulations 2006 <ul style="list-style-type: none"> ○ Part B (light regime) for healthcare <p>NHS Cooperation and Competition Panel currently enforces “Principles & Rules of Cooperation & Competition”</p>	<p>the possibility that competition law will apply. This has been raised in the context of competing sickness funds within the Netherlands social</p>
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the possibility that competition law will apply. This has been raised in the context of competing sickness funds within the Netherlands social

insurance system. The European Health Management Association has expressed concerns that the threat of the application of competition laws may limit healthcare reform across Europe(Saltman et al., 2002:pp44-45).

It has been stated that:

If a Member State chooses to operate a health service predominantly on the basis of social solidarity, decisions of the bodies comprising it will not be covered by competition law. If, however, a Member State decides to introduce competition – for example, by contracting services out to competing suppliers of health care provision or by creating a competitive internal market – then competition law will apply, as the various bodies involved will be acting as undertakings”.(Mossialos, 2010).

This does not, however, preclude the Article 86(2) exemption for services of “general economic interest” which has been used to defend socialised ambulance services against competition complaints from private competitors, in view of the real risk that the private providers would ‘cream skim’ the market and not provide a universal service. This exemption was highlighted in Article 16 of the Amsterdam EC Treaty, which signaled that services of general economic interest should be free to “*fulfill their missions*” if competition law would otherwise prevent this. (ibid: 326-7).

New Regulations for GP Consortia

- Good Procurement Practice
 - Competitive tendering
 - Managing anticipated conflicts
- Protect & Promote Patient Choices
- Promote competition in service provision

Powers of Monitor may include

- Investigate complaints & deal with breaches
- Directions to put services to tender

Decisions could lead to damages action in courts

The OFT has summarised the current situation saying that NHS entities are unlikely to be considered to be engaged in economic activity if they provide universal or compulsory services; with the same benefits for all regardless of contributions; and operate with a redistribution mechanism between the relevant entities in order to remedy financial disparities.(OFT, undated)

Competition law is complex and, to a degree, unpredictable in its application as case law develops. Whatever ministers may assert to the contrary, the continued rise of competition and choice in the NHS will inevitably be matched by a rise in legal conflicts, and litigation costs for the NHS. European competition law already impacts to some extent upon the NHS providers, in their private sector activities, and as NHS and independent providers begin to compete more actively for NHS “business” competition rules may become directly applicable. Giving Monitor concurrent powers with the OFT will also blur the distinction between the enforcement of NHS competition rules and the enforcement

of UK and European competition law, which are currently the respective responsibilities of the CCP and OFT.

When Britain joined the European Community it was always envisaged that our health service would remain outside the scope of European law. This principle has, over time been eroded despite attempts in recent Treaty revisions to clarify and restate Member States' competence in this area. In part this has been due to the European institutions' desire to extend its own competence. We have seen this in the very damaging effect of the Working Time Directive on the hours of work of health professionals who have hitherto been willing to accept longer working hours. But it has also been due to the gradual commodification of European health systems since the 1980s. Unlike the French, who resisted EU competition law affecting their railway system, the UK has increasingly shown no such willingness to resist the EU coming into our NHS.

What needs to be established by careful amendment to the Bill is that NHS commissioning services will be exempt from competition law, given that they will be fulfilling a statutory social mission and not acting as economic “undertakings”. Another difficult issue not really dealt with in the Bill is how to deal with the undoubted conflicts of interest for GPs fulfilling both their commissioning and providing roles.

What is Health?

Health is in a different category to Wealth. It is an existential category. Management talk from a former Secretary of State for Health, Patricia Hewitt, of making health professionals "*fit for purpose*" presupposes a knowledge of what individual health care outcomes are likely. Prediction is very inaccurate in advance of the initial consultation and the process that follows. Members of the health professions can and should use all the techniques available to improve the management and the cost effectiveness of publicly provided health care. However within that context there are many uncertainties.

The two values that health and social care professionals have to negotiate are; on the one hand that they must be advocates of their patients health and welfare. In effect the relationship with an individual and their individual needs is a primary value; on the other hand they are applied scientists and science always applies to groups, not individuals. Medical science is therefore not individualised. Yet public health and the fair distribution of finite resources is also a primary value. The two values, the primacy of the individual relationship and the primacy of the group good can be incomparable and they can conflict. Health professionals within the NHS have to negotiate their way through these conundrums and in doing so retain the trust of the public.

The patient-doctor, patient-nurse relationship is personal, intimate and largely unquantifiable. The internal market is a device that can create a climate helpful to managing the NHS, and in general it has done so, but the moment the patient believes that the decisions of doctors and nurses are taken on cost grounds as the result of competitive trading the relationship of trust will alter. Politicians, in attempting to cross over into an external market for health, as this Health and Social Care Bill does, are embarking on a course involving the deepest conflict with age-old values, traditions and

concepts of respect and the public good. Health is not a market commodity.

The health professions are starting to recognise that the proposed Health and Social Care Bill could change the very basis of vocational care. It may be on a relatively slow fuse but an explosion will take place when health professionals finally realise that a relatively few Coalition politicians have embarked on an external market that will erode the very art of Hippocratic medicine which the NHS, for all the gibes from the US about “socialised medicine”, never did. Neither did rationing of health care. Whilst the internal market introduced greater financial discipline, it did not provoke the health professions to sense that their clinical freedoms were being challenged in the way that introducing an external market is bound to do.

There are also limits to the extent to which the NHS can lose its basis in democratic government without also losing the trust of the people who pay for it out of general taxation. The rationing of care in the NHS has broad-based support. No other public service retains the same levels of affection and respect, and poll after poll, shows satisfaction with the NHS. Indeed, satisfaction today is at a record high according to the longest-running NHS satisfaction survey (Appleby, 2011). No wonder people are asking why the Coalition has decided upon such large scale reform.

How to Achieve Efficiency and Choice

A future integrated care strategy requires community-based care closer to home for people with long-term conditions and needs to develop patient pathways to support self-management of their conditions. This is likely to require support from care providers beyond the traditional NHS, particularly in hard-to-reach communities. These providers will often be social entrepreneurs and charities. All of these desirable developments are current practice, and are fully compatible with the NHS internal market, with the NHS as the *preferred* provider.

Mental health organisations have long been working through these kinds of strategic alliances with other providers in an integrated delivery strategy made up by a form of plural supply chain. Doing so also, for the most part, amicably. Crucially, this has been done on the basis of co-operation between providers rather than competition, although there is already competition in the internal market against tenders for different supply chains. It needs to be recognised that in end of life care, hospices and other charitable organizations supply most of the care already, within the framework of the internal market.

Another way of proceeding compatible with the internal market is that developed by the Cystic Fibrosis Trust. Starting as a Payment by Results (PbR) Development Site they introduced a mandatory national currency for cystic fibrosis care with local prices. The currency comprises a complexity-adjusted yearly banding system, using seven bands of complexity, with no distinction between adults and children. The bandings are derived from clinical information including cystic fibrosis complications and drug requirements. They range from band one, in which patients have the mildest requirement, with outpatient treatment two or three times a year and oral medication, up to a band for patients in the end stage of their illness on intravenous antibiotics for more than 113 days a year.

Sensibly, the Health and Social Care Bill makes suitable provision in Clause 11(3) for the Secretary of State to require the NHS Commissioning Board to arrange for specialised services, such as is currently provided for complex conditions such as Cystic Fibrosis.

Yet, what is never clear from the Bill is exactly how it will help the NHS to stay within its substantially reduced budget, let alone deliver its efficiency savings. The NHS in 2011 faces a unique period of financial constraint. From an historic trend of real annual budget growth averaging 3.8%, this more than doubled from 2000 to 2005 (Thompson, 2 June 2009:2). The NHS expects to see its budget grow by just 0.1% per annum from 2010. That is the lowest rate since the 1950s. This is also before an allowance is made to ringfence and transfer around £1bn a year to local authorities for their new public health responsibilities and the removal of “end year flexibilities” to cover overspends. If these are included in the calculation then the NHS faces an unprecedented period of sustained budget cuts. (Commons, 9 Dec 2010). Additionally the NHS is also expected to offset some of the lack of funding by achieving a dramatic £20bn of efficiency savings over the current Spending Review period to 2014.

There is no escaping the fact that providing choice is expensive, and it is no surprise therefore that PCTs have, in practice, been doing their utmost to limit patient choice. The Interim Report of the Department of Health’s Cooperation and Competition Panel (CCP) has highlighted some of the strategies being pursued by PCTs in order to balance their books as the financial crunch begins to take effect.

It found that almost half of all PCTs were taking steps to frustrate policy on competition and patient choice using:

“directions to GPs, activity caps, waiting list requirements, and triage and referral management systems which direct patients to particular providers; and seeking to insert provisions into contracts with providers that restrict patient

choice including, for example, activity caps and reductions in the types of procedures that providers can offer.” (CCP, 24 Feb 2011)

The CCP report also highlights the potential savings from such restrictions on competition and choice, alongside other steps including *“uniform minimum waiting periods before patients can be treated”*. It is bizarre that at a time of great financial pressure in the NHS the Government remains determined to impose the “Any Willing Provider” model on the English health service, and continue to promote and enforce a wider range of patient choices when they know that the new consortia will have to deliver unprecedented levels of NHS efficiency.

Choice in routine elective care is questionable, given that few clinicians would recognise that much elective care is in any way routine. Just as patients vary, their care varies too. Whilst the NHS Tariff gives the impression of common prices across the NHS, the Market Forces Factor applied to it location by location ensures significant variation in the prices that commissioners must pay to providers.

Patients and many clinicians may find it difficult to accept established thresholds for intervention. A treatment that is beneficial for one patient can be harmful for another, and enforced patient choice can provide a strong drive for excessive medical intervention. The quality of information available to patients and clinicians must be very high in order to manage the pressure to reduce intervention thresholds, particularly in such a time of financial constraint. Furthermore, robust incentives need to be in place to reward those who adhere to best referral practice.

In recent decades a huge amount of care has become possible and available in a community setting. Routine elective care cannot be regarded as separate to this, and care has to be integrated across the

spectrum of hospital and community settings. As Martin McShane, a doctor and PCT strategic director, has written:

“The elderly patient with ischaemic heart disease, diabetes, and chronic pulmonary disease who requires a hip replacement needs close and integrated working between the hospital and out of hospital services”. They do not need to be organizationally integrated. In fact McShane argues that they should not, but should be able to work in an integrated fashion. Thus limiting choice to ensure good communication, threshold and protocol adherence will deliver the best outcomes.

To some patients choice will be helpful, McShane suggests, for a fit young man with a hernia. The only basis for differentiating between patients is the one-to-one relationship between the doctor and the patient, or nurse and patient. All this points to commissioners being able to restrict choice along a care pathway when they are confident and can demonstrate that this will deliver better outcomes and efficiency.

The changing nature of medicine, with shortening hospital stays and the rise of community-based care, raises new threats of disintegration in care. Sharing patient information between both settings can be beneficial to the quality of care. Having strong relationships between commissioners and providers is crucial, and the volume of interaction required for some types of care is simply not possible within a fragmented and uncoordinated environment of “any willing provider”.

What can be done?

It is an understatement to say that this Bill lacks "the whole hearted consent of the British people" let alone the support of the health professions. A mindset is developing that ensures that this Bill should not be enacted in anything like its present shape and form.

My father was a General Practitioner, so was my great uncle and two aunts. I started off in medicine wanting to be a GP, yet I have from my medical student days been an NHS reformer and first published in 1968 a book called "*A Unified Health Service*". Part of the compromise over the foundation of the NHS in 1948 was that GPs were to remain independent contractors within the NHS. They have always had much to contribute to NHS decisionmaking: They represent the tip of the inverted pyramid of decisionmaking in the use of resources that is a unique feature of the NHS. But they are not the whole NHS, and they know it. Health care is a team effort. Long since gone are the hierarchical days when the single consultant or GP totally dominated NHS decisionmaking. They are part of a team and a part of an integrated health care system.

In many university graduation ceremonies a World Health Organisation (WHO) Geneva Declaration, which endorses a modern Hippocratic Oath, is said by all new members of the health professions; nurses, physiotherapists, speech therapists, radiographers, along with dentists and doctors. The oath is more general than the original, but it is still a call to vocation; a check on behaviour.

It is a fact that the UK medical profession has been the subject of much legislation and administrative change in the last two decades aimed at improving accountability and professional standards, much of it shifting the emphasis from punishment to remedy, and starting in 1992 with a sustained process of reform at the General Medical Council. The National

Clinical Assessment Authority, now with “Service” in its title replacing “Authority” (NCAS), originally set up in 2001, covers consultants, general practitioners and dentists. Under the Bill this will now be a service which is not imposed on the NHS, but which can be used and paid for by the appropriate decentralised authorities.

Aberrant behaviour in health professionals I would suggest is anyhow best controlled not by regulation but by maintaining and reinforcing the very concept of vocational care. Also, as far as it is practicable and reasonable within the NHS by maintaining the concept of continuity of care. The art of practicing good medicine is the best regulator.

An imposed *external* market would have a deep impact on the behaviour of health professionals in the NHS. It would challenge the very nature of the vocational aspect of medicine. It could very well alter the relationship of trust between patient and doctors working with other health care professionals. The patient in such a system will not be able to rely on their treatment and care being chosen on the basis of what best suits their own individual case, but rather left fearing, sometimes correctly, that what is presented as a general practitioner’s decision is in name only and in reality the decision will be made far more on the basis of cost. If that perception becomes accepted it will irrevocably harm the patient-physician or patient-nurse relationship.

We must start to ask of our politicians: Is health care to them just a commodity to shop around for? Do they really want to fashion NHS health care evermore as if it is just a commodity? Do they want medical practitioners to appear evermore as commodity managers? Some practitioners do, others may, many will not.

Already it is clear that GP consortia are subcontracting these, in part, unwelcome responsibilities to privately run providers of commissioning services. It is a salutary fact which needs emphasising that politicians in

Scotland, Wales and Northern Ireland have taken their freedom to choose to stay with the existing NHS model. Only in England is the NHS about to cross over the legislative line between an *internal* and *external* market. It is a paradox that voting for these English NHS reforms, will be Liberal Democrat MPs in Scotland and Wales.

The UK NHS has provided the best system yet devised for rationalising health care. Surprisingly, despite it's relatively low investment only recently improved, all along it has retained high satisfaction rates and the provision of good quality care with universal coverage. This legislation towards an *external* market in health care puts this proven balance in jeopardy. It warrants very careful thought, before being voted onto the Statute Book, particularly since close scrutiny of the experience and evidence accumulated from the internal market of the past 20 years does not justify such a revolution.

The principles surrounding the limits of a market in NHS-funded care need to be openly debated, redefined, and established. Decentralisation and patient choice are welcome as the direction in which to travel, but we need more honesty that they are more costly, while creating a wider range of local health services, and ensuring a greater variety of provision across England. This variety, which may see each commissioning consortia becoming a distinctly local NHS, requires more planning and debate. It also requires the development of new definitions of equity that are not linked to geographic location, but based on continued equity in financing and a clear set of NHS "values". Such values were proposed by Lord Darzi in 2008 (HMG, 2008) and later incorporated into the NHS Constitution to apply to any organisation providing NHS-funded care. This could provide a firm foundation for local variety in the NHS. As the Social Market Foundation health project concluded:

"While unintended and unexplained variation in care should not be tolerated, variation itself should be enthusiastically embraced by

policymakers as the best way to ensure locally appropriate services that will save money overall” (Furness, 2009:35-36)

In developing his ideas Professor Ara Darzi spoke to over 60,000 people in and associated with the NHS in his two years as a health minister. We have seen no such dialogues from the incoming Coalition in the run-up to this Bill. Their proposals have been handed down from on-high. Well-informed people fear that an NHS that is over-administered and over-managed will under this Bill emerge under-administered and under-managed.

The Bill promotes too much cherry-picking and does not provide a fair, let alone a level, playing field. Introducing evidence-based GP commissioning can be beneficial, but the Coalition has not made the case for its changes, nor defined their purpose. An unintended consequence of evidence-based medicine is that the activity of healthcare can be re-described in terms of a set of discrete interventions. Those interventions then afford an analysis which is like a commodity analysis. If this is mixed with an ideological commitment to individual choice and decentralisation that does not concentrate on developing the community and involving the community then, unintentionally perhaps, health becomes treated in the same way as wealth.

What this Bill does is focus on means with little concept of ends. Perhaps the Government are deliberately hiding the ends because they know if they did not do so it would make its health policy even more unpopular and incoherent.

There was no mention in either the Conservative or Liberal Democrat party manifestos at the 2010 General Election of an intention to carry forward anything like this revolutionary change. Under the Salisbury Convention the House of Lords is entitled therefore to make substantial amendments to this Health and Social Care Bill.

In the Summer of 2011 the House of Lords may be faced with an important task if the Bill is not substantially changed in May at the Report Stage in the House of Commons. The House of Lords traditionally does not vote against the Second Reading of Bills. Yet the surprise at the scale of the reforms in the Health and Social Care Bill, and the shocked response of so many in the health sector to some of its provisions is but a demonstration that the Coalition lacks a mandate for many of the policies set out in this Bill.

At the very least, these substantial proposals that affect the founding principles of the NHS must be given the time and consideration they deserve. Referral to a Select Committee of the House of Lords, as part of an acceptance of its Second Reading, is a very realistic possibility rather than subjecting this Bill immediately to an ad hoc battle of amendments between the Lords and the Commons. At the Second Reading of the Public Bodies Bill referral to a Lords Select Committee went to the vote and the Government only had a majority of 30 against referral (HL Deb, 9 Nov 2010)

I believe that a referral motion to a Select Committee of the Health and Social Care Bill would be carried in the Lords, particularly if there was a time limit attached to the motion, giving a date when the Select Committee would have to finish, and envisaged working in part through the Summer recess.

Even after such a Select Committee had reported there would still be a necessity for substantive amendments to be passed by the House of Lords. If these are passed and then rejected by the House of Commons, an amendment “ping pong” follows between both Houses. The Lords, however, are entitled to hold out and let the Coalition government decide whether to accept an amended bill or to delay the Bill’s introduction for

the statutory period of a year or more when there has been no agreement.

The Prime Minister will hopefully act long before this happens in the summer and replace the existing health ministers in the House of Commons and allow for fresh thinking, and much less dogmatism. Such a decision would allow the Coalition Government to return to their primary task of helping the NHS deliver the large efficiency savings that they have already quantified as part of the necessary reduction in the UK's structural fiscal deficit.

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