



Limits of the Market, Constraints of the State: the public good and the NHS

Rt. Hon Dr John Reid MP
Secretary of State for Health



The Social Market Foundation

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Introduction

1 National Centre for Social Research (2003) *British Social Attitudes: the 20th Report. Continuity and Change Over Two Decades*. London: Sage Publications.

No one doubts the British public's commitment to the NHS. Poll after poll confirms its support for a health care system that provides equal access free at the point of delivery. The most recent survey of British Social Attitudes found that around three-quarters of the population oppose any move towards a private health care system. This solidarity remains consistent across income groups, with high earners being as supportive of a universal NHS as low earners.¹

The NHS matters so much to people because it represents justice in the distribution of health care. The British people believe that no one should be discriminated against on financial grounds in their access to health care. They do not expect this equality of distribution for a whole range of goods and services but, for national and historical reasons, they do for health services. This notion of social justice resides at the heart of the public's commitment to the NHS – in the health care arena, we can rightly claim that the British people are confirmed social democrats.

The principles of the NHS can be described as social democratic since they are premised on the idea that collective action can provide us with some services that individual self-centred actions alone cannot. Risks to our health and overall wellbeing are so numerous, and indeed so varied, in our day-to-day lives that it is unfeasible that we as individuals can be the sole guarantors of our own welfare. We need collective provision. Every day, the experience of the NHS materially demonstrates that *we need each other*.

The flip side of this coin is altogether less comforting. An NHS failing to meet the expectations of the British public does great damage to the cause of social democracy – and public

expectations have never been higher. Compare and contrast the contemporary political profile of the NHS with its profile during the 1950s and 1960s, when its ‘inferior status...was disguised by political rhetoric’, according to its leading historian, Webster. This historian also claims that ‘the effectiveness of this propaganda, reinforced by the evident improvement on the previous system, habitual stoicism and misplaced confidence among the public concerning the prospects for improvement, [as well as] a general disinclination to criticise a cherished national institution’ also meant that ‘the NHS drifted into a political limbo and thereby risked becoming a neglected backwater of the welfare state’.²

Not so today. Satisfaction with the running of the NHS, for example, fell from an all time high of 55% in 1983 to just 40% in 1986 and has since remained stubbornly static.³ If collective provision of health care, paid for through general taxation, is felt not to be working by the public, then public confidence in collective social provision as a whole will be undermined. In addition, those who wish to commercialize every aspect of human existence will be the beneficiaries.

The stakes could hardly be higher. Between 1972 and 1988 Britain invested a cumulative £220 billion less in its health care than the EU average. The current government has begun to reverse this sustained under-investment: between 2003-4 and 2007-8, £34 billion more is being invested in the health service. This increase, 43% in real terms, means that by 2007-8, £90 billion will have been invested in the NHS in England.

In this pamphlet, I want to argue for a decentralised, personalised, but publicly owned and funded NHS, committed to patient preference and the extension of choice. I will argue

Satisfaction with the running of the NHS, for example, fell from an all time high of 55% in 1983 to just 40% in 1986 and has since remained stubbornly static.³

² Webster C (1998) *The National Health Service: A Political History*. Oxford: Oxford University Press.

³ National Centre for Social Research (2003) *British Social Attitudes: the 20th Report. Continuity and Change Over Two Decades*. London: Sage Publications.

that improving the NHS depends not only on the decentralisation of power but also on a willingness to learn from best practice worldwide – even when this best practice is located within market-based health care systems. We can, I will contend, learn from markets without importing either their ethos or the market itself.

Proceeding in this way, our NHS will be well placed to meet the demographic, scientific, and technological challenges of the twenty-first century, as well as the challenge posed by the public’s rising expectations of the quality of health care provided by the money they pay in tax.

1. Rising Activity, Rising Expectations: the NHS in the 21st century

Ensuring equal access to health care is essential in a civilised society. As a gift relationship, it stands testament, in Titmuss's famous phrase, to our altruistic as well as self-interested impulses. We may not find it easy in life and death matters to count the costs, yet practically speaking, scarce resources constrain ethical absolutes and make difficult choices inescapable in the vexed area of preserving life.

Public resources are not infinite. If any of these resources are wasted, public service provision suffers, and a proportion of the public using these services must consequently lose out. In terms of the health service, any waste of resources will mean that someone, somewhere, will be in pain unnecessarily. This is why in 2004 we developed with the trades unions and professional associations new contracts for nearly all NHS staff. All of these contracts are aimed at productivity improvements, ensuring that there are no unnecessary restrictive practices.

By October 2004 the numbers of central staff at the Department of Health were cut by nearly 20% compared to a year earlier. As I will argue later in this pamphlet, the central authorities of the NHS will be devolving their responsibilities, and under those circumstances there needs to be fewer people at that centre.

Technology, demography and rising costs

The NHS has always discomfited the guardians of the public purse. The first financial crisis occurred within six months of

its inception – Bevan's assumption that once health care was free at the point of delivery demand would rapidly fall proved to be mistaken. Indeed, the story of the NHS has in many ways been one of continually rising demand and supply. In 1948 the NHS offered 400 000 operations, and one million out-patients were seen in NHS hospitals. It now performs 6.5 million operations and schedules more than 40 million out-patient appointments.

Constant technological advance has done much to increase demand and supply. Technology has opened up vast new areas of diagnosis and treatment. The rate at which new knowledge has been accumulated – and the rate at which this knowledge has been accompanied by new medical interventions – continues to rise. A pharmaceutical and biomedical revolution has taken place, and it continues apace.

This revolution must be celebrated. Ever-longer life expectancy rates are one of its most obvious consequences, and improved technology should also enable more of us to live more of our lives free from disease. In addition, technology often increases cost effectiveness – many new technologies (minimally invasive surgical procedures) are cheaper because they are less traumatic and thus reduce hospital stays, at the same time as their convenience generates greater uptake.

On the other hand, technological advance also generates new demands for use of effective treatments – demands that place an ever-greater burden on the public purse. During the 1990s, the average annual increase in the cost of medicines, dressings and appliances was 10%. Some drugs (such as those for the treatment of metabolic disorders) can now cost £10,000 per prescription.

The demographic trend towards a larger and older population also needs attention. The British population is expected to grow to 64 million by 2020, with the number of over-65s rising by nearly a third to 12.5 million. The average cost of an 85-year-old to the NHS is 6 times that for 16-44 year olds.

However, as life expectancy rises, people will tend not to suffer severe long-term illnesses towards the end of their lives. According to Wanless, the phenomenon of compressed morbidity means that the implications of demography are more cost neutral than previously thought. He calculates that

demographic trends will add only 1% a year to UK health bill.⁴ Wanless's calculations are important here since the assumption has always been that an 'ageing population' would in some way massively increase costs for the NHS. In fact, as Wanless explains, the major costs are compacted in the period before death in precisely the same way as when people died a few years sooner.

The same counterintuitive outcome, where the rising costs may not be as bad as expected, may also be the case in other areas. It is to be hoped that the considerable increase in cholesterol controlling drugs, such as statins, would mean the need for less heart surgery. In addition, as I shall explain below, improved delivery of chronic disease management will cut the number of emergency bed admissions.

Rising Expectations

Increasing demand has also been a consequence of broader social change. An increasingly well-educated and affluent society expects much more from its public services – especially the NHS. Although this process has been in train for the last half century, acceleration has been evident during the last two decades. The decline of deference and social paternalism (one of Thatcherism's more attractive consequences), together with the ongoing information revolution, has significantly altered people's perceptions of health and health care.

Expectations are also mediated by a powerful trust in the medical profession. The doctor's surgery and the hospital ward are, of course, among those places in which deference to professional expertise has been most advanced. In some situations such deference will inevitably and rightly continue. When someone becomes suddenly and acutely ill, for example, they depend totally upon the skill and commitment of the medical professions. At such times we expect and hope doctors and nurses will be totally 'in charge'. But amongst the 17.5 million patients in the UK suffering from long-term conditions, and requiring chronic care, rising public expectations have created a desire for greater participation in the management of their own conditions.⁵

Patients' desire for greater participation in their own health care operates on several levels. It can involve no more

4 Wanless D (2002) *Securing our Future Health: Taking a Long-Term View*. London: HM Treasury.

5 For analysis of these rising expectations see: Coulter A (2002) *The Autonomous Patient: Ending Paternalism in Medical Care*. London: The Nuffield Trust; Coulter A, Hagee H (2003) *The European patient of the future*. London: The Nuffield Trust. For the story of increasing public expectations in the US see Gerters M, Edgeman-Levitan S et al (1993) *Through the patient's eyes: understanding and promoting patient centered care*. San Francisco: Jossey Bass Publishers. The notion of the expert patient is now firmly established both in the US and here in the UK: Department of Health (2001) *The Expert Patient: A New Approach to Chronic Disease Management for the 21st century*. London: The Stationary Office.

6 Appleby J, Harrison A, Devlin N (2003) *What is the Real Cost of More Patient Choice?* London: The Kings Fund.

than merely the wish to be kept fully informed so that one can better understand one's medical condition(s). This desire gave rise to the vocabulary of 'patient partnership' which has been developing since the early 1990s.⁶

But the desire for greater knowledge and understanding often extends further than this; it is both harbinger and creator of the public's demand for greater *choice*. The desire among women to choose not only their method of childbirth delivery but also their main carer (midwife versus obstetrician) is a striking example of this trend.

When Derek Wanless argued that to improve people's health we would have to fully engage them in this task, he was not talking about the health of the health service. Nevertheless, the same is true of the NHS. If we engage people in choices about their health services, not only will their health improve, so too will the quality of the health services they use. It must be the policy aim of the centre left for people to take more control of their own health.

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2. The Limits of a Market in Health Care

There has always been a strong ethical imperative militating against a free market in health care: among those of all political persuasions, the idea that a human life can be compressed into monetary units for use in the economic market is simply unacceptable. However, to the ethical imperative against a market in health care, one can add what the Chancellor Gordon Brown describes as the ‘public interest’ test: detailed examination of the intellectual case for a system of health care where individuals pay for care delivered by a variety of private providers reveals that such a system fails to advance the cause of either equity or efficiency.

There are a number of more specific arguments that can be levied against the idea of a private market in health care.

Information Asymmetries

The belief that health care is a commodity to be bought and sold like any other through the price mechanism ignores the inherent existence of information asymmetries. The eminent economist Kenneth Arrow drew attention to these asymmetries more than forty years ago:

‘The value of information is frequently not known in any meaningful sense to the buyer; if indeed he knew enough to measure the value of information, he would know the information itself. But information in the form of skilled care is precisely what is being bought from most physicians, and, indeed, from most professionals. The elusive character of information as a commodity suggests that it departs considerably from the usual marketability assumptions about commodities’.⁷

⁷ The Welfare Economics of Health Care (originally published 1963) in Cooper M H, Culyer A J (1973) *Health economics – selected readings*. London: Penguin.

These information asymmetries produce serious inefficiencies in private purchasing and pricing, since individuals are often unsure whether they need medical treatment and, if so, when and what kind of treatment. Private insurers often possess poor information upon which to base their risk assessment. The result of this uncertainty is that many citizens are considered too high a risk, too expensive, and are therefore excluded from coverage.

Indeed, some insurance policies in the United States are now thought to have a 40% loading simply to cover the administrative costs involved in risk profiling and billing. In America, premiums today average around \$100 a week, and are rising by 13% a year (with some estimating the rise in California in 2004 between 20 and 30%). Even then, these often exclude high cost treatments. In April 2001, it was estimated that annual premiums for employer-sponsored plans were more than \$2,500 for single coverage and over \$7,000 for family coverage, with employees paying between 50 and 70% of these costs.

Administrative costs in the US are twice as high as in Canada – a system based predominantly on funding from general taxation – largely due to the cost of insurance companies selling and handling policies, processing claims and pre-approving procedures, and in some cases overruling doctors and denying needed care.

Inequitable Outcomes

These serious inefficiencies in private purchasing and pricing combine to produce inequitable outcomes. Indeed, the paradox of health care systems based on private insurance is that the people who need care most are least likely to be able to afford it.

We know that the poorer and older someone is, the more likely they are to fall ill. And in America – as with private insurance systems anywhere in the world – the less healthy pay the highest insurance premiums, with premium costs climbing sharply with age. According to the American Consumers’ Union, the sickest 10% of the US population spends six to seven times what the average person does on health care.

As a result, more than 26% of families in America report that they have foregone necessary medical treatment over the

last year because of prohibitive medical costs. In total, 18% of adults of working age and 12% of children do not have any insurance in the US, which represents about 40 million people. 80% of these are in working families, many of them in small businesses or self-employed.

Even financially comfortable families in America can be faced with huge additional bills because insurance packages tend to exclude high cost chronic care altogether and have co-payments of 20% or more. Someone with a private insurance policy covering 80% of charges can face additional costs of nearly \$2000 when hospitalized for childbirth and up to \$5000 for a heart bypass operation.

The German system offers people on higher incomes a choice between public insurance offered by sickness funds and private insurance: two-thirds choose the public option because it is considered cheaper and less risky.

No private scheme covers every treatment an individual might need during his or her lifetime at an affordable price. Private insurance policies currently on offer in the UK usually exclude primary care and emergency care – together currently accounting for over 90% of patient contact – including GP visits. Also usually excluded are outpatient drugs and dressings, hospitalization for childbirth, and treatment for HIV/AIDS or other pre-existing or chronic conditions.

Advances in the field of genetics seem likely to further exacerbate the deficiencies inherent in private insurance systems. Those with a predisposition to a particular disease will be open to discrimination and may face excessive premiums, reductions in coverage, or might find it impossible to obtain private insurance altogether.

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Health care markets that directly involve money and price do not generate value for customers

In a conventional well-functioning market, the price set by the producer is the most efficient. But in health, not only is the consumer not sovereign, but a free market will also fail to produce either the most efficient price for health care services or a fair deal for the patient.

This is because the market for health care is dominated by a combination of :

- highly imperfect and asymmetric information and the potentially catastrophic and irreversible outcomes of health care decisions based on that information
- the necessity of local clusters of medical and surgical specialisms.

With the consumer unable – as in a conventional market – to seek out the best product at the lowest price, and constrained by information gaps that cannot be satisfactorily bridged even over the long term, market failure can lead to catastrophic consequences for the patient.

The inadequacy of the market is even more profound when these market failures are combined with a policy that puts profit maximization by hospitals at the centre of health care. It is then that the consumer, i.e. the patient, would be at greatest risk of being overcharged, given inappropriate treatments for financial rather than medical reasons, and offered care not based on clinical need but based on ability to pay. This would lead to with some paying for care they do not need and others being unable to afford care they do need.

3. The Limits of the State and the Extension of the Public Realm

This Government believes in an NHS funded through general taxation and free at the point of use. But one of the biggest barriers to reforming the NHS is the widespread belief that a public health care system is synonymous with a health care system controlled from the centre by a strong state. This belief is mistaken. It derives from the broader assumption that the state is the only way of organising the public interest; an assumption that has come to dominate British social democracy in the course of the last half-century.

The debate that has occurred within the left about the structure and organisation of the NHS has concentrated on this issue of national versus local. There have been those who have argued against the ‘breaking up’ of central control, because they have seen it as losing the ‘N’ in the NHS. They have confused the overall national organisation and payment for the health service with the system that runs the day-to-day practice of the health service. Those arguing this position hold to the classic model of nationalisation developed just after the Second World War.

Some would argue that it is simply not possible to have a system that has national standards and national funding, but recognises that the service is delivered in localities. They claim that there has to be a choice between national and local, rather than recognising that there is a relationship between the two. What is important is to get the relationship between these two *right* – not to close down the relationship.

Public ownership does not have to mean state ownership. The state is merely one way of organising the public interest.

One of the clearest examples of how to build this relationship is through the correct application of IT systems. An IT system which will enable a complex national system of health care to communicate across a very wide set of institutions must be organised from the centre. If a GP in Birmingham is to communicate with a hospital in Truro then their IT systems must be able to work together. This needs central planning and co-ordination. However, if the GP’s computer software is not the same as that of the hospital it is not likely to be any good for either practitioner. Therefore, whilst the exact nature of the front end of any IT system will be different in each location, the centre needs to run the whole system to make sure they can communicate with each other.

Public ownership does not have to mean state ownership. The state is merely one way of organising the public interest. There are other organisational forms, which can be public and are not market-based. It can mean, for example, ownership by employees (e.g. the John Lewis partnership). The Labour Party was historically a leading proponent of such diversity. Having emerged from the more autonomous institutions of civil society (the friendly societies, trade unions and co-operative movements with their strong traditions of self-help and mutual support) Labour’s pioneers understood its value. Their own experience told them that democratic public engagement did not have to be mediated by the central state; that mutualist politics could exist, and indeed prosper, independent of government control. This tradition remained a strong one within the Labour Party until WWII. The demands of total war necessitated a command and control policy in which the central state loomed larger and larger. The post-war Labour government was a product of this intellectual climate. Not only this, but the Attlee government also concluded that only

a powerful central state could ensure the rapid implementation of its enormous reform programme.

In the last two decades, governments have failed to fully encourage the more voluntarist, decentralising tradition of public ownership. And we in the Labour movement must also take our share of the blame. This Government has only gradually come to the conclusion that centrally driven and managed reform has distinct limits. Over the same period much of the broader Labour movement has tended to view statism as synonymous with social democracy.

However, promoting diverse forms of public ownership and public management has never been more essential. Public services need different organisational forms precisely because they are serving the public – a group of individuals with diverse and shifting needs. Furthermore, the NHS cannot simply *deliver* a person's health without the committed involvement of that person. That involvement is not some add-on to the process, but must be integral to the public service organisation. Given these challenges, mere reform – that is, an attempt to make the existing system or structure work better – is not enough. Fundamental and systemic change is necessary.

Decentralisation

In terms of large organisations such as the NHS, this transformation must begin with a genuine decentralisation of power. Left to their own devices all systems have a remarkable capacity to self-organise. An experiment run jointly by the Santa Fe Institute and the US Marine Corps is profoundly suggestive in this regard. A large number of Marines were equipped with unusual transceivers, and then sent off in all directions. The transceivers enabled everyone to speak to, and hear, everyone else. No protocol was issued on how this equipment should be used. No orders were issued, except to take the town of Oakland surreptitiously. No officers were present. It was theoretically possible for several hundred Marines to be speaking into their transceivers simultaneously. Yet, it took less than 30 minutes for the system to self-organise, by which time only one Marine at a time was speaking. The organisers concluded that the key to this was probably the lack of orders and absence of hierarchy. Left to their own devices,

even the most potentially anarchic system will develop its own structure. Command and control systems stifle this capacity for self-organisation. The NHS is also too complex and too fluid to predict, command, and control.

Contestability

Yet, it is more than just a matter of devolving power and encouraging autonomy. The promotion of contestability is also essential if the NHS is to continue to be a model of best practice. Contestability between providers on the basis of quality and efficiency enables a massive organisation such as the NHS to learn from other health care systems. Where the private sector can add to, not undermine, NHS capacity and challenge current practices by introducing innovative working methods, it has a proper role to play. It always has.

National Standards

Alongside decentralization and contestability, the Government remains committed to maintaining a framework of national standards and target setting. Again, we can learn from the modern company that has lean headquarters that establishes clear targets, sets incentives and rewards, provides the freedom for local managers to deliver, and then collects the information so that results can be monitored and assessed.

Where objectives are clear and well defined, targets can provide direction. Where institutional expectations are properly shaped, they provide the necessary ambition. Where people can see and assess the impact of policy, and where national standards are achieved and can be seen to be achieved, targets can make for the consistency, accountability, equity and flexibility to meet local needs that the NHS has sometimes lacked. Indeed, without targets providing that necessary focus and discipline for achieving change, the reduction in waiting times, and the improvement in cancer and heart disease care could not have been achieved.

When one also considers that local autonomy without national standards might lead to increased inequality between groups of individuals and regions, and the return of the post-code lotteries, the necessity of national standards is clear. In a small country like ours, the public expects a truly *national*

health service. The creation of bodies such as the National Institute for Clinical Excellence (NICE) and the Health Care Commission are central to achieving quality across the board.

Conclusions

In the modern world, we all lead different – and changing – lives. The public does not exist as a series of blocks to be served by large scale state institutions. The public exists as a series of very different individuals with different sets of needs. This calls for considerable change in how public services are organised. As one commentator remarks:

“The challenge then is not just to personalise services but to shift from a model in which the centre controls, initiates, plans, instructs and serves, to one in which the centre governs through promoting collaborative, critical and honest self evaluation and self-improvement. Reforms to public services should drive in this direction promoting new sources of information for users, creating new interfaces such as NHS Direct for them to access services and get advice.”⁸

The NHS can achieve this different approach, but it will require changes to every part of the service from the role of the Secretary of State to the role of the receptionist who greets the patient.

⁸ Leadbeater C (2004) *Personalisation through participation*. London: Demos. pp.89-90.

4. Learning from the Market Experience without introducing money into the Doctor/Patient relationship

The provision of an excellent health service that can satisfy contemporary expectations demands constant innovation. Innovation is intrinsic to medicine. As the original publicly funded and publicly delivered health care system, the NHS has been an example to many others. Health care systems around the world have integrated best practice learned from the NHS, and they continue to do so today.

The reverse, however, has rarely been the case. Precisely because of its status as the pioneer of public health care, the NHS has historically been less than willing to learn from abroad, and especially from health care systems with market elements. Despite the incontestable fact that markets are one of the most fruitful sources of human innovation, studies of market-based health care systems have been frowned upon. In part, this reluctance stems from a belief that the innovation and dynamism of markets is driven solely by cash exchange at the point of delivery. This cash exchange simply cannot be replicated by a non-market health care system such as the NHS.

However, it is not true that cash exchange at the point of delivery is the sole driver of change within market-based health care systems. Those working within a market-based system innovate in terms of self-care, chronic care and integration because of the need to keep premiums – the cash paid by patients – low. What we can learn from market-delivered health care is *not* how to introduce payment as a driver of change, but

rather how *other* drivers can also lead to innovation.

There are health service innovations that both save resources and improve services for the patients. One such area is the movement of health services back from acute hospital services to a primary care setting. Primary care services are not only cheaper – they are nearly always more popular with patients. They usually involve less drastic interventions and can allow the patients to carry on a more normal life while they are being treated.

Switching care from secondary to primary care has long been a goal for the NHS. Previously, the alternative trend – to provide more and more acute care – has predominated. Within managed care systems in the US, there has been some success in establishing a greater long term role for primary care. The Department of Health is currently learning from two US care providers: Ovation's Evercare programme for improving the care of older people and the Kaiser programme for developing better care for people who are suffering from long term conditions. In autumn 2002, the Department of Health invited Ovation to contribute Evercare's tools, techniques, and expertise to the working practices of Primary Care Trusts (PCTs). Nine PCTs implemented the Evercare programme between April 2003 and August 2004. This has delivered a number of significant benefits:

1 *It has encouraged the strategic use of information and tools for the active care management of a previously unidentified high-risk population.* The implementation of the Evercare programme has alerted PCTs to the necessity of improved use of data. Subsequently, an 'invisible' high-risk population responsible for 35% of all unplanned hospitalisations of people over 65 years of age was identified; a population 76% of whom, on further investigation, turned out not even to be on district nurses' caseloads. This discovery gives PCTs an opportunity to improve care for a previously unidentified population that demands extra intervention. The use of predictive data to encourage the practice to go out and check on high risk patients ensures that those at risk are given treatment before the emergency takes place.

- 2 *It has accelerated a reform of the nursing workforce consistent with the NHS vision of promoting generalists with special interests.* Evercare's emphasis on the importance of Advanced Primary Nurses (APNs) in the delivery of community-based care is critical in this respect. Evercare makes clear that APNs must act more like dynamic generalists than the reactive specialists characteristic of traditional nursing. This means that a patient does not have to be referred on to another health care specialist, since the nurse has the expertise to treat and manage the condition themselves.
- 3 *It has improved collaborative patient care and information flow across organisational boundaries.* The Evercare programme has dramatically improved the flow of information between secondary and community care.

Health care for patients is much more likely to be successful where the care package is seamless. Such a system, mentioned in the NHS Plan, is therefore in the interests of the patient as well as the health service.

Evercare reveals two further themes key to realising effective population health improvement strategies within the NHS:

- *Understanding the NHS from a patient perspective.* Over the years, the NHS became defined by its structures, budget, and professional domains, without sufficient regard for patients' experiences within that system.
- *Achieving increased effectiveness using existing resources.* Historically, the NHS has relied on new funding for doing new things. However, it ought to copy the Evercare practice of redeploying existing resources to achieve their greatest benefit by designing more effective processes that maximise outcomes and minimise the cost of achieving improvement.

The Evercare models used in the US health care system have been developed with an eye to both improving patient treatment as well as reducing costs. Up until now, the NHS has not succeeded in developing incentives that increase the involvement of primary care and decrease emergency admissions. Since this is an object of policy, there are some important lessons for the

NHS in these pilots.

A team from the Department of Health has also been studying another US care provider: Kaiser Permanente, a non-profit organisation also operating within the competitive US health care system. Like the Evercare programme, Kaiser's approach to the integration of care pathways, the active management of patients, self-care and shared care, and the usage of information, demands close examination.

Integration

Kaiser integrates inpatient and outpatient care enabling patients to move easily between hospitals and the community. Medical specialists are uncoupled from the hospital and focus on providing care in the most appropriate setting: there is no incentive to build up facilities and resources in the hospital at the expense of other settings. Prevention, diagnosis, treatment and care are integrated. In the outpatient setting doctors have fast access to diagnostic services thereby avoiding unnecessary referrals to hospital – and they practice from relatively large centres (at least from an English perspective) that are equipped on-site with diagnostic and other kinds of equipment.

Operating within a market system has encouraged Kaiser to pursue integration. However, integration also makes sense in a non-market health care system. The establishment of PCTs provides an opportunity to pursue such integration within the NHS: it makes possible the development of stronger linkages between prevention, diagnosis and treatment. The sterile debate regarding the balance between primary and secondary care ought to be replaced by an emphasis on *integrated* care.

Keeping patients out of hospital

The number of beds used by Kaiser for the commonest causes of admission like asthma, bronchitis and strokes among the over 65 age group is around one quarter of that in the NHS. Kaiser's philosophy is that 'hospitals are an indication of system failure': admissions to hospital signify a failure of preventive and community-centred treatment. Early discharge is facilitated by the availability of intermediate care often delivered by nurses and therapists. This necessitates greater imagination in the development of the roles of nurses and therapists.

The active management of patients

When patients are admitted to hospital, there is a strong emphasis on minimising stays and maintaining the flow of patients through the hospital. A good example is orthopaedics where care pathways have been developed for patients undergoing hip replacements and knee replacements specifying what should happen on each day of hospital treatment. Lengths of stay for these conditions are typically around 4 days in Kaiser hospitals compared with twelve days in the NHS. Discharge is planned either on or before admission with the emphasis placed on early rehabilitation. Kaiser employs specialist discharge staff to manage this process and to ensure that patients are not kept in hospital unnecessarily. The aim is to keep patients moving through the system and to review readiness for discharge on a daily basis.

Such an approach can guard against the development of institutional sclerosis. The increasing focus in the NHS on chronic disease management and discharge planning demonstrates our recognition of the necessity of actively managing patients. In the case of chronic conditions, this includes identifying patients most at risk, and intensively case managing them, as well as ensuring patient compliance with standards set out in clinical guidelines. For patients who are acutely ill, active management entails the development and use of care pathways, and the adoption of roles such as discharge planners whose functions include avoiding unnecessarily long hospital stays.

Self-care and shared care

An extensive support network enables patients to do as much as possible for themselves – allowing them to return home more quickly. Self-care is at the heart of Kaiser's philosophy and practice to the extent that patients, carers and families are seen as co-providers in health care. Orthopaedic patients are therefore taught how to dress themselves, the rehabilitation exercises they need to undertake, and how to ensure that the taking of their anticoagulation medicine becomes a part of their daily routine.

Self-care and shared care are particularly important in relation to chronic diseases. Kaiser makes a substantial investment in patient education and the provision of information to help

people with conditions like diabetes and asthma remain independent and healthy. Group consultations involving several patients and a health care professional are used to support self-care.

The NHS has started to promote self-care through the Expert Patient Programme and by giving patients access to health information by means of, for example, NHS Direct Online. Earlier I have referred to this as the co-production of health – the patient is as involved as the professionals. This is a vitally important process that crosses over the boundary between service and patient. It creates a much stronger connection between patient and health service.

The use of information

Kaiser's IT system is being developed and replaced and this involves a substantial commitment of resources. The existing system enables easy access from different sites to patients' records. In this way, tabs can be kept on tests that need to be done in line with relevant clinical guidelines. It also enables the development and use of disease registries for chronic conditions. These registries are then used to review compliance with the standards set out in guidelines and to identify doctors and patients whose practice or care may be departing from the guidelines. The data captured on the information system is used in part as a tool for peer review and quality improvement, and in part to inform how Kaiser physicians are paid.

Data capture is an important potential resource. Across the NHS, there is a large amount of data that is not at the moment transformed into information to be used in managing health care. The lessons from Kaiser is to ensure that this data can be used in a dynamic way to improve the quality of care provided.

Across the NHS, there is a large amount of data that is not at the moment transformed into information to be used in managing health care

Conclusions

It is clear that the NHS can learn from these pockets of excellence within the US health care system, and can seek to import the aforementioned good working practices without importing the idea of cash exchange at the point of delivery.

The argument we have developed in the last few sections of the pamphlet builds in this way. First, working people have increasing expectations of how their services are delivered. For people involved in politics on the left, this is a good thing, since those raised expectations are the very reason why we are involved in politics. Second, markets that are run by the money from individual consumers buying their health services creates a health service with severe problems. Third, whilst health services need to be paid for and strategically organised through central government, there are different, more decentralised public service models for delivering them. Fourth, whilst it is vital that health services are not bought and sold like other goods, there are interesting issues that can be learnt from different organisations of health care.

I now want to turn to the issue of patient choice and empowerment.

⁹ Dixon A, Le Grand J, Henderson J, Murray R and Poteliakhoff E (2003) *Is the NHS equitable?* London: London School of Economics.

5. The Choice Agenda: empowering patients

The political arguments for choice

Three different arguments for choice can be mounted from three quite different political positions. First, from the ideological right, choice is argued for because markets need choice. For those on the right, these choices, to be real, need to be backed up by the use of people's own money. Within this political view, people will only really bother with choice if they have a direct pecuniary interest, in which case choice will have an important impact. This is why the right claims that the only way that choice will become real in the public services is if people use their own money.

From the centre of the ideological spectrum, there is an argument that choice is simply the way of the modern world. People have choices all the time and rising living standards have given people more and more choices. It is true that those with more money than others have more choices, but recent decades have taught us that everyone has more experience of choice. Under those circumstances, it is claimed that if public services are the only place that choice is not experienced they will be experienced as being out of step with the 'norm' in modern society.

The third argument on choice comes from those on the left of the political spectrum, and it takes as its fulcrum the idea of *empowerment*. It might surprise some to hear that there is a leftist argument in support of choice, since the left-wing argument *against* choice is rather well-known. This argument states that unless someone – administrators or professionals – make allocative decisions, the distribution of the resources will

inevitably be unequal. Such a belief in scientific allocation formulae as the only way of ensuring equity has been at the heart of many welfare policies.

The left argument against choice, which pits choice against equity, poses a number of problems. Firstly, it is wrong to think that systems that do not allow choice are somehow thereby guaranteed to produce equity. Dixon and Le Grand⁹ demonstrate that existing non-choice systems within the NHS did not create equity. Indeed, they concluded that 'there is strong evidence that lower socio-economic groups use services less in relation to need than higher ones'. Some of this inequity stems from the way in which people from the higher socio-economic classes provide themselves with choices that are not open to others. They do this through social contacts and pressure. No system can exclude them. No form of system of resource allocation based upon administrative criteria, including those of the old system, can exclude middle class pressure from providing them with greater, *hidden* choice.

Secondly, the alternative to people *choosing* where to go is someone else *telling* them. This situation is justified in a number of ways. Sometimes it is argued that the public simply do not have enough experience of choice for them to choose effectively. But until the public are empowered, this will never change. The status quo will be maintained, with others making choices *for* people, rather than people being empowered by the experience of choosing.

It is patronising to argue that working people are not 'up' to choice. If we succumb to that argument, it would mean that the Labour Party, a party that has always been interested in empowerment for working people, should be in favour of such an experience in every area of life *except* public services. This is absurd, since public services are the area of which the Labour Party is most proud.

The politics of these three arguments are important. If the right-wing argument is the only one engaged in political debate, the right will engulf the centrist argument and leave people feeling that the *only* way that choice will work in the public sector is if it involves people's own money.

On the other hand, if the left engages in this debate it can demonstrate that choice and empowerment can be carried out

in public services *without* the inequality of private money entering the equation. While the right believe in inequality and money, those on the left believe in equality and empowerment.

Lurking in the background, however, there is a further political argument about choice. Some social democrats feel that the more we extend choice in public services the more we degrade the overall experience of the citizen. If individuals choose aspects of their service, this experience in some way undermines the nature of citizenship. Since citizenship is a core value for social democrats, they argue that choice and consumption of public services must be resisted.

This argument assumes that citizenship necessarily involves the state telling people what to do. Because the state *can* exercise considerable control over our lives – it forces us to pay taxes, can compel us to join the army in time of war – then this (somehow) must be what true citizenship is all about. Any state that tells you where to go to school and which hospital to go to must be a good state, and accepting these state decisions makes one a ‘good citizen’. Yet this is a curious and old fashioned view of political and social relationships. We don’t have a citizen army any more, we employ professionals, and it has not diminished the relationship between the public and its army. We are all less used to being told what to do and if we conflate citizenship with being disempowered, then citizenship will wither on the vine.

Social democrats sometimes muster another argument against the extension of choice in public services. They argue that the more the individual experience of consumption is encouraged, the more we will erode the sense of citizenship required to provide collectively for one another through public services. It is useful to look specifically at the NHS in discrediting this argument. Resources are collected nationally and are distributed by a collective organisation. Here, citizenship is strong. When a person chooses one NHS service over another NHS service, they choose from *within* a publicly organised service that is paid for by the collective citizenry. This strikes me as clearly both an experience of consumption *and* an experience of citizenship. To pose these two as opposites is absurd.

Social democrats also sometimes worry that choice will have the following negative consequence: leaving aside the

10 Le Grand J (1991) *Equity and Choice: An Essay in Economics and Applied Philosophy*. London: Harper Collins. p.67.

11 Glennerster H (2002) ‘United Kingdom Education 1997-2001.’ *Oxford Review of Economic Policy* (18) pp.120-136.

concern that different groups in society are differently capable of choosing wisely, many individuals might rationally choose options that are less than optimal in health terms. Their doing so will produce inequalities. An example might help make this point clearer: imagine two patients with equal needs, A and B. Both are offered the option of faster treatment, but only A accepts. As a result, A is treated quicker than B. Is this an equitable situation? Some social democrat critics of choice would say ‘no’ – A’s choice results in inequity of access.

Against this social democratic complaint we could point out, however, that both patients were at least *offered* the same choice. As Le Grand has argued: ‘[O]ur judgements concerning the degree of inequity inherent in a given distribution depend on the extent to which we see that distribution as the outcome of individual choice. If one individual receives less than another owing to her own choice, then the disparity is not considered inequitable; if it arises for reasons beyond her control, it is inequitable.’ So long as the respective outcomes faced by patients are the product of their individual calculations about the advantages and disadvantages of various treatment options, and as long as these calculations are not income contingent, then any difference in outcome cannot be seen to offend equity. It behoves our social democratic critics to recognise that equity is not synonymous with uniformity.

If we step outside the NHS for a moment, and look at the choice mechanisms developed in the primary school sector in the later 1990s, we can see how choice can actually *serve* social democratic outcomes. Here, a combination of open enrolment, league tables and formula funding created a mixture of incentives that not only improved performance, but also advanced equity. The percentage of pupils gaining the expected level of competence in maths on leaving primary school rose from 45% in 1995 to 70% in 2001. Impressive in itself; but especially so when one considers that the evidence suggests there to have been no improvement in maths skills of children in the early years of high school for 30 years before 1995. Furthermore, it was the schools performing *worst* in 1995 that showed the greatest improvement by 2001. The same is true of schools ranked according to the wealth of the area. Over the same period, schools in poorer areas were closing the gap on schools from rich ones.¹²

Of course, choice mechanisms will not *always* produce social democratic outcomes; but – and this is the crucial point – they can do so if properly constructed. As I shall outline below, the constraints built into choice mechanisms are critical, as is the flexibility to cope with the demands that the exercise of choice places upon them.

What choice within the NHS means

In our 2001 Manifesto we committed ourselves to ‘give patients more choice’. We specifically argued for the patients’ right to book their hospital appointment at a convenient time and with a hospital of their own choice. We wanted a mandate for these changes, to demonstrate that we could provide within a public service a personalised system that provided choice.

Between 2002 and 2003 we carried out a number of pilots on choice of elective surgery, which I will discuss below. In addition, in December 2003, we published *Building on the Best: Choice, Responsiveness and Equity in the NHS*. This document discussed six changes that, taken together, form the first stage of developing choice in the NHS:

- Giving people a bigger say in their treatment by means of recording each patients’ health and personal preferences. In time these preferences will be integrated into each individual’s electronic patient record.
- Increasing access to a wider range of primary care services.
- Increasing choice of where, when, and how to get medicines.
- Booking appointments at a time that suits patients from a choice of hospitals.
- Widening choice of treatment at the beginning and end of life.
- Ensuring people have the right information, at the right time with the support to use it.

Choice is a mechanism that will, I believe, lead to the overall reduction of inequalities; an increase in patient satisfaction with their experience of NHS care; and an improvement in health outcomes.

What choice does *not* entail

We also need to be clear about what choice in the NHS will not mean. No single or simple principle can cover all cases –

12 For more on this point see Le Grand J, Dixon J, Smith P (2003) *Can Market Forces be used for Good?* London: The Kings Fund. pp.12-13.

and there is no suggestion that patients will be encouraged to believe they are merely consumers in some kind of medical supermarket.

In no aspect of life is there a completely free and endless choice. Such an offer is a cruel deception. Choices always exist within parameters and whilst we will want those to be as wide as possible, we cannot pretend that choice is endless.

The right to choose treatment is not being translated into the right to choose *anything*. The doctor is not there to prescribe whatever pills the patient fancies, or to carry out surgical procedures at the patient’s whim. Doctors have an inescapable duty to consider what is in a patient’s medical interests. He must not do anything against patient’s medical interests however much the patient may wish him to do so.

Nor am I suggesting that the very frightened or the very ill want to be presented with an endless choice of alternatives – in such circumstances a doctor’s judgement is sought and welcomed.

Choice will inevitably be restricted in a number of ways. Where it conflicts with improving the overall health of society, choice will not always be possible. The maintenance of public health requires a collective commitment in which individual choices often have to be overridden in the broader public interest: individuals may desire to opt out of immunisation and vaccination services, for example, but these decisions may adversely affect other people’s health and not just those making the choices.

There will be three important parameters on how choice of elective care in the NHS will take place. First, the operation or treatment must be recommended by a GP – it is simply not possible for individuals to self refer to a hospital irrespective of what their GP says. There is also obviously a potential conflict – in the context of a fixed health care budget – between allowing individual patients unconstrained choice of treatments that are free at the point of consumption, and the allocation of resources in a cost-effective manner. Individuals who choose treatments that are not cost-effective thereby levy corresponding opportunity costs in terms of health gain foregone by other patients. In short, one patient’s choice may deny another’s treatment.

The second parameter on choice must be that the provider chosen by the patient must be recognised as safe by the Healthcare Commission. They will inspect to national standards, and patients will not be able to choose to go to a provider that is not recognised as safe within the national system.

The third parameter on choice is that providers must be able to carry out the procedure within the national tariff.

Provided we adhere to these three parameters, patients will be offered choices that are safe, cost effective, and levied at fair cost. From 2008, the Labour Government will offer open choice within these three parameters.

Choice and empowerment

I have already argued that there is no necessary conflict between the promotion of choice within the NHS system and social democratic ambitions. What I now want to claim is that one of the main goals prized by social democrats, and by many others on the left of the political spectrum – namely, empowerment – can actually be well served by the application of choice mechanisms. Fundamentally, our political objective is to redistribute power in the direction of the citizen-consumer, which in the NHS context is the *patient*. I have already described how our *Building on the Best* document sets out the range of choices that will be available to patients. There is considerable evidence from the voluntary sector that the more choices you give people, the more wisely they will choose. The medical profession itself increasingly recognises the necessity of replacing what the former president of the General Medical Council, Donald Irvine, has called ‘150 years of paternalistic culture’. This is to be replaced with ‘patient centred professionalism’.¹³ In Irvine’s view, the medical profession is ready to shed the ‘deeply conservative’ and ‘paternalistic’ attitude, which saw it view ‘patients’ interests through its own eyes and on its own terms’.¹⁴

This is a crucial shift in perspective. As the next section discusses, the absence of such a patient-centred view could undermine the quest for equity by means of choice.

Real choice for all

Choice in a consumer society is often linked to money. The

13 For discussion of this concept see Stacey M (1992) *Regulating British Medicine: The General Medical Council*. Chichester: Wiley.

14 Irvine D. (2003) *Patient centred professionalism – decision time*. The Duncan Memorial Lecture, Liverpool; Irvine D (2003) *The doctor's tale: professionalism and public trust*. Oxford: Radcliffe Medical Press.

more money you have, the more choices you will be able to make. Therefore, the rich will become experienced in making choices. They will get better at choosing, and will seek to exercise choice over wider aspects of their lives.

Of course, it is not that the disadvantaged never make choices. If you live in an inner city estate and have very little money, the only way you can survive at all is by being capable of making very difficult choices everyday. People from minority ethnic groups and those with lower incomes have to find their way through life by making very difficult choices. It's not that disadvantaged groups do not make choices, but they do not get to make as many and as wide a range of choices as their more advantaged counterparts.

Disadvantaged people rely on public services more than others. Since these services have traditionally offered very little choice, disadvantaged people have had little experience of choosing which hospital to go to. Now, our political choice is either to defend that status quo and remove people from those choice experiences forever, or to start introducing these choices to people now.

If we do not extend real choice to everyone, this position will never change and people with money will not only have more wealth but also more capacity to choose. That is why we need to extend choice to all, but that is also why people, when choice is first opened up, will need some assistance.

Social democratic fears about choice often stem from the fact that we start with different past experiences of choice. They think it will do nothing to reduce, and may even exacerbate, inequalities in access to health care. The anxiety is that in a system in which choice is no longer clandestine but open to all, the cultural, material and educational advantages of the affluent will prove even more decisive in ensuring access to the best services. In such circumstances, disparities in health outcomes would increase rather than become less pronounced.

This is, of course, a legitimate anxiety – even if, at times, the argument is laced with undue pessimism about the capabilities of the working classes familiar to any student of Labour Party history. However, we are either stuck with the existing distribution of choice experiences forever, or we attempt to tackle this inequality by introducing more choice now. I believe that the

question is not whether we should extend choice to those who have traditionally not enjoyed it; rather, the question is what kind of support ought we to provide these individuals in order that they might be able to exercise choice effectively?

It is at this point that the importance of a medical profession committed to the principle of patient autonomy asserts itself. The expertise of doctors and nurses must in the future lie not just in the delivery of excellent health care, but also in assisting patients to make their own decisions. The development of such a culture has been one of the most striking features of the heart surgery choice scheme. The task of offering patients a choice of faster treatment is carried out by the scheme's Patient Care Advisers (PCAs), who are usually nurses. Feedback suggests that patients have very much appreciated the PCAs: because they both guided these patients through the choice process and provided information and support.

Other pilot projects are developing similar support systems to ensure informed patient choice. Care advisers working in GP practices and primary care trusts are allocated to patients, drawing up a treatment plan in conjunction with the GP, and aiding patients in managing transport support and understanding the choices available to them.

Here, surely, the ideal of public service coincides with the encouragement of individual choice. What better expression of this ideal than to act as an informed agent, ensuring optimal treatment for one's patients?

Is choice incompatible with a public-service ethos?

Another objection to the choice agenda is that it will destroy the public service ethos without which the NHS could not flourish. The ethic of public service is certainly precious. Not all goods are market goods and not all values can be quantified. Indeed, as I made clear in the introduction, the nourishing of this social ethos is critical to a successful NHS.

Yet to serve the public, the professions surely cannot be granted total licence by them. Part of the public service ethos must be a commitment to improving services. Choice mechanisms offer the prospect of improvement without necessarily damaging the altruism that motivates many who work within the NHS –

they provide the opportunity to serve the public by delivering them the preferences that they want.

Again, the design of the choice mechanism is critical: it must ensure that purely self-centred motivations are counter-balanced by incentives to act for the good of others. Those choice mechanisms being constructed within the NHS are designed with this principle in mind.

The concluding chapter discusses these mechanisms. It explains why encouraging patients to register their preferences by means of such mechanisms is critical to ensuring continual improvements in NHS health care. It also demonstrates that it is possible to do this without patients having to use personal finances

6. Creating a Modern Health Service through Patient Preference

Rationale

Following our 2001 Manifesto commitment to provide patients with more choice, this Government is committed to embedding patient preference within the national health care system. An NHS shaped by patient preference will be an innovative and responsive one.

The dynamism of the market flows in part from the way in which it enables consumers to demonstrate a preference for one kind of activity, service or product over another. These signals are transmitted to organisations that adjust their behaviour accordingly. I contend that individuals' finances do not have to be brought to bear in order for preferences to be expressed, and for providers to respond accordingly.

What the Government will do is harness the power of patient preference within the NHS without recourse to the use of the price mechanism, where the patient is forced to use their own money. A health service in which individuals were allowed to make choices about their own health care would enable the registering of preferences. This, in turn, acts to lever improvement: an individual choosing provider A and not provider B within the range of NHS providers sends a powerful signal to both A and B. Sensitive services develop and, over time, this will have an impact on the way in which both A and B delivers their services. B will learn, not in the abstract, but as a consequence of a series of individual choices made by NHS patients. In an organisation as large as the NHS, preference – if organised properly – can be an engine of genuine continuous improvement.

15 Wanless D (2002) *Securing our Future Health: Taking a Long-Term View*. London: HM Treasury.

16 Boaz M (1999) *Teaching at a Distance: A Handbook for Instructors*. Washington DC: American Association of Community Colleges.

Such improvement is not just a matter of increasing the responsiveness of the NHS. Genuine patient preference will also encourage changes in the behaviour of patients, and potential patients. Empowerment of patients, by means of more choice and opportunities for intervention in the system, will encourage citizens to take a greater role in their own health care and well-being.

This is critical, since a society committed to healthy living would reduce the pressures on scarce NHS resources to a greater degree than any kind of organisational or management reform. Derek Wanless referred to a 'fully engaged scenario' to describe the preferred relationship between the public and the NHS.¹⁵ Full engagement will need patients and the public to develop much closer and more powerful interactions with NHS services. The power of choice is a part of that engagement.

Encouraging a preference for prevention amongst the public is crucial then; but there are other reasons to believe that patient preference would improve the NHS. Empirical evidence also suggests that an empowered public would prefer not to go into hospital if there were other clinical options, and would choose not to stay in hospital if presented with medically valid alternatives. Unsurprisingly, studies suggest that older people want more choice and independence with four fifths of older people strongly wanting to remain in their own home for as long as possible.¹⁶ Choices along these lines, as the previously discussed evidence from the US system suggests, helps keep costs down at the same time as being a wise choice on health grounds.

*Unsurprisingly, studies suggest that older people want more choice and independence with four fifths of older people strongly wanting to remain in their own home for as long as possible.*¹⁶

Payment by Results

In April 2003, the 'Payment by Results' initiative began its phased implementation in the acute sector. First introduced to the acute sector in 2003/4, it will become fully operational in 2005/6, and the intention is that it will eventually be extended to outpatient, community, mental health, and learning disability services.

In the past, NHS trusts received income on a block basis, based on their past years' payments, plus a sum for improvement and change. Most primary care trusts have until recently had 'block contracts' for acute services, which have not been based on the actual activity carried out by a provider – they are generally based upon historical patterns of care and cannot reflect changing patterns of service provision. They are unsophisticated methods of budgeting and may not reflect the activity being carried out by different departments.

Within these providers, the management of demand is variable, and the costs and benefits of different patterns of activity have been unclear. This has meant that the existing system has left hospitals with very different cost bases, since there has been no rational basis to bear down on costs.

'Payment by Results' significantly alters the arrangements for funding providers of routine elective surgery. NHS trusts will now receive part of their income based on a fixed cost per case – for specific treatments associated with long waiting times – rather than on a block basis.

The basic elements of the programme are four-fold:

- There will be a prospective, nationally set tariff for most NHS activity.
- The tariff will be built on clinically meaningful groups of treatments and activities known as 'health care resource groups' (HRGs).
- The price for the service will be based on NHS averages, as reported by NHS organisations.
- The same process will apply across the NHS in England (adjusted only for unavoidable, nationally set, geographical cost differences).

17 Propper C, Burgess S, Green K, (2003) *Competition and Quality: Evidence from the NHS internal market 1991-1999*. Bristol: University of Bristol.

This constructs a clear national price for work to be done. The price cannot be varied by a hospital cutting corners. The system provides a transparent, rules based schema for paying for NHS care. It will reward efficiency and promote fairness in payment for work done.

Clear, transparent patient flows are necessary for patient choice. It will mean that funds can literally follow individual patient choices for treatment, and it will help encourage a growing plurality of provision in the delivery of NHS services. Providers will be paid for the activity they actually deliver, rather than based on historical patterns of care, as was the case with block contracts. Commissioners will have sufficient funding to look for alternative providers if agreed activity levels are not met. In addition, the intention is that trusts should also be able to reinvest any surpluses they earn by providing care (which meets quality thresholds) at costs below the tariff rate.

Safeguards

'Payment by Results' has been designed to avoid the flaws inherent in the old internal market. Instead of price competition (which did not work for emergency cases, was destructive of relationships between organisations, and had high transaction costs) providers will compete on *quality*.

Moreover, there is no splitting of purchasing between health authorities and GP fundholders – a separation that previously generated inequities in access. Primary care trusts commission care from providers and not, as in the past, from a mix of health authorities and fund holders. Before implementing 'Payment by Results', we created a rigorous framework of national standards and independent inspection. The absence of such a framework in the internal market left the door open to reductions in some aspects of quality.¹⁷

Other safeguards are also in place. This radical change will take some time to achieve and there will be a three-year transition path so that trusts can adjust local costs to fit the new arrangements. It is expected that within the next three to four years the majority of hospital and community health care will be fully reimbursed through the national tariff. Transitional arrangements will help ensure that the casemix classification (on which tariffs will be based) reflects the cost implications

of specialist services.

New treatment categories are also being developed with the aim of reducing the variation in complexity within each category: this will minimise the number of patients within each category who have a cost of treatment significantly different from the tariff cost and could potentially be ‘cherry picked’ by the private sector. It is planned that there will a supplementary tariff for long-stay patients and the possibility of reducing the tariff for very short-stay patients is also being explored.

Since payment to trusts will be based on national average costs and length of stay, we also recognise the potentially perverse incentive to discharge patients prematurely. There is a fine line to be trodden here since, at the same time, trusts will have a further incentive to avoid unnecessary delay in discharging patients. Critical in this connection are the provisions of the Community Care (Delayed Discharges etc.) Act 2003, which embed within the system the absolute necessity of taking discharge decisions solely on clinical need. When one considers, in addition, that any trust discharging patients prematurely risks an almost immediate increase in emergency re-admissions – an increase which would harm its performance rating, with all the attendant consequences of a drop in rating – the incentive mix appears robust.

Transformation of commissioning policy

‘Payment by Results’ therefore exerts pressure on high-cost providers to improve their performance, encourages a greater plurality of provision in the delivery of NHS services, and represents an initial step down the path towards a system driven by patient preference.

However, ‘Payment by Results’ should not be viewed in

The new contract for general medical services accepted by GPs in June 2003 signals the most ambitious attempt to reform primary care services since the creation of the NHS

isolation. It is part of a broader transformation of commissioning policy. With control over 75% of the overall NHS budget, Primary Care Trusts now have the freedom to innovate and design locally appropriate solutions – not only with respect to securing the provision of services but also in terms of their broader remit: improving the health of the local community and integrating health and social care.

Services can be commissioned from wherever and whoever offers the highest clinical standards at the best value for money. From April 2004, PCTs must ensure that patients who have waited 6 months for treatment receive a choice of providers, and from December 2005 all patients will receive a choice of providers at the point of referral.

However, effective commissioning also relies upon the input of local health professionals in primary and secondary care; it requires the development of ‘care pathways’ ensuring that the ‘right’ services are available at the ‘right’ time in the ‘right’ location for the ‘right’ patients.

The new GP contract

The new contract for general medical services accepted by GPs in June 2003 signals the most ambitious attempt to reform primary care services since the creation of the NHS. Primary care professionals will be rewarded for the outcomes they achieve, not just how many patients they treat, with extra rewards for providing quality service.

It provides a new allocation formula that removes the historical inequalities of the current system of per-doctor payments, which penalised practices in under-doctored areas. Resources will be allocated to practices more fairly based upon patient need, practice workload and costs and not just on the numbers of people on the practice register. This new incentive structure will foster even better chronic disease management in the community – thus relieving pressures on hospitals. GPs will be rewarded for a more active approach towards the management of long-term conditions amongst their population rather than allowing people to develop as an emergency medical admission.

The range of services available at GP surgeries will be widened as part of this strategy to ensure access to a greater

range of treatments in the community. This will help engender the preferences of patients to be treated close to home, preventing unnecessary hospital stays.

Conclusions

Because the purchase of many goods and services involves a cash transaction, there is a woolly belief that *all* experiences of consumption are linked to payment. However, this is far from the case. We consume many services without recourse to payment. Walking in the local park, listening to the radio, playing with our children on the beach, and, in the UK, going to the doctor's surgery – all these things do not necessitate cash changing hands. Each of these services absorbs resources; yet the individual has to provide no money of his or her own as they receive the services.

Indeed, the knowledge that consumption is not coterminous with payment is central to social democratic thinking. The creation of the NHS extended access to treatment and care to millions of people who had previously been unable to exercise this fundamental choice because of their lack of income. For social democrats, consumption and citizenship are not therefore antithetical. The embedding of patient preference, the choice agenda if you will, is a genuine attempt to empower patients and the public within a national system of public health care.

We will encourage contestability without recourse to price competition. The new NHS is in fact placing the private sector under increasing pressure. With NHS waiting lists falling in many places, the number of people paying for one-off operations is falling. Laing & Buisson, the private health care analyst, recently warned its clients that 'Plans for the NHS undoubtedly pose a threat to the traditional private hospital sector as we know it'. And as the Financial Times said in its leader on 23 April 2004: "Britain's private health sector is about to undergo a sudden, potentially painful, and wholly welcome transformation. For decades now most of it has operated as an inefficient and expensive cottage industry, far from the cutting edge..... This world however is about to change thanks, ironically, to the NHS. For the government is demonstrating it can create a market in health care."

By 2005, we expect that no one will wait longer than 6

18 BBC News Online (2003, 27 November) 'NHS shows signs of improvement.' Quoting Professor Sheila Leatherman.

months, with an average wait of just 3 months. Patients will be able to shop around for the shortest waiting times anywhere they want. By 2008, the maximum wait will be just 3 months, and the average wait only 7 weeks.

Transforming the NHS is our objective. A recent report by international health specialists, commissioned by the Nuffield Trust, described our programme as 'the most ambitious, comprehensive and intentionally funded national initiative to improve health care quality in the world'.¹⁸ Let us get on with it.

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In this essay, Secretary of State for Health Dr. John Reid lays out the case for extending patient choice within the NHS. He tackles two misconceptions head-on: the belief that 'choice' is a value solely for those on the ideological right; and the idea that choice is only meaningful within markets where the chooser's own private money is brought to bear. Dr Reid argues that choice in health care ought to be welcomed by those with social democratic instincts, since it empowers individual patients irrespective of their personal wealth, and holds out the promise of more responsive, higher quality services for all users. This new model of service organisation signals a welcome shift away from the old structure of central state planning and provision. But it need not, Dr Reid argues, entail the introduction of markets into the structure of the NHS.