



# Designing the 'new' NHS

IDEAS TO MAKE A SUPPLIER MARKET  
IN HEALTH CARE WORK

Report of an independent working group  
June 2006

# DESIGNING THE ‘NEW’ NHS

Ideas to make a supplier market in health care work

Report of an independent working group

Chair: Greg Parston

Report Editor: Nicholas Timmins

*King's* **Fund**

Recent changes in the NHS have triggered significant expansion in the involvement of independent and voluntary sectors in the delivery of services. How can this involvement be developed to ensure quality of care for patients and to enrich choice? This question was addressed by a small independent working group, commissioned by the King's Fund. This report is based on discussions within the group and on a one-day workshop that proposed and assessed alternative developments in the future NHS. This report highlights many of the issues that need to be addressed by government and by people providing health services in all three sectors.

The independent working group was convened by the King's Fund to stimulate debate. The views and recommendations included in the report are, however, those of the group and not necessarily those of the King's Fund.

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## Letter from chair of independent working group

20 April 2006  
Niall Dickson  
Chief Executive  
King's Fund  
11–13 Cavendish Square  
London W1G 0AN

Dear Niall

### **Designing the 'new' NHS:**

#### ***Ideas to make a supplier market in health care work***

I am pleased to submit the report of the independent working group charged with examining what needs to be done to develop a more effective and patient-centred supply of health services in the emerging NHS marketplace.

Recent changes in the NHS have triggered significant expansion in the involvement of independent and voluntary sectors in the delivery of NHS services. Much of that additional capacity has potential to enlarge patient choice and drive competitive improvements in service provision; but there are costs and worries involved. Many old ways of working will have to change; many suspicions of profiteering will have to be addressed; and high standards of quality care will have to be assured.

You invited me to chair a small working group which was asked to look at how the role of the for-profit and not-for-profit sectors, in

particular, could be developed most positively in the changing NHS market. We were asked to tease out the key issues that need to be addressed to ensure that NHS reforms are introduced in a way that benefits patients' quality of care and enriches choice. This report brings to the fore many of the issues that need to be addressed by government and by people providing health services in all three sectors.

The working group comprised the following people from the NHS, independent and voluntary sectors:

Victor Adebowale, Chief Executive, Turning Point  
Zenna Atkins, Chair, Portsmouth City Teaching PCT  
Robert Creighton, Chief Executive, Ealing PCT  
Mark Goldman, Chief Executive, Heart of England Foundation Trust  
Neil Goodwin, Chief Executive, Greater Manchester SHA  
Tom Hughes-Hallett, Chief Executive, Marie Curie Cancer Care  
Ed Mayo, Chief Executive, National Consumer Council  
Keith Palmer, Senior Associate, King's Fund  
Chai Patel, Chief Executive, Priory Healthcare  
Carolyn Regan, Chief Executive, NE London SHA  
Rebecca Rosen, Senior Fellow, King's Fund  
Bryan Sanderson CBE, Chairman, BUPA  
Michael Shaw, Chief Executive, John Grooms  
Ian Smith, Chief Executive, General HealthCare Group

Nicholas Timmins, Public Policy Editor of the Financial Times, worked with us to shape and write the report; he was also an invaluable source of information and clarity in our deliberations. Tabitha Brufal, on secondment to the Fund, worked with us diligently to ensure we kept pace and focus. Both of them served the group extraordinarily well.

We did not have time to carry out any deep analytical work but we met on three occasions to identify and discuss the issues, in what were often lively debates. We also conducted a day-long workshop which brought together a much wider group of people in a scenario-based whole systems event that proposed and assessed alternative developments in the future NHS. On behalf of the working party, I extend thanks to the workshop participants for their expertise and insights, which we drew upon in this report.

The report is the product of the working group, but I must stress that, whilst the members of the working group are happy with the broad thrust of the report's analysis, not all of them agree with every recommendation and none can be held personally accountable for the contents. The members of the group worked hard, in spite of some differences, to produce a report that we hope will be helpful in adding force and clarity to what needs to be done now in the NHS. And they all share a common concern, which is that we must work together to reconstruct a national health system that truly meets the need of today's more demanding and sophisticated public.

Yours sincerely

Greg Parston  
Chairman of OPM and Director of the Priory Group  
London

## Foreword

The NHS is changing, indeed it is undergoing more far-reaching change than at any time in its history. Central to the current reforms has been a willingness to move away from a centrally controlled state-provided system and towards a more devolved model in which a variety of different organisations provide services. In one sense the definition of what we understand by the letters NHS has been altered so that now it means a more or less comprehensive system of tax-funded care available free at the point of use.

On the supply side this has already produced a changing landscape. There has been a discernable increase in the use of the independent and voluntary organisations to provide services for NHS patients in recent years. In particular, sizeable contracts covering diagnostics and elective procedures have been awarded to independent sector providers, and the government says it is also committed to building on the significant contribution the voluntary sector already makes to the NHS in areas such as mental health and end-of-life care.

This shift in policy towards the introduction of a supplier market has been achieved with surprisingly little serious discussion, especially given all the fuss around the creation of NHS foundation trusts. If this market or quasi-market is to be effective there are obvious questions that need to be addressed as soon as possible. How committed is the government to the development of a market? How should such a market be regulated and inspected? How can the quality of care received by patients be assured? How can diversity of provision be introduced in a way which is acceptable to the public and to staff?

In response to these and other questions, I asked Greg Parston to chair a small independent working group of health service leaders from the NHS, independent and voluntary sectors.

Many of the recommendations in this report resonate with work that we have been carrying out at the Fund. We do not agree with every one but we welcome the thrust of its argument and hope that its call for greater clarity about the long-term objectives of current policy is heeded.

If the government is committed to the development of a supplier market, it will be essential for all three sectors to work together – the process of producing this report showed that there are many shared issues and concerns.

Organisational structures, regulation and incentives are but means to an end. The success or otherwise of the current changes will be judged on what they achieve for patients and the public who fund the NHS. Just as they should have an increasing say in the care and treatment on offer, so ultimately they should decide whether the emerging set of reforms have lived up to the expectations of their architects.

I should like to thank the working group for the time they have devoted to this initiative and for producing such a compelling and stimulating report. It provides a thought-provoking and timely contribution and I hope that many of its recommendations influence future policy and debate.

Niall Dickson  
Chief Executive, King's Fund

## Introduction

The National Health Service (NHS) in England is undergoing the biggest revolution in health care provision since its foundation in 1948.

A powerful mix of Payment by Results, patient choice, new independent sector providers, and the deliberate creation of new forms of what were once directly run NHS provision – both foundation trusts and newer forms of social enterprise spun out of old NHS organisations – is creating a supply-side market in the provision of health care.

At the same time, primary care trusts are intended to become more active commissioners of care, while family doctors are once again to control budgets – initially indicative ones; in time, perhaps, real ones. The more entrepreneurial will again be encouraged to find new organisational ways of delivering care.

All this offers enormous opportunities. But it also carries great risks. It is not difficult to envisage a future in which a poorly operating market could succeed in tackling a traditional NHS weakness – long waits for elective care – while seriously damaging widely acknowledged strengths – prompt and high-quality emergency care, and effective treatment of serious illness. At the same time, care for long-term conditions and for what have traditionally been dubbed ‘the Cinderella services’ – for example mental health – could also degrade, perhaps badly.

Against that, it is possible to glimpse a future in which a well-functioning supply-side market produces a service that is more

flexible and innovative and more responsive to patients' wishes, while operating more efficiently and delivering better value for money. This service would not only produce good clinical outcomes but would also give patients a positive experience – the 'soft side' of quality, so to speak – and help them manage their own health, lives and treatment better.

Getting there, however, will not be easy. This report is aimed at easing the journey. It tries, succinctly, to set out the necessary actions for that better future to have the best chance of being realised.

It originates from a commission by Niall Dickson, chief executive of the King's Fund. The brief was, assuming government policy continues on a path towards a supply-side market, to provide recommendations aimed at a) improving the range and diversity of high-quality services that respond to the needs and choices of NHS patients and their families, and b) helping to develop more effective and innovative patterns of care and support.

A working group was set up to address this brief; the membership of the group was drawn from the various parts of the NHS – strategic health authorities (SHAs), primary care trusts (PCTs), trusts and foundation trusts – and from the private and voluntary sectors. The group was unable to undertake any analytical work, but it met to debate the issues and then set up a day-long workshop that drew on the experience and skills of a much wider range of people across all three sectors. The workshop used scenario planning – setting out a version of the future in which the worst appeared to happen against another version that produced appreciably better outcomes for patients – and drew on the experience of the people there to help devise recommendations aimed at achieving the best possible result. The output from the workshop was then analysed and debated again by the working group to produce this report. The

scenarios are set out in appendix A, and workshop participants are detailed in appendix B. The work has therefore been deliberative and discursive, based on views and experience, rather than on more formal analysis or evidence.

The report takes no particular stand on the desirability of introducing a supplier market in health care. It merely notes that it is the policy of both the current Labour government and of the Conservative opposition. The Conservative position, certainly as set out by David Cameron, its new leader, might be characterised as ‘the same, but even more so’.<sup>1</sup>

A supplier market is likely. Assuming it is a given, the questions are how far it will go, and how it can be made to function well, in the interests of both patients and the taxpayer.

Its goals – its core principles – too are given. If the statements of politicians are to be believed, they are shared across the parties. These are that the ‘new’ NHS will remain a universal, tax-funded service, at least as comprehensive as the current one, based on clinical need, not ability to pay. No changes are envisaged to the funding side.

It will also strive continuously to improve quality across all six of its dimensions. These are:<sup>2</sup>

- access to service
- relevance to need
- effectiveness
- equity
- social acceptability
- efficiency.

Quality encompasses a determination on the part of the NHS to work with others to provide a seamless service across health and social

care, while encouraging investment in public health both as a goal in its own right, and to control demand on the health system. Services will as far as possible be shaped around the needs and preferences of individual patients, their families and carers. The system will work to minimise errors, and taxpayers' money will not be used to subsidise individuals' privately funded health care beyond the current level.

Much of this report, perhaps inevitably, contains recommendations for government, but it also contains recommendations that affect NHS-run bodies and all parts of the independent sector: private, voluntary, and the new forms of enterprise such as foundation trusts and new businesses formed by NHS staff.

The report is the report of the working group. There is no minority report. However, on some issues – notably on regulation, practice-based commissioning and on the future configuration of the most senior jobs in the Department of Health – there were widely diverging views. It should be stressed, therefore, that not all its members agree with every recommendation. Individually they cannot be held accountable for them. Most, however, agree with most of the recommendations, and with the thrust of the analysis.

## Introducing a supplier market

From the point of view of patients, four actions are necessary if the introduction of a supplier market is to allow the best to happen and the worst to be avoided. These actions are not ‘pick and choose’ options; they are interlinked and interact.

They are: clarity at the centre, the reform of structure and regulation, a major strengthening of commissioning, and some critical developments in the health system’s infrastructure.

### **1 Clarity at the centre**

Clarity at the centre is essential because it sets the parameters for everything else. The National Health Service (NHS), despite its (almost entirely false) public image of a monopolistic state-run system, has always used, and been involved with, the voluntary and private sectors.

#### ***Contracted services***

Most of the NHS’s money goes on staff. But even here it has long contracted with, rather than employed, family doctors. Indeed, it was Aneurin Bevan, the founder of the NHS, who insisted, against opposition from some of his own backbenchers, that GPs should be independent contractors, paid chiefly by capitation and some fees, rather than by salary. He did so in order that patients would be able to have a choice of doctor, something he believed would be difficult to achieve with a purely salaried service.

So even today, after 20 years of growth in the number of salaried GPs, 70 per cent of them remain independent contractors, who pay

themselves out of the profit of running a small business, even if some of them, conceptually, don't see it like that. In addition, of course, the NHS has long bought beds, drips, other medical equipment and much else from the private sector, and not since the 1960s has any mainstream politician seriously suggested nationalising the pharmaceutical industry.

Since 1948, the NHS has held a small number of contracts with voluntary and charitable hospitals for care. It has long had a semi-contractual, semi-grant giving relationship with the hospice movement. Patients needing long-term care are funded by the NHS in independent nursing homes. And it has bought operations, usually under so-called waiting list initiatives, from private hospitals since the 1980s. Large chunks of mental health care are bought in from the private and voluntary sector, including a large element of the medium-secure accommodation that is needed for some of the most vulnerable patients with whom the NHS deals: those compulsorily detained under the Mental Health Acts.

More recently the government has let contracts worth £2.5 billion over five years for the first wave of independent sector treatment centres (ISTCs). A second wave worth the same amount is under negotiation, as is the first part of what is promised to be a £1 billion contract over five years for diagnostics. By 2008 the NHS will be spending at least £5 billion annually on care supplied by the private sector – and that is aside from spending on contracted services from GPs and any effect from patient choice (where patients may opt to have their elective operations in private hospitals), as well as any greater involvement of the commercial and voluntary sectors in primary and community care and any moves by NHS staff to leave the service and contract their services back.<sup>3</sup>

In addition, currently there are 32 foundation trusts, with another 25 applications in the pipeline. Health department planning

documents talk of 65 to 80 foundation trusts by March 2007.<sup>4</sup> Foundation trusts stand part way between the traditional public and private sectors. They remain formally part of the NHS; in the last analysis their ownership can be returned to the Secretary of State. In the meantime they operate as not-for-profit private trading bodies, owning their own assets, and able to make surpluses, do deals with each other, with the private sector and with anyone else who crosses their path, and able to go bust.

### *Role of the independent sector*

Despite all this, it is not yet clear whether the government is fully committed to a supplier market, or whether it merely wants to use the stimulus of limited competition from the independent sector as a tool intended to improve the performance of NHS-run organisations.

There are precedents both ways in other areas of government. In criminal justice, for example, private finance initiative (PFI) prisons have been used to challenge the performance of state-owned institutions. To date, however, they have all been green field constructions. While a small number of newly built state-owned prisons have been handed over to private sector management, the private sector has not taken over the management of existing establishments. Policy has been to use the private sector to challenge the public sector rather than to create a full supplier market, although with the creation of the new National Offender Management Service this may change. The same is true in education, where the private sector has taken over the running of some local education authorities, but on a small scale, with contracts usually reverting to the public sector when they end. This again is use of the private sector as a form of challenge, not as a fully competing supplier.

In social care, by contrast, the outcome of the policy of successive governments has been that a large majority of care home places and a clear majority of home care services – around 90 per cent and almost 70 per cent respectively – are now supplied by the independent sector.<sup>5</sup> In so far as council-run provision remains, it is part of a fully competitive market, even if it is one in which local authorities have in the main proved to be poor-quality commissioners.<sup>6</sup> Equally, in social security, it is now officially declared government policy that the private and voluntary sectors will provide the bulk of the expansion of Pathways to Work, the government’s welfare-to-work programme for people on incapacity benefit. In that area of benefits policy, there will be a full supplier market.

Clarity on the intended composition of the supplier market matters because large parts of the private and voluntary sectors retain doubts over whether they are merely being used as a short-term tool – one that will later be discarded – to stimulate better performance from the public sector; or whether they have a long-term future as suppliers of care to the NHS. Without the certainty of the latter, both parts of the independent sector will be more cautious about investment; they may be less innovative; and the government/ Department of Health/NHS will have to subsidise the cost of market entry (usually capital costs), as happened with the first wave of ISTCs. The result is likely to be higher costs, a reduced willingness by the independent sector to take risks, and less innovation.

If the government believes there is a permanent role for the independent sector in a full supplier market, it should say so unequivocally. The Conservative opposition also needs to be clearer about this in detail than it has so far been. At the moment, the signals from health ministers remain mixed: one day implying they are in favour, another denying some of the likely consequences.

## *Change in thinking*

Commitment to a supplier market will involve an important change in thinking. Ministers and commissioners (whether SHAs, PCTs or practice-based commissioners) will need to think of the NHS as a purchasing organisation: a national health system as much as a national health service, one that buys care from a variety of competing organisations (who may well also co-operate) and one in which new suppliers can enter the market without the ‘permission’ implied by centrally run contracts. Subject to normal licensing and regulation, they will be able to offer services rather than merely have services requested from them.

This change of understanding of the nature of health care provision in England will need to take root not just in the minds of successive ministers, but also in the minds of commissioners – that they are responsible for the purchase and provision of care to patients, and not directly for the institutions and services that deliver it. They will be charged with ensuring that care is there, but not that any particular institution provides it. Foundation trusts will have to be treated as what they are: large, not-for-profit suppliers of NHS care, not NHS-run institutions.

Without clarity on this, there will be muddle. Muddle will be dangerous for patients.

Clarity will allow ministers to understand their distinct (and in future more limited) role in the health care system: raising the money for the NHS from the Treasury, establishing policies for health outcomes, setting basic standards and the goals they expect the money to achieve – but then stepping back from day-to-day involvement, allowing the market, its management and regulation to function.

Ministers also need to be clear that there will be limits to choice. It is right that the service should become more responsive and offer patients more choice about how, where and when they are treated. But the NHS remains a tax-funded system. It has to balance the preferences of individuals against their demands on the taxpayer. The service has been described as both one of the biggest health insurance systems in the world, and the world's biggest health maintenance organisation. In practice it will, as it broadly does now, deliver a form of managed care.

This means patients will not be able to 'choose' a ten-day stay for a hip replacement (unless their medical and social circumstances so dictate) when hospitals are able to discharge them with equally good, if not better, results in four or five days. Patients will not be able to 'choose' treatments that the National Institute for Health and Clinical Excellence (NICE) has deemed cost ineffective. This would apply equally if the NHS was funded by social insurance, or operated in a mix of public and private insurance. But it does mean that there are, and will be, limits to choice. Politicians, while rightly seeking to make the NHS more responsive, should not gloss over that, or seek to deny it. They should thus be careful about raising unrealistic expectations in the name of 'choice'.

If the government truly wants a supplier market, the following recommendations flow.

1

**The government needs to state unequivocally that it sees a supplier market in health care as the long-term future for the national health system. It should not, as ministers have tended to do so far, state or imply an upper limit to independent sector provision. The proportion of care coming from NHS-run, private and voluntary sectors should emerge from the operation of the market. It should not be artificially defined.**

- 2** Ministers need to understand that in future they will be responsible for a national health system, not a state-owned national health service. Their role (and see section on regulation below) will be to raise the money for the NHS from the Treasury, define broad priorities and set the regulatory framework. But they will not then be involved in the day-to-day management of the service. Instead a commissioner will buy it from whoever offers the best value and quality.
- 3** Ministers need to explain this clearly not only to the public but to their own backbenchers and other members of parliament. As that happens, MPs, councillors and others will need to understand that their role is to defend the quality of services to patients, not institutions.
- 4** Primary care trusts' future role will primarily be commissioning, co-ordination, and an element of regulation, not direct provision of services. They will primarily be responsible for the purchase of care for patients – charged with ensuring that care is there, not that particular institutions, whether run by the NHS or not, thrive or survive.
- 5** Even as they seek to make the NHS more responsive, and to increase choice, politicians also need to be honest with the public in explaining that in any collectively funded system of health care, there will be limits to choice.

## **2 The reform of structure and regulation**

Regulation is a word that is used to mean different things. Sometimes it is used in a narrow way to mean the rules set by statutory bodies to control or require actions in institutions or markets. Sometimes it is used more broadly to include inspection, not just of whether regulations are being followed but also whether other goals, which may not be statutorily defined, are being

achieved. On other occasions the term is used to embrace demands for information that may not have to be statutorily supplied but that in practice has to be provided. In this report it is chiefly used in the first two of those definitions.

The NHS is not short of regulation at present, certainly using the broadest definition. Well over 100 bodies have the right to inspect, audit, enforce actions on and demand information from the average district general hospital. Unfortunately, much of it is the wrong sort of regulation for a supplier market.

A system is needed to deal with market exit and entry, with financial and performance failure, with mergers and acquisitions, and with abuse by a monopoly supplier or monopsony purchaser (a purchaser so dominant that it can abuse its position – something that has arguably happened in the social care market). All of that has to happen within a framework of inspection aimed at guaranteeing standards, quality and consumer protection.

The reform of regulation will also require fundamental changes to who does what within the Department of Health, affecting politicians, civil servants and the service's top management.

### ***Regulation in supplier markets***

How far and how fast regulation has to change depends, however, on how far the government wants to have a genuine supplier market in health care. In a fully fledged supplier market, the following is probably required.

Ministers would still raise the money for the National Health Service, negotiating with the Treasury. They would be responsible for the framework of the supplier market: how standards are set, how it is regulated. They would also define overarching goals for the NHS: what they expect to be achieved with the money. But they would

cease to manage the service or to be responsible for its day-to-day running.

In the Department of Health, this would require big changes to the most senior posts. For the past five years, the role of permanent secretary and chief executive of the NHS has been a combined one. But as the government has begun to develop a supplier market, the combined post has been subject to increasingly irreconcilable conflicts; one person cannot be expected to be head of policy, of commissioning and of NHS-run provision, while attempting at the same time to ensure a level playing field between public and private providers and that NHS organisations remain financially viable. Such a combination of roles will in future be unsustainable.

In a fully fledged supplier market, the jobs of permanent secretary and chief executive of the NHS would therefore have to be split into at least two functions, possibly into three. The reason is that there will not be a national health service, as we currently understand it, to be chief executive of.

The service would remain, as now, tax funded and largely free at the point of use. But the Department of Health would need a separate policy arm, headed by a permanent secretary, overseeing, and no doubt in time adjusting, the regulatory framework, helping ministers decide on priorities, and helping make the case for NHS cash.

There would then need to be a commissioner of care – a chief buyer for patients who would be responsible for delivering the policy goals, working through strategic health authorities (SHAs), primary care trusts (PCTs) and commissioning GPs: setting their targets, holding them to account, deciding what is best purchased nationally, regionally or locally, and creating a framework that ensures that services do not collapse or patients fall through the net. The commissioner would be responsible for the viability and

quality of services, but not for the viability of individually run institutions.

Unless and until all existing NHS organisations operate either as independent contractors, or become foundation trusts, there will need to be a functionally separate head of operations – a chief executive for NHS-run bodies who will need to be operationally independent of ministers and the commissioner. However, as a full supplier market develops, this role will decline over time. Eventually it will probably disappear.

The issue then is how the market is regulated. The government currently has a review of that under way. It raises some extremely difficult issues. There is broad agreement among the existing regulators and inspectors that two essential functions are needed: economic regulation and quality inspection. There is, however, disagreement about whether there should be one body or two.<sup>7</sup>

Monitor, the current regulator for foundation hospitals, has argued that the bodies should be separate. Linking the two, it argues, would create a conflict of interest in which quality of care could be traded off against the financial viability of the bodies being regulated, in this case foundation hospitals. Arguably, it is that very trade-off, undertaken with no transparency within the Department of Health, that led, prior to 1999, to years of under-funding for the NHS. If economic regulation and quality regulation are kept separate it would be possible for a quality inspector to warn that standards are falling and that patients are being put at risk, even as the foundation trust regulator is able to say that the bodies for which it is responsible are financially viable. Any tension between the two would be transparent – although there could be dangerous time lags between the two sets of judgements becoming public.

The counter argument is that finance and quality are inextricably linked. As the Healthcare Commission has argued, if financial

viability requires a reduction in staff, or the termination of certain services, that can have a direct impact upon patients.

### *Forms of regulation*

Then there is the question of who should be regulated and in what way. It is a given that private sector health providers require a licence to operate; that is essential to provide basic assurances to patients. Foundation trusts also require a licence to operate. But NHS-run hospitals and units do not. Voluntary organisations, where they are charity based, have to be registered with the Charity Commission. Over time, more consistency between the various regimes will be needed to create a level playing field.

Foundation trusts currently have an economic regulator (Monitor) whose remit includes not only approving their applications but having extensive powers to monitor their performance and intervene if necessary. In the initial stages, at least, that is fitting. But it is not a requirement of the health care market that an economic regulator will have similar powers of intervention for private sector companies or voluntary organisations. While they operate on their current scale, they can be allowed to succeed or fail, with the likelihood of takeover of their operations in the latter case.

In the longer run, should that apply to foundation trusts as well? Or does the nature of the health care market, and the fact that big towns cannot be left without a major health care facility, mean that foundation trusts will always be subject to a more intrusive regulation and potential intervention than independent sector operators? And whose job will it be to oversee mergers and acquisitions when a foundation trust fails? Currently, that lies with Monitor. But purchasers (PCTs and SHAs) need a key stake in that because, as commissioners, it is their job to ensure continuity of care for patients. In turn, that raises questions about whether, over time, it is the performance of purchasers – SHAs, PCTs and practice-

based commissioners – that should be measured and monitored (in other words regulated) more closely than that of providers. Such an approach might allow the burden of regulation on suppliers to be reduced.

It is also not yet clear how far competition law will come to apply to the NHS. At the moment it has only the most limited application as state-owned hospitals are not classified as undertakings for the purposes of competition law. In addition, contracts for clinical services do not have to be put out to open tender under European Union procurement rules. As ex-NHS organisations and foundation trusts become more independent, however, competition law may begin to bite. And while no health care provider is likely to become large enough at a national level in the foreseeable future to create the sort of worries about monopoly provision that would concern the Office of Fair Trading or the Competition Commission, that could easily happen at a more local level. Who will prevent mergers, acquisitions or simple business deals leading to local monopolies of supply? The economic regulator? The purchasers, and if so at what level? Or the two acting in concert?

The situation is further complicated by the government's repeatedly stated desire to have one single regulator for both health and social care. From the patient's point of view, care across the two sectors should be seamless. Many inpatients discharged from hospital need care from both sectors, as do many patients with long-term conditions. But the two markets are very different. In health, many of the suppliers are large institutions, or sizeable independent sector suppliers: in social care, the supplier market is much more fragmented, with hundreds of small-scale organisations and few big players.

Furthermore, despite instances of 'postcode prescribing', health is a nationally prescribed service provided largely free at the point of

use. Social care is means tested, and eligibility is decided by local authorities, not nationally. While the two markets are so different, and their funding and eligibility rules so unaligned, common regulation will be hard to achieve. The Commission for Social Care Improvement holds the view that ‘economic and quality regulation are inextricably intertwined and should not be separated’.<sup>8</sup>

### *The tariff*

An additional complication is who sets the prices – the so-called ‘tariff’ – for the health care market. At present the Department of Health does. The independent sector, and some in the NHS, would, in the interests of transparency, like to see the tariff set independently of government. That would remove any suspicion that it is being set in the interests of NHS-run institutions. Some – in foundation trusts, for example – are equally keen to see that it is set to provide a level playing field between them, the independent sector, and the NHS-run bodies.

The tariff, however, is likely to remain one of the few tools that ministers and the policy arm will retain to allow them to define the output of the NHS. How much care the NHS buys will ultimately be constrained by its overall budget. But the tariff will decide how much of each treatment is purchased. It can be used to drive efficiency through the system by adjusting the price downwards to require efficiency gains. Price can also be used to encourage activity that policy makers and purchasers favour, and discourage activity that is seen as inefficient or less cost effective.

This is already happening. The tariff for 2006 is going up by only 1.5 per cent on average. But within that, the tariff for elective procedures is up by 5 per cent (to encourage providers to cut waiting times), that for non-electives is actually being reduced by 0.5 per cent, while outpatient payments will rise by the 1.5 per cent average and payment for A&E attendances by almost 3 per cent.<sup>9</sup>

Ministers will, almost certainly, be reluctant to let the tariff go because of its power to define what the NHS buys. But the existing regulators doubt that Whitehall has the skill to set it well.<sup>10</sup> A compromise might be to hand its construction over to an independent body operating under published guidelines from ministers. But even then, there is a question of whether it should be set by an entirely independent body, or should be one of the tasks of the economic regulator or economic/quality regulator.

These are all critical issues. Some members of the working group hold strong views about how regulation should be constructed, but their views differ. To reach a viable regime, the government needs to set out its own views, with options, in an open consultation aimed at allowing everyone to edge their way towards the ‘right’ answer (which may well need adjusting over time).

### *Separation of functions*

The issue of regulation, however, cannot be ducked. It is also inextricably linked with the future of functions currently combined at the top of the Department of Health. Decisions that ministers take – or do not take – on these issues will define the future face of health care provision in England. As in other sectors – gas, water, electricity, telecommunications – the decisions made by regulators will shape the market and define what is and is not possible.

From the working group’s deliberations, it is clear both that a separation of functions in the Department of Health will be needed, and that there is an issue of timing.

The timing issue first. Given the current organisational and financial turmoil in the NHS, there is a case that when the periods of office of the current acting permanent secretary and acting chief executive come to an end, the two jobs might most sensibly be recombined. That would provide an opportunity to stabilise the NHS financially,

provide it with some clear leadership, and allow the new SHAs and PCTs to begin to settle into their new roles.

This would, however, be a purely temporary arrangement, a staging post that makes it easier to get to the new dispensation. Whoever took the combined job would be charged with, over a three to four year period, abolishing it and dividing it into its new functions.

There is a spectrum of possibilities. Towards either end of it, the post could be split into two, or three. In the latter case the Department of Health would retain a policy arm, headed by ministers and a permanent secretary. They would be responsible for raising cash for the NHS from the Treasury, setting broad policy goals and the regulatory framework. There would then be a separate commissioner of NHS services, operating as a separate entity at arms length from the Department of Health. Arms length means constituted, at the minimum, as a special health authority, and more likely as a free-standing body with a constitution similar to that of Monitor or the Healthcare Commission. The commissioners would use the budget to buy care for patients. There would then be a separate, and again organisationally distinct, agency for NHS operations. Its role will diminish over time to the probable point of extinction, as more hospitals and other services acquire foundation trust status or become independently contracted from former NHS staff operating as social entrepreneurs, or via 'chambers-like' organisations – businesses run by staff who leave formal NHS employment but contract their services back.

At the other end of the spectrum, the post would merely be divided into two. A statutorily independent agency (NHS Providers) would be created to oversee NHS-run organisations. Again, its role would diminish over time. Under this model, the permanent secretary and commissioning roles would remain combined, and, by definition, would remain within the Department of Health.

The argument for this second arrangement is that fundraising, policy creation and the decisions about what the new national health system should buy are so interlinked as to be indivisible. If the commissioning side is entirely separated out it could become as neutered as the boards of the old nationalised industries (coal, steel, gas, British Leyland) did, where they became supplicants for money to ministers who lacked the clout to extract both operating capital and capital investment from the Treasury. Over time that would lead to an inevitable deterioration in the service to patients.

The argument against this is that separating policy from commissioning (in other words, creating three roles: policy, commissioning and the remaining direct provision) might further help depoliticise the day-to-day operation of the service. It is acknowledged that the provision of health care cannot be, and should not be, depoliticised. Even were the United Kingdom to move to a mixed system of funding (private insurance allied to tax-funded provision for the poor and elderly, as in the United States) the provision of health care will remain a politically charged issue. There remains a need, however, to remove from politicians a current duty that the very nature of politics makes them ill-equipped to perform – day-to-day oversight of the operation of the service.

There was no agreement within the working group about the best route forward here. But with that qualification and in the interests of helping define the debate, it makes the following recommendations.

**6 In the short to medium term (short defined as six months, medium as perhaps two to four years) there is a case for retaining a joint post of permanent secretary/ chief executive of the NHS. In the medium term, however, its functions must be separated. Whoever takes the post needs to understand that their job is to work their way out of it, creating one of the two following structures.**

**Either:**

**A policy arm headed by ministers and a permanent secretary, responsible for raising cash for the NHS from the Treasury, setting broad policy goals and the regulatory framework.**

**A commissioner of NHS services, operating as a separate entity at arms length from the Department of Health and using that budget to buy care for patients.**

**A separate head of NHS operations, again a statutorily distinct entity from the Department of Health, responsible for NHS-run organisations – a role that will diminish over time as more hospitals and other services acquire foundation trust status, and as more primary care and community staff leave formal NHS employment to form their own businesses to supply the NHS.**

**Or:**

**A combined post of permanent secretary/chief executive/chief commissioner of the NHS with remaining NHS-run organisations hived off into a statutorily separate NHS Provider organisation whose role will diminish, probably to the point of extinction.**

**On the balance of the current debate, the majority of the working group favoured the first of these two options.**

**7**

**To speed and ease this transformation, NHS trusts need to move as rapidly as possible to the foundation trust financial regime: handling cash budgets as businesses and able to borrow to invest. Initially, because of their legal status, this borrowing will have to come from an NHS bank. The current NHS accounting system, with its statutory duty to break even on a given day, must go and be replaced by one that reflects a trust's position as a going concern.**

- 8** The government was right in its July 2005 circular to argue that primary care trusts should primarily become commissioners not providers. It was wrong in the way it handled it. This split needs to be made, but it needs to evolve, not be enforced everywhere overnight.
- 9** When NHS staff form new not-for-profit businesses to supply NHS care, for contracts of any size above, say, a few million pounds a year, the service should as a matter of good practice be offered for tender, even though this is not a legal requirement. Where it is judged that for the time being it is more important to hive off the service, to create a broad purchaser/provider split within PCTs rather than to ensure full competition, such contracts should, as a matter of principle, be put out to tender on renewal. The NHS has done this before when, for example, the then regional health authorities got rid of their architects' departments in the 1990s.
- 10** The government must explore in more detail and reach decisions on regulation. The working group's view is that to attempt a merger now between the Commission for Social Care Inspection and the Healthcare Commission is not advisable. At present the very different nature of their markets, eligibility rules and payment mechanisms militate against that. It is an issue that should be left for another day, although joint working between the two needs to be strengthened.
- 11** Monitor's role will clearly expand as more NHS organisations gain foundation trust status. Its key task is to oversee the financial viability of foundation trusts, while having powers to require them to provide services if a PCT so insists. Its current role does not embrace competition issues, and it would face a conflict of interest were that to be added.

- 12** The working group's tentative view is that the quality inspector – the Healthcare Commission – should remain a separate body, reporting on standards and quality. It should increasingly focus on the quality of commissioning.
- 13** The setting of the tariff should be moved out of the Department of Health to an independent body, working to published guidelines set by ministers.
- 14** There is a need for a competition regulator, dealing with issues of local monopoly referred to it either by other providers, or by commissioners who find their normal purchasing powers cannot break a local monopoly that they no longer judge to be in patients' interests.
- 15** This body cannot be Monitor as that would involve a conflict of interest with its duty to keep foundation trusts viable. It equally cannot be the Healthcare Commission because, again, there would be conflicts between independent oversight of standards and a duty to ensure that competition was effective. It would seem to require a third institution – an Ofhealth on the lines of Ofwat and Ofcom where these regulators both set the price for their market and act to deal with unfair competition within it.

A key element of the new market, and of regulation, will be how to deal with failure. Failure in the NHS, both financial and clinical, is not new. Examples of the latter include the paediatric cardiac deaths at Bristol and the damage done to patients in both the public and private sectors by poorly performing surgeons. Financial failures are currently being exposed to greater public scrutiny both by changes to the NHS accounting regime and by the Audit Commission's decision to publish many more public interest reports where it believes trusts, PCTs or local health economies are failing to address structural issues.

For independent sector providers, financial failure will see takeovers and mergers, with the commissioner retaining a responsibility to ensure that the service continues. For NHS-run organisations, and for foundation trusts, which can ultimately be taken back into direct ownership by the Secretary of State, the position is much less clear.

The first task of a failure regime is to spot problems early to avert more serious consequences later. Tackling clinical failure has to be a joint responsibility between provider organisations, PCTs, the royal colleges, the Healthcare Commission and ultimately the professions' disciplinary bodies. Responsibility for financial failure of NHS-run organisations is shared between the PCT and SHAs. For foundation trusts it lies with Monitor, although commissioners retain a direct interest in the outcome. Where the problems are structural, PCTs and SHAs will need to work with financially stressed providers (and, in time, with the NHS providers agency) to help them achieve any necessary service reconfigurations.

It is important to understand that, while sustained financial failure in NHS trusts and foundation trusts will lead to service failure, prompt action will see mergers and reconfigurations that both preserve services and lead to financial recovery.

The fact remains, however, that the Department of Health has been repeatedly warned for close to two years now by Monitor, the health service itself, external lawyers and by others that there is no clarity over the processes to be followed when financial recovery for a foundation trust is not possible. As NHS trusts move to the foundation trust financial regime, the same will apply to them. Devising a failure regime involves, unfortunately, not just a set of principles but considerable technical work that is beyond the scope of this report. Nonetheless the group recommends that:

**16** The government, working with commissioners and regulators, must develop a failure regime for foundation trusts and NHS-run organisations: a piece of work that should have been completed more than a year ago.

### **3 Strengthening commissioning and creating a more level playing field**

Between 1988 and 1991, when the then Conservative government was designing its ‘internal market’ for the NHS, it produced a series of papers on how the new system would work. The paper on commissioning was number 26. That meant in effect that the government judged that there were 25 more urgent things in the new market than deciding what the NHS should buy.

#### **Commissioning**

The same mistake has been made this time around. The government has, again, strengthened the provider side – foundation trusts, new private sector suppliers – way ahead of strengthening commissioning. The one thing it has got right that the Conservatives did not consider is the creation of a commercial directorate in the Department of Health. This has demonstrated that governments can indeed create a market: in this case in the provision of independent treatment centres and supply of diagnostics to the NHS. By structuring the market clearly and itself marketing the proposition, the commercial directorate has succeeded in attracting new suppliers to the NHS and creating meaningful competition between them.

Beyond that, however, the government has repeated the mistakes of the past and is only now correcting them. The picture remains confused. The restructured PCTs are meant, it would appear, to be the primary purchasers. But the government also wants to introduce practice-based commissioning, to the point where it is virtually

foisting it on practices that may have no real desire to become involved.

The relationship between the two is uncertain. Under the internal market, there was the advantage of clarity. GP fundholders – the Conservative equivalent of practice-based commissioners – started out small. Their budgets chiefly covered elective care and prescribing. There was, in effect, a ‘stop loss’ insurance for expensive cases. The remainder of care was, in theory, commissioned by health authorities. Over time, fundholding developed, some practices taking on a wider commissioning role. Later others banded together to create ‘total purchasing’ pilots where practices in effect played the role of the then health authorities – a role that it appears PCTs are intended to play – of commissioning the complete spectrum of care. The independent evaluation of these appeared after the incoming Labour government had abolished fundholding and replaced it with the first version of what have become PCTs. The evaluation of the total purchasing pilots showed them to offer distinct promise as a means of purchasing care.<sup>11</sup>

Under Labour’s plans, however, the role and strength of practice-based commissioning remains unclear. It appears that, at least initially, it will operate on indicative budgets, not real ones. The rules over how GP fundholders could spend surpluses may have been far from ideal. But the existence of real budgets offered clear (possibly over-powerful) incentives to GPs both to manage demand and to reshape services in a more cost-effective manner.

Under the government’s current plans, it is not clear whether GPs or practices (some of which are nurse led) are meant to define what services they want, with the PCT negotiating call-off contracts for them, or whether practices are to have a more direct relationship with providers. Added to that, for elective care, patients themselves

will have choice, and GPs, at least in theory, will have no veto over the choices made, even though, at least initially, they are likely to have considerable influence.

It is therefore not clear, when it comes to commissioning, who should be doing what, and on what scale. The government's ambitious plans to shift more care out of hospital and closer to people's homes<sup>12</sup> will create unprecedented challenges to the operation of district general hospitals, aside from the financial difficulties that a significant minority currently face.<sup>13</sup> Individual practices are highly unlikely to have a sufficiently clear view of services to ensure maintenance of them in such circumstances; even individual PCTs may not be large enough to see the big picture. SHAs clearly have a role here, but where does that leave practice-based commissioning?

There were divided views within the working group on two issues: the role of practice-based commissioning, and the question of whether PCTs should be allowed to continue to be direct providers of service.

On the latter issue there were divisions among the NHS members of the working group, as well as between the independent sector and public sector members. Some NHS members feared that if PCTs are required to divest themselves of all direct provision the result will be costly as services 'fragment into millions of little providers'. Economies of scale would be lost, with the likelihood that for some services in some areas there will never be alternative providers. Even those who held that view, however, saw the need for regular market testing of the services that PCTs continue to provide.

On practice-based commissioning, the private and voluntary sector members favoured dealing with a small number of purchasers – in other words with PCTs and SHAs – to the point where some of them

wanted the abolition of practice-based commissioning. As one member put it: ‘practices lack either the scale or competence to commission effectively and there will always be the temptation to contract from themselves’. The NHS members saw practice-based commissioning as essential. Without it, they fear practices will lack the incentives to manage demand, innovate, and take their share of the responsibility for PCTs managing within their budget.

The present lack of clarity will lead to muddle, again a muddle that threatens patient care. To put it another way, GP fundholding was designed to introduce challenge and instability into the NHS in order to produce a response from providers. The best GP fundholders clearly succeeded in that, even if the worst were ineffective.<sup>14, 15</sup> The danger this time is that an unclear mix of patient choice, practice-based commissioning and PCT commissioning may introduce not just a degree of instability but dangerous disruption into a system that is already seriously challenged by historic deficits, new providers, and Payment by Results. The result could be service breakdown.

### *Interaction of roles*

Commissioning thus needs to be thought through much more thoroughly and its rules established. There is an obvious, and difficult, interaction here with the new roles needed at the centre and regulation.

Among other issues, a balance needs to be struck between central and local purchasing and commissioning. The way the ISTC programme was purchased has its critics, even amongst those who approve of the programme. But the centralised programme did create a new supplier market with tangible results. Pilot projects are under way for new, centrally purchased contracts to provide care in under-doctored areas. And the department plans to purchase further

waves of such services through contracts that will be nationally procured but locally determined.

Where the NHS, in effect nationally, can use its buying power without abusing a monopsony position, it should do so. But to create a proper supplier market, local commissioners need to think of themselves purely as purchasers in a health care system, rather than as people charged with protecting providers (other than to the extent necessary to ensure maintenance of services). Such commissioners will not in principle care who provides a service – the private, voluntary or public sectors – so long as it is provided well, seamlessly from the patient's point of view, and at good value for money. In other words, they need to be willing to change suppliers, change them between the public and independent sectors, and make a market capable of attracting new entrants. This will require real commissioning skills.

Such skills, however, are currently rare in the United Kingdom. They exist, to a degree, in the United States amongst health maintenance organisations and others but, while some of the skills used there are relevant to the NHS, others are not as they operate in a very different health care market even to the one towards which the NHS is heading. Some English PCTs have begun to develop them. But a large-scale learning programme, in addition to clear rules, is needed in England.

The independent sector needs to contribute to this, and that means private and voluntary sector providers as well as those parts of the independent sector that may themselves be interested in taking on commissioning. In the short term, helping to create effective commissioners may make life more difficult for the independent sector. But it is an investment it has to make in its long-term future as a supplier of NHS care because without effective commissioning a supplier market will fall into disrepute.

There will need to be incentives for commissioners to perform well. In its latest White Paper<sup>16</sup> the government has taken some tentative steps towards that. Ministers have declared that, while PCTs will remain responsible for commissioning, they will be free to contract out its operation to the independent sector, an idea originally floated by the Thames Valley Strategic Health Authority for Oxfordshire, but put on hold while the White Paper was developed.

Furthermore, ministers propose to allow patients a ‘voice’ that would force a PCT to put the services it provides out to tender. Patients dissatisfied with community services will be able to petition the provider for improvements and the PCT will have to produce a plan to achieve that. If, after 12 months, sufficient improvement is not evident, ‘the PCT will be required to undertake a comprehensive best-value tender of services from any willing provider to ensure that local needs are met’.<sup>17</sup>

The trigger thresholds for dissatisfaction have yet to be defined, as have other potential performance measures that could set off similar action. The Department and ministers, however, say they are ‘clear about the key elements’. This outline programme clearly opens up contestability, not just of service provision but also, potentially, of commissioning. The question here will be whether the independent sector, in practice, has skills it can bring to the aid of the NHS. One way to find out is to try, and to monitor the results carefully.

Some in the steering group would go further than merely allowing patients a collective ‘voice’ through petitions. They would like to see patients able to ‘choose’ their care commissioner – probably the PCT – on an annualised basis, much as patients can change insurers in the US system. That would provide powerful incentives for commissioners to perform. It would, in effect, create a form of competing, publicly funded, health maintenance organisation in the United Kingdom. It would, however, require a capitation-based

system in which money is attached to individuals, not just for episodes of care (as under Payment by Results) but also for periods of cover. It would require measures to prevent ‘cream-skimming’ and adverse selection by commissioners. And it would challenge the residency-based nature of the current health spending formulae whereby PCTs are paid to provide care for their local population. These challenges may not be insuperable, though they are large. Their resolution, however, would help answer one of the criticisms of the NHS – that it is an administered system with a democratic deficit. Giving patients choice of commissioner would overcome that.

Whether or not this step is taken, the need to improve commissioning is central. It will require the combined skills of the public, private and voluntary sectors, plus the acquisition of lessons from other health care systems, to stand a chance of success. If commissioning is not strengthened, a poor-quality market, with poor quality for patients, is virtually guaranteed.

For commissioning to work well, however, some measures to create a more level playing field between health care providers are needed. This applies to NHS-run providers, foundation trusts, the private and voluntary sectors and to the new independent organisations set to emerge from within the NHS itself.

Some of the detail is again beyond the scope of this piece of work. However, a joint report by the Confederation of British Industry (CBI) and the Association of Chief Executives of Voluntary Organisations has underlined that there are important differences in the tax and VAT treatment of public, private and voluntary sector providers that at different times and in different ways can advantage one sector over the other.<sup>18</sup> These need to be addressed. Equally, there have been sustained complaints from the voluntary sector that too often it is offered only short-term, often annual, contracts, with excessively detailed and highly bureaucratic monitoring.<sup>19, 20</sup> The

latter is burdensome and costly: the former makes it impossible for voluntary organisations to borrow on anything like commercial terms to develop services. At the same time, as corporate providers move into primary and community care, practices fear they lack the financial muscle to afford lost bid costs.<sup>21</sup> Some transitional support through the Department of Health's planned social enterprise unit may be needed here.

Furthermore, the NHS-run organisations will need to become more nimble to compete in the new market. The current section 11 consultation requirements over change of service are a barrier to that. At present these apply, with some confusion over their precise requirements, to both NHS commissioners and providers. This is yet another thorny issue. In the absence of patient choice over both provider and commissioner, both patients and the public are entitled to a view on how services are provided. The current arrangements, however, hamper service change amid little or no evidence that the statutory consultation results in a better outcome. The government has signalled its intention to review them.<sup>22</sup> In addition, NHS trusts can face conflicting views on proposed service changes from their own and PCT patients' councils, and from local authority Oversight and Scrutiny Committees, which themselves can define what a 'major' service change is. For foundation trusts there is the additional view of its members' council. These ingredients produce a recipe for conflict rather than swift service change.

More thought needs to be applied to the role of charities and voluntary organisations. No one wishes to discourage the charitable impulse, and the NHS should work with that. But the role of charities and their trading arms against that of NHS and independent sector providers does need further analysis. The hospice movement, for example, provides a large amount of charitable care plus a significant amount of care on contract to the NHS. But where charities and voluntary organisations develop trading arms, it

should be clear that, where they are in competition with the NHS and other parts of the independent sector, they should not be able to cross-subsidise from charitable funds bids for contract work.

In the search for a level playing field, however, it is important not to try to be too pure. A gain from having three sectors competing for NHS work is that at times one will have an advantage over the others, and in a few years' time the NHS will be a £90 billion business with room for all three. The following recommendations flow.

- 17** PCTs need to evolve, and evolve fairly rapidly, into primarily commissioning bodies, performance managed by SHAs and the NHS commissioner. This should not preclude them from retaining some direct provision, with a clear Chinese wall between the provision and purchasing side. Nor, in the longer term, should it prevent them from creating directly managed operations to plug gaps in service, or to ensure continuity of care where a service fails. As far as possible, however, such arrangements should be temporary and subject to regular market testing. In other words, they should retain a role as provider of last resort.
- 18** Practice-based commissioning needs to move as soon as possible to real budgets. At this level, however, a pure purchaser/provider split is not possible. Practices are service providers, but by their referrals (even with patient choice) they remain commissioners of care. Where they introduce new services they will be, in effect, both commissioners and providers. They remain, however, small profit-making businesses. Where they wish to commission new services from themselves rather than from external providers, they should be subject to regulatory oversight and a potential veto by PCTs to ensure that public money is being properly used.

**19** Length of contracts, and whether they are negotiated nationally, regionally or locally, is not something that can be stipulated through central guidance. They are a matter for judgement. Where additional physical capacity costing large sums is needed, contracts will clearly need to be longer than where capital investment is minimal. The NHS commissioner, working with SHAs and PCTs, will need to take a view of:

- when (as with ISTCs and diagnostics) national negotiations can create a market or produce the best value – a mix of quality and price that does not necessarily mean the cheapest
- when local contracts would best be combined into a regional one
- when purchasing is best left to an entirely local decision at PCT and practice level.

**20** The commissioner will need to take the precautionary approach of any sensible private sector buyer of being careful to maintain a range of alternative suppliers, avoiding the risk of subjecting NHS purchasers to monopolies.

**21** Once PCTs understand their role as commissioners, they should be open to approaches from any source for better ways to organise care – whether from practices, NHS trusts, private providers or voluntary providers.

**22** Although the new market involves a degree of competition, such approaches may well involve collaboration between different sectors to produce innovative forms of care. There should, for example, be no bar on foundation trusts working with independent sector providers, nor on foundation trusts extending out into what in the past has been classified as primary or community care. Indeed one of the aims of the new commissioning system should be to destroy traditional concepts of primary and secondary care. Commissioners will need to examine each case on its merits, while

retaining future contestability. If local monopolies of care do emerge, PCTs will be able to go to the economic regulator to have them broken up.

- 23** In the longer term, the working group favours turning PCTs into competing commissioners, with patients able to choose their commissioner. That, however, requires a lot of work as outlined above, as well as ways of retaining needs assessment and public health measures within the commissioning role.
- 24** In the shorter term, however, and in part to address the ‘democratic deficit’, PCTs should be given the ‘membership councils’ that have been created for foundation trusts. Indeed it would be better if this ‘voice’ element was removed from foundation trusts, as they are essentially health care providers, and placed solely with PCTs. They are the commissioners for their local communities and the place where the patient voice should be heard. If and when recommendation 23 is implemented, such membership councils will not be needed. Patient choice would replace them.
- 25** For commissioning to work well, some measures to create a more level playing field with regard to tax and contracting rules is needed between existing and emerging health care providers.
- 26** To have the flexibility to compete with the private and voluntary sectors, the section 11 consultation on changes of service for NHS organisations needs to be revised and its time scales reduced. Some rationalisation is also needed of the plethora of patient forums at PCT and trust level, and of the ability of local authority Oversight and Scrutiny Committees to intervene.
- 27** Independent sector providers, as well as those interested in taking on a commissioning role, need to work with the NHS to improve its commissioning skills. In the short term, improving commissioning

may make life more difficult for the independent sector. In the long run, however, it is an essential investment. Without skilled commissioners a poor-quality market, with poor quality for patients, is virtually guaranteed, with the result that the whole concept of a supplier market would fall into disrepute.

**28** Issues of competition and cross-subsidy involving charities and voluntary organisations need to be addressed in the longer term.

## 4 Developing the infrastructure

Both regulation and commissioning are essential parts of the infrastructure. But more is needed.

### *Information technology*

A top priority is an effective information technology (IT) system that stretches across both public and independent providers. It is needed both to provide the electronic record that can allow care to be delivered safely across a much more diverse range of providers and to provide existing NHS-run organisations and foundation trusts with a far better understanding of their costs and finances. It should also allow patients access to their own records through ‘my health space’ while providing them with information better to navigate their own way round the system and to make informed choices.

It is this that Connecting for Health, the NHS’s £6.2 billion ten-year IT programme, currently the biggest civil IT programme in the world, is tasked with delivering. Currently, many aspects of it are running late, and doubts remain about the ultimate viability of ‘the spine’ – the central messaging system that will deliver and effectively hold the summary electronic record. It is, nonetheless, beginning to deliver working applications.

Its success is crucial. Yet it rarely seems to figure high on the Department of Health's list of priorities. There remain serious doubts that NHS trusts will make the necessary additional investment needed to run the systems that the national programme will provide. It cannot be stated too strongly that both these issues must be addressed. Patient safety and financial performance in the new market depend upon it. And the independent sector needs to build into its business plans the necessary investment in compatible systems.

**29 NHS and independent sector organisations need to make the success of the NHS IT programme a top priority. Both need to recognise that this will involve their own investment in training and infrastructure above the applications and services being provided by the national programme. Without high-quality IT both patient safety and financial performance will be at risk.**

### ***Better boards***

The boards of health providers, not just in the public sector, need to be developed and in some cases restructured to cope with the 'new' NHS. In institutions that are currently NHS-run, and in foundation trusts, this means acquiring the financial skills, among both executive and non-executive directors, to understand the very different financial regime that Payment by Results and patient choice involves: one in which cash flow and working capital are key, in place of the current statutory duty to break even one year with another.

The principles of the Langlands report need to be applied – that boards are there for governance, not representation of sectional interests.<sup>23</sup> If there is room for a 'members' council' approach it should be at the level of PCTs and SHAs – on the purchaser side – rather than with foundation trusts who are providers.

For the independent sector (both for profit and not for profit), certainly their organisations, and ideally their boards, need new competencies in terms of partnership working with the NHS. There may or may not be such a thing as ‘public sector values’. There certainly is a concept of ‘public service values’ that is distinct from a purely short-term profit motive and the independent sector needs to embrace it.

**30** **Boards of NHS-run organisations need to strengthen their financial skills. All those appointed to them need to understand that they are not there as representatives of sectional interests. They are there to focus on the organisation’s purpose: the outcomes produced for patients.**

### *The tariff*

Payment by Results needs to be developed and refined. The tariff is already complex and is likely to get more so. As currently constructed, it runs the risk of sucking care into hospitals, when both patient wishes and good clinical outcomes delivered at lower cost may well demand a movement the other way.

The government has already acknowledged that the tariff needs to be ‘unbundled’, so that it no longer merely represents the average payment for complex and costly cases, and for all of a treatment.<sup>24</sup> This will make it yet more complex. But the change is probably essential.

This raises questions about whether England is right to introduce Payment by Results both further and faster than any other country in the world. Up to the time of writing, and save for the limited number of foundation trusts, Payment by Results has been used only for elective care. From April 2006 the government plans to use it also for outpatients, accident and emergency, and urgent cases. From that date, Payment by Results will account for around 60 per cent of

a typical district general hospital's activity, against 30 per cent before that.

The department has extended Payment by Results in this way partly because it fears that using it only for elective care and long-term conditions will lead to cross-subsidy by hospitals and exploitation of service contracts for emergency and urgent care. There may, however, be better ways to address that issue. Patient choice is not an option for much of emergency and urgent care, and big volume shifts could be highly destabilising for emergency care providers.

More fundamental questions about the tariff also remain. It is currently a fixed price, in theory negotiable neither upwards nor downwards. The laudable aim is to get commissioners to focus on quality and access, not to spend large amounts of time and money negotiating over price (as happened in the internal market). The last thing the NHS needs is the large on-cost of the US insurance system, much of which is accounted for by billing and price negotiation. But there must be doubts that the position in England can hold.

For a start, national negotiations over ISTCs, scans and diagnostics are clearly price sensitive. Indeed, the Department of Health boasted that the contract for scans that it negotiated with Alliance Medical came in way below the average NHS cost per scan.<sup>25</sup> If national negotiations are price sensitive, more local ones are likely to become so. Challenges in court under competition law are not inconceivable if private providers believe they can supply a service at equal quality more cheaply than NHS-run providers, but are denied the contract.

Furthermore, as the tariff is 'unbundled' into pre-operative diagnosis and post-operative care,<sup>26</sup> in order to allow care to be provided and paid for out of hospital, it is hard not to see out-of-hospital providers

wanting to compete on price (value for money) for those elements of the tariff.

Already there are questions about the way the tariff produces an ‘average’ price for treatments, embracing both simple and complex cases. When treatment centres, whether independently or NHS run, take, by their design, the simpler cases, the payment of the tariff to them inevitably leaves the providers of more complex care (currently foundation trusts and acute hospital trusts) at a disadvantage. As routine elective care moves out of their wards, they cannot cross-subsidise complex elective cases from the same ‘average’ payment from the simpler cases they no longer treat. This presents a challenge to the finances of acute providers that cannot be ignored.

**31** **In time the tariff will almost certainly become a ‘benchmark’ price, rather than one that cannot be negotiated downwards, or one where elements of it cannot be negotiated upwards. For example, as it is disaggregated, that should allow providers from whichever sector to offer better and more cost effective packages of care – in which some elements may be above tariff, some below, but where the whole can be shown to offer better quality and value for money.**

**32** **For long-term conditions there is an urgent need to disaggregate the tariff to achieve the objectives of the recent White Paper on care outside hospital.**

### ***Pensions and pay***

One of the most intractable problems remains the NHS and local authority pension schemes. At a time when final salary provision is fast disappearing in the private sector, initially for new employees but now also for existing employees, and when few final salary schemes ever matched the generosity of the NHS pension scheme, pensions have become a barrier to change. NHS staff are reluctant to launch new businesses because the loss of the NHS pension is

worth around 25 per cent of salary and offers a taxpayer-backed guarantee of the final outcome that no money purchase or defined contribution pension can match. Solving this problem is outside the scope of this report. Until it is solved, a level playing field between the public and private sectors in health care will by definition be difficult to construct.

As NHS suppliers diversify, so will the type of staff they employ to provide the same type of care. Given national pay negotiations, and despite Agenda for Care, staff is a major fixed cost for NHS-run organisations. To provide more flexible care, however, more flexibility over who is paid for what service is almost certainly needed. To date foundation trusts have yet to use on any scale their freedoms to negotiate local pay deals. Even so, as more NHS organisations become foundation trusts and as staff migrate into free-standing businesses ('social entrepreneurs' and 'chambers'), the relevance of national pay bargaining for the NHS will increasingly be called into question.

**33 The government should undertake a review of the need for continued national pay bargaining in the NHS.**

***Training and research and development***

Without training and research and development the NHS will die. The doctors, nurses, therapists and other staff of today have to help to produce the staff of tomorrow, and without research and development the service will stagnate. As the range of suppliers diversifies, the location of training and research and development will also have to. The private sector already undertakes postgraduate nurse training, and rather more of it than most people realise. But it is clear that the current ISTC programme has disrupted training for ophthalmologists and orthopaedic surgeons, and a widening range of suppliers of NHS care could disrupt it further.

This problem is far from insuperable. The private sector already undertakes postgraduate nurse training at its own expense because it can see the gains in so doing. It does not yet undertake initial nurse training.

In time, it is likely to do at least some of the same for postgraduate medical training. Initially, however, until the private sector has become an established part of a supplier market, it may need to be paid to do so. That should be perfectly possible. Training comes at a price, even for the NHS and even if it is not one that is always transparent. At the right price (the NHS price), the private sector can and will provide it, in tandem with NHS-run organisations and the voluntary sector, although, initially, that will have to be built into the contracts. Achieving such a shift, however, will require the application of imagination by the royal colleges and others that oversee postgraduate training and research and development in order to allow them to be provided in a mix of settings rather than (in the case of training) purely in NHS-run organisations.

**34 The NHS, the independent sector, the royal colleges and others that oversee training and research and development, such as the Clinical Research Collaborative, need to develop programmes to allow both training and research and development to take place across the sectors.**

## List of recommendations

- 1** The government needs to state unequivocally that it sees a supplier market in health care as the long-term future for the national health system. It should not, as ministers have tended to do so far, state or imply an upper limit to independent sector provision. The proportion of care coming from NHS-run, private and voluntary sectors should emerge from the operation of the market. It should not be artificially defined.
- 2** Ministers need to understand that in future they will be responsible for a national health system, not a state-owned national health service. Their role will be to raise the money for the NHS from the Treasury, define broad priorities and set the regulatory framework. But they will not then be involved in the day-to-day management of the service. Instead a commissioner will buy it from whoever offers the best value and quality.
- 3** Ministers need to explain this clearly not only to the public but to their own backbenchers and other members of parliament. As that happens, MPs, councillors and others will need to understand that their role is to defend the quality of services to patients, not institutions.
- 4** Primary care trusts' future role will primarily be commissioning, co-ordination, and an element of regulation, not direct provision of services. They will primarily be responsible for the purchase of care for patients – charged with ensuring that care is there, not that particular institutions, whether run by the NHS or not, thrive or survive.

- 5 Even as they seek to make the NHS more responsive, and to increase choice, politicians also need to be honest with the public in explaining that in any collectively funded system of health care, there will be limits to choice
- 6 In the short to medium term (short defined as six months, medium as perhaps two to four years) there is a case for retaining a joint post of permanent secretary/chief executive of the NHS. In the medium term, however, its functions must be separated. Whoever takes the post needs to understand that their job is to work their way out of it, creating one of the two following structures.

Either:

A policy arm headed by ministers and a permanent secretary, responsible for raising cash for the NHS from the Treasury, setting broad policy goals and the regulatory framework.

A commissioner of NHS services, operating as a separate entity at arms length from the Department of Health and using that budget to buy care for patients.

A separate head of NHS operations, again a statutorily distinct entity from the Department of Health, responsible for NHS-run organisations – a role that will diminish over time as more hospitals and other services acquire foundation trust status, and as more primary care and community staff leave formal NHS employment to form their own businesses to supply the NHS.

Or:

A combined post of permanent secretary/chief executive of the NHS with remaining NHS-run organisations hived off into a statutorily separate NHS Provider organisation whose role will diminish, probably to the point of extinction.

On the balance of the current debate, the majority of the working group favoured the first of these two options.

- 7** To speed and ease this transformation, NHS trusts need to move as rapidly as possible to the foundation trust financial regime: handling cash budgets as businesses and able to borrow to invest. Initially, because of their legal status, this borrowing will have to come from an NHS bank. The current NHS accounting system, with its statutory duty to break even on a given day, must go and be replaced by one that reflects a trust's position as a going concern.
- 8** The government was right in its July 2005 circular to argue that primary care trusts should primarily become commissioners not providers. It was wrong in the way it handled it. This split needs to be made, but it needs to evolve, not be enforced everywhere overnight.
- 9** When NHS staff form new not-for-profit businesses to supply NHS care, for contracts of any size above, say, a few million pounds a year, the service should as a matter of good practice be offered for tender, even though this is not a legal requirement. Where it is judged that for the time being it is more important to hive off the service, to create a broad purchaser/provider split within PCTs rather than to ensure full competition, such contracts should, as a matter of principle, be put out to tender on renewal. The NHS has done this before when, for example, the then regional health authorities got rid of their architects' departments in the 1990s.
- 10** The government must explore in more detail and reach decisions on regulation. The working group's view is that to attempt a merger now between the Commission for Social Care Inspection and the Healthcare Commission is not advisable. At present the very different nature of their markets, eligibility rules and payment mechanisms militate against that. It is an issue that should be left

for another day, although joint working between the two needs to be strengthened.

- 11** Monitor's role will clearly expand as more NHS organisations gain foundation trust status. Its key task is to oversee the financial viability of foundation trusts, while having powers to require them to provide services if a PCT so insists. Its current role does not embrace competition issues, and it would face a conflict of interest were that to be added.
- 12** The working group's tentative view is that the quality inspector – the Healthcare Commission – should remain a separate body, reporting on standards and quality. It should increasingly focus on the quality of commissioning.
- 13** The setting of the tariff should be moved out of the Department of Health to an independent body, working to published guidelines set by ministers.
- 14** There is a need for a competition regulator, dealing with issues of local monopoly referred to it either by other providers, or by commissioners who find their normal purchasing powers cannot break a local monopoly that they no longer judge to be in patients' interests.
- 15** This body cannot be Monitor as that would involve a conflict of interest with its duty to keep foundation trusts viable. It equally cannot be the Healthcare Commission because, again, there would be conflicts between independent oversight of standards and a duty to ensure that competition was effective. It would seem to require a third institution – an Ofhealth on the lines of Ofwat and Ofcom where these regulators both set the price for their market and act to deal with unfair competition within it.

- 16** The government, working with commissioners and regulators, must develop a failure regime for foundation trusts and NHS-run organisations: a piece of work that should have been completed more than a year ago.
- 17** PCTs need to evolve, and evolve fairly rapidly, into primarily commissioning bodies, performance managed by SHAs and the NHS commissioner. This should not preclude them from retaining some direct provision, with a clear Chinese wall between the provision and purchasing side. Nor, in the longer term, should it prevent them from creating directly managed operations to plug gaps in service, or to ensure continuity of care where a service fails. As far as possible, however, such arrangements should be temporary and subject to regular market testing. In other words, they should retain a role as provider of last resort.
- 18** Practice-based commissioning needs to move as soon as possible to real budgets. At this level, however, a pure purchaser/provider split is not possible. Practices are service providers, but by their referrals (even with patient choice) they remain commissioners of care. Where they introduce new services they will be, in effect, both commissioners and providers. They remain, however, small profit-making businesses. Where they wish to commission new services from themselves rather than from external providers, they should be subject to regulatory oversight and a potential veto by PCTs to ensure that public money is being properly used.
- 19** Length of contracts, and whether they are negotiated nationally, regionally or locally, is not something that can be stipulated through central guidance. They are a matter for judgement. Where additional physical capacity costing large sums is needed, contracts will clearly need to be longer than where capital investment is minimal. The NHS commissioner, working with SHAs and PCTs, will need to take a view of:

- when (as with ISTCs and diagnostics) national negotiations can create a market or produce the best value – a mix of quality and price that does not necessarily mean the cheapest
- when local contracts would best be combined into a regional one
- when purchasing is best left to an entirely local decision at PCT and practice level.

**20** The commissioner will need to take the precautionary approach of any sensible private sector buyer of being careful to maintain a range of alternative suppliers, avoiding the risk of subjecting NHS purchasers to monopolies.

**21** Once PCTs understand their role as commissioners, they should be open to approaches from any source for better ways to organise care – whether from practices, NHS trusts, private providers or voluntary providers.

**22** Although the new market involves a degree of competition, such approaches may well involve collaboration between different sectors to produce innovative forms of care. There should, for example, be no bar on foundation trusts working with independent sector providers, nor on foundation trusts extending out into what in the past has been classified as primary or community care. Indeed one of the aims of the new commissioning system should be to destroy traditional concepts of primary and secondary care. Commissioners will need to examine each case on its merits, while retaining future contestability. If local monopolies of care do emerge, PCTs will be able to go to the economic regulator to have them broken up.

**23** In the longer term, the working group favours turning PCTs into competing commissioners, with patients able to choose their commissioner. That, however, requires a lot of work as outlined above, as well as ways of retaining needs assessment and public health measures within the commissioning role.

- 24** In the shorter term, however, and in part to address the ‘democratic deficit’, PCTs should be given the ‘membership councils’ that have been created for foundation trusts. Indeed it would be better if this ‘voice’ element was removed from foundation trusts, as they are essentially health care providers, and placed solely with PCTs. They are the commissioners for their local communities and the place where the patient voice should be heard. If and when recommendation 23 is implemented, such membership councils will not be needed. Patient choice would replace them.
- 25** For commissioning to work well, some measures to create a more level playing field with regard to tax and contracting rules is needed between existing and emerging health care providers.
- 26** To have the flexibility to compete with the private and voluntary sectors, the section 11 consultation on changes of service for NHS organisations needs to be revised and its time scales reduced. Some rationalisation is also needed of the plethora of patient forums at PCT and trust level, and of the ability of local authority Oversight and Scrutiny Committees to intervene.
- 27** Independent sector providers, as well as those interested in taking on a commissioning role, need to work with the NHS to improve its commissioning skills. In the short term, improving commissioning may make life more difficult for the independent sector. In the long run, however, it is an essential investment. Without skilled commissioners a poor-quality market, with poor quality for patients, is virtually guaranteed, with the result that the whole concept of a supplier market would fall into disrepute.
- 28** Issues of competition and cross-subsidy involving charities and voluntary organisations need to be addressed in the longer term.

- 29** NHS and independent sector organisations need to make the success of the NHS IT programme a top priority. Both need to recognise that this will involve their own investment in training and infrastructure above the applications and services being provided by the national programme. Without high-quality IT both patient safety and financial performance will be at risk.
- 30** Boards of NHS-run organisations need to strengthen their financial skills. All those appointed to them need to understand that they are not there as representatives of sectional interests. They are there to focus on the organisation's purpose: the outcomes produced for patients.
- 31** In time the tariff will almost certainly become a 'benchmark' price, rather than one that cannot be negotiated downwards, or one where elements of it cannot be negotiated upwards. For example, as it is disaggregated, that should allow providers from whichever sector to offer better and more cost effective packages of care – in which some elements may be above tariff, some below, but where the whole can be shown to offer better quality and value for money.
- 32** For long-term conditions there is an urgent need to disaggregate the tariff to achieve the objectives of the recent White Paper on care outside hospital.
- 33** The government should undertake a review of the need for continued national pay bargaining in the NHS.
- 34** The NHS, the independent sector, the royal colleges and others that oversee training and research and development, such as the Clinical Research Collaborative, need to develop programmes to allow both training and research and development to take place across the sectors.

## Appendix A: The workshop scenarios for NHS futures

This exercise is to contrast two possible futures for the National Health Service, seen from five years out. Neither will happen in the form depicted. The idea is to stimulate thinking about possible outcomes, and from that to define the actions needed to avoid the worst and ensure the best for patients. A means to that end should be to use whatever mix of public and private provision appears most likely to be successful.

### **Scenario 1 – Contestability angst**

#### ***The national headlines***

It is 2011. The NHS remains tax funded and largely free at the point of use.

#### **THE POLITICAL SITUATION**

Labour remains in power, but on a very narrow majority. The Conservatives have taken back many seats from the Liberal Democrats but still have to make sufficient advances in the cities and the suburbs to eject Labour from power or to win an outright majority.

#### **THE FINANCIAL PICTURE AND PUBLIC HEALTH**

Money is tight. Since 2008, NHS growth has run first at 4 and then at 3 per cent in real terms. That might be the historic average. But after years of 7 per cent growth it feels mean. And a whole generation of the more senior NHS managers who knew how to get by on less have retired since 1999, when the spending spurt started.

The years since 2005 have been characterised by financial instability. There have been big swings in income for individual institutions as Payment by Results, patient choice, reduced junior doctor hours, advancing technology and a shift from hospital to primary and community care have taken effect.

The public health agenda continues to be prominent – particularly given the continued high levels of smoking and obesity. Services with a preventive focus have been set up throughout the country. But there is not a lot of money in the system, and evidence for a return on this spending is slow to come through.

### **HEALTH ORGANISATIONS**

Although there remain a significant minority of NHS trusts, most trusts now have foundation status and account for well over 85 per cent of the patients and more than 80 per cent of the ‘traditional’ acute sector money.

Practice-based commissioning has become a reality. Primary care trusts both commission themselves and oversee GP commissioning. They provide fewer services directly.

New providers have entered the market, notably in primary care. There are now privately provided walk-in centres, disease management programmes, diagnostic centres, independent sector treatment centres (ISTCs) and entire privately provided (run and organised) GP services. Including care provided in UK-owned private hospitals, there are more than 20 significant private providers of NHS care.

Globalisation is starting to have an impact on the UK health system. With greater information available about quality and outcomes for services in the United Kingdom and abroad, patients are starting to travel, and some private providers are attracting patients from abroad for certain procedures in which they have expertise.

## **THE TARIFF**

The government is trying to hold the line that the tariff is a set price, not a negotiable one, so that providers compete on access and quality. But it faces an internal contradiction. It wants to prevent price negotiation with NHS-owned and run facilities, in part to avoid the associated costs and bureaucracy. But it wants to drive down the price from private providers, particularly when it negotiates nationally, both as a means of making the money go further and to put pressure on NHS-owned providers to raise productivity.

Added to that, the tariff is itself subject to an annual 1.5 to 2.5 per cent 'efficiency savings' squeeze. There has been little progress in developing successful tariffs for mental health, and the approach remains problematic for some long-term conditions.

## **THE WORKFORCE**

There has been a growing shift of care from doctors to nurses, pharmacists, health care assistants and new breeds of non-medical specialists and therapists. But there remains a shortage of doctors despite the increased investment in medical schools in the 1990s.

But the increase has been offset by a continuing rise in the number of female doctors who want a different work/life balance, which in turn has led many male doctors of the younger generation to seek the same. The European working time directive, with all its impact on junior doctors' hours, is fully in force.

## ***On the ground***

### **POSITION OF PRIVATE PROVIDERS**

The 2006 White Paper on health care out of hospitals leads to a whole new set of entrants to the primary and community care market. That was driven partly by a set of national contracts broadly mirroring those for the first wave of ISTCs and the subsequent diagnostic contracts. But a minority of primary care trusts (PCTs) –

the better-managed ones – have now taken on the ‘contestability’ and ‘competition’ agenda themselves.

Private providers now operate across the spectrum of primary and community care, both in ‘difficult’ inner city areas and ‘leafy’ suburban and shire areas (where prices are challenging but where they judge they can shift some patients to the private sector while still hitting the access targets set for NHS ones).

Contracts for the first wave of ISTCs have come up for renewal, and guaranteed volumes no longer exist. But the two waves of ISTCs produced enough private providers willing to give what is now a multi-billion pounds a year market a serious go.

Initially, private providers, both those running ISTCs and those UK private hospital operators prepared to supply services at tariff, did well. Patients, given a choice, opted for them, not least because their MRSA rates appeared lower. But in the capital-intensive elective care side, competition is serious and occupancy rates are now well below those on which the business cases were built – say 65 per cent. There is a lot of activity, but not much money being made.

Those providing diagnostics are doing better. Volume-related, though not volume-guaranteed, contracts are easier to negotiate there, at both national and local level. And the primary/community providers are successfully sucking care out of hospitals.

A number of PCTs have contracted out their commissioning function to private providers, and in several areas there are multiple commissioners, which allows patients to choose who commissions services on their behalf.

### **FRAGMENTATION**

Across the whole health sector, there are now many, many players, most providing only some bits of care (diagnostics, long-term conditions, primary care, elective and so on). There has been a significant expansion in independently provided community-based services targeted at people with complex long-term conditions, and some of these providers are attempting to include preventive care and health education. And, as a result, care has become much more fragmented and the NHS IT programme is not yet working well enough for the care record to provide the basis of a ‘seamless service’.

### **FINANCES**

Finances are tight. Public spending is already at 46 per cent of gross domestic product and the Conservative party, since the 2009 election, is again beginning to believe that tax cuts have real electoral appeal.

### **PRIMARY CARE**

Primary care is more accessible but far from all of this is GP delivered, and patients are increasingly irked at the near total disappearance of ‘their’ GP. Family doctors (the term feels increasingly outdated) are divided into specialists, who are whizz kids but whom you see as rarely as a hospital consultant, and ‘old dodderers’ (some of them young) who complain about the service when you do see them.

### **WORKFORCE AND RECRUITMENT**

One result of the private sector’s growing involvement has been its large-scale recruitment from NHS institutions, both doctors and more specialist nurses. Older doctors, eyeing the pension, have largely stayed put. Younger ones, once they have the secondary qualifications, have taken jobs in the private sector. NHS-run hospitals and the less glamorous of the foundation trusts are losing

staff and struggling to recruit, while living with a more aged workforce.

### **POOR STANDARDS OF EMERGENCY CARE**

The scandals now are not about waiting times, but about poor standards for emergency care and serious conditions – the one element of the NHS that people in the past felt the service absolutely guaranteed, even if it did not always happen in a terribly user-friendly way.

But even the more innovative PCTs and GP commissioners are cautious about procuring such services from the private sector because:

- the UK providers lack serious experience and serious facilities in these areas;
- the US and other overseas providers are used to a billing system that the tariff is not really designed for;
- the overseas providers have no capital base for such services, and providing it is a costly, and thus a risky investment;
- the tariff anyway has trouble pricing it properly;
- GP commissioners on their own lack the clout or expertise to buy such services.

### **FOUNDATION TRUSTS AND JOINT VENTURES**

The bigger and more innovative foundation trusts have found a way round some of the problems of competition law that were perceived in 2005 (state-owned and funded entities in theory cannot bid against privately owned ones for government contracts). That has been achieved either through an adjustment of the law at the edges, or more likely through carefully constructed joint ventures with the private sector that circumvent the problem. Through these joint ventures, and their joint financial strength, these foundation trusts and their partners have become sufficiently strong players to solve their own recruitment (and thus declining services) problems.

Some of these joint ventures have expanded outwards into primary and community care, allowing these trust/private sector operators to offer relatively seamless care. The best move services out of hospital and closer to patients. The worst, however, suck them in. In both cases, their survival depends on continued growth and a degree of gaming the system to get as much money as possible. They talk British. But, certainly to the purchasers, and in time to the patients, they feel American.

PCTs, whose purchasing skills in general remain underdeveloped, are alarmed at the lack of competition these behemoths provide in some parts of the country. They are equally perturbed about weak trusts elsewhere, whether foundation or otherwise. The worst performing foundation trusts are being taken back into NHS ownership, but that solves no one's problems. There are huge rows about hospital services closing, and in a few cases whole hospitals closing. This problem is worst south of the Wash and particularly around London. That is both not far from Fleet Street and where Labour needs to hold seats and the Conservatives need to win them.

### **SUPPLY-INDUCED AND SUPPLIER-INDUCED DEMAND**

There is a lot of both supply-induced demand and supplier-induced demand. The former has come from the expansion in diagnostic capability that has revealed a lot of unmet need, expressed by GPs lowering their referral thresholds for diagnostics. This in turn has generated much more elective work, and in some cases earlier diagnosis of serious disease.

Supplier-induced demand has come from the need for both private operators and the stronger foundation trusts, either on their own or in partnership, to attract business. 'Why you should come to us' is now widely advertised in newspapers, on the internet and on buses and the tube (volumes still are not big enough for TV advertising).

## PROFESSIONAL AND PUBLIC OPINIONS OF THE HEALTH CARE SYSTEM

No one is happy. PCTs locally, and the NHS nationally, repeatedly bust the budget and the annual deficit is getting bigger. Many patients feel care is fragmented and that services are failing. Politicians and the Department of Health's statisticians can and do produce semi-credible evidence that the system is more efficient and getting more for its money. But only the academics believe it, and half of them don't.

The headlines talk of both empty and crowded wards, failing services, and wasted money. The staff affected pour petrol on those stories. Some private providers are losing serious money. But even the finance directors and chief executives of the currently successful private operators and foundation trusts worry about where this is going: on the private sector side, they worry whether the game is worth the candle.

Private medical insurance dipped in the years running up to 2008 when the NHS waiting lists fell close to 18 weeks. It is now rising again. Furthermore, there is demand for more comprehensive policies that cover emergencies and much more serious care. But the insurers don't know how to price that, or how to provide it. When they try, the price of policies is horrendous.

Most media commentators declare that 'the NHS model has failed'. But there is no agreement on an alternative (social insurance, private insurance, charges, subsidies to go private?) – not least because the private sector, having become so seriously involved in NHS provision, is seen to be as much a cause of the problem as a solution. This might fairly be described as the UK's worst health care crisis, at least in terms of provision, since the black plague or the Spanish 'flu.

## Scenario 2 – Commissioned competition

### *The national headlines*

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#### **THE FINANCIAL PICTURE AND PUBLIC HEALTH**

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But the increase has been offset by a continuing rise in the number of female doctors who want a different work/life balance which in turn has led many male doctors of the younger generation to seek the same. The European working time directive, with all its impact on junior doctors' hours, is fully in force.

### ***On the ground***

#### **STRUCTURAL REORGANISATION**

The reorganisation in 2006 of PCTs and SHAs has gone better than anyone dared hope. Not all, but a significant proportion of PCTs have turned into effective commissioners. GP commissioning has also taken off, though somewhat patchily. The best now have real budgets but are using them at the margins in a PCT-set framework which itself operates within strategic commissioning and planning of services run by the 11 SHAs.

PCTs still run some services themselves, but chiefly in default mode. A steady transfer of their services to new forms of foundations trust, GPs, voluntary groupings and staff-run ventures, with some transfer to the private sector, has taken place.

## **ROLE OF THE DEPARTMENT OF HEALTH AND REGULATION**

The Department of Health is now clear about its role. Ministers negotiate with the Treasury and set the basic targets of what should be achieved with it, working with the policy side of the NHS, which now has enough policy makers with a decent understanding of supply-side markets to keep tweaking the way the system works. Both ministers and the policy side of the department see themselves as overseeing health and social care provision generally, not just as being responsible for the NHS.

The NHS chief executive is no longer the permanent secretary. Instead she heads what is in essence a health purchasing organisation whose delivery arms are the SHAs and PCTs.

Providers are overseen by a new regulator and a standards inspector (these have just emerged as separate entities from the overarching federation of inspectors, auditors and regulators created in 2006/7). There is now as level a playing field as there can be in their impact on the public, private and voluntary sectors.

Patients are exercising choice, on a scale large enough to apply pressure to all provider organisations (public, private and voluntary) but not on such a large scale as to cause financial mayhem.

## **COMMISSIONING AND CONTRACTING**

The NHS chief executive rarely feels the need to let national contracts for care. PCTs now look for the best form of provision, whether from foundation trusts, the remaining NHS-run organisations or the independent sector. PCTs are getting to grips with the commissioning process. The best are conducting effective needs assessments; commissioning integrated care pathways and packages of care for people with complex needs; drawing up robust contracts and monitoring providers against these. Three or four PCTs have let the commissioning function out to the independent sector,

but this is a deliberate, carefully run experiment that is operating for, and will be evaluated after, five years.

### **THE FINANCIAL PICTURE**

The years since 2005 have been characterised by considerable financial instability as patients exercise choice and Payment by Results kicks in. But by a combination of good work and early action by PCTs, SHAs and the regulator, this has just about been contained to manageable proportions. Nonetheless, the service has continuing propensity to hit a 2 per cent plus deficit in a bad year.

### **THE PATTERN OF CARE DELIVERY**

Patient choice has been good for private hospital operators prepared to get their prices down to tariff and for ISTCs, as factors such as perceived MRSA rates have seen patients opt for them. This has put acute pressure on the traditional district general hospital model. Significant numbers have lost their 'blue light' A&E, with A&E now run through networks that take advantage of a much better trained and equipped ambulance service, which treats many more medical emergencies at home but can also safely transfer patients who do need hospital admission across greater distances.

Much more care is delivered out of hospital, a trend driven by commissioning GPs and PCTs. Better management of long-term conditions has helped to contain the growth in demand for hospital services.

There are many more providers of care, private as well as public. But the danger of fragmentation (and of fewer A&Es), which was becoming acute in 2008, has been offset by the care record service now working well. NHS IT is the envy of the world, and Richard Granger has a knighthood.

But money is tight. And having got surprisingly close to the 18-week target in 2008, waiting times are slowly, but only slowly, getting worse.

### **TENSIONS IN THE SYSTEM**

The NHS, however, is far from problem free. The chief executive's organisation is now chiefly a purchasing body, but it remains responsible for performance management of those parts that have not yet – and may never – reach foundation trust status. This produces repeated outbreaks of tension between it, the regulator and the independent sector as it tries to protect these services from the full effect of the market – particularly as many of them involve mental health and care of the elderly.

Tensions are becoming ever more evident between the regulator and the inspector, and the clash of goals they produce. The regulator is helping most (though not all) foundation trusts run a tight financial ship. But the inspector is issuing too many reports pointing out that service standards and waiting time targets are being missed. Squaring the circle between affordability, financial stability and the quality of care (broadly defined) is proving difficult, and while it has always been difficult, the new system makes that transparent.

Some of the bigger foundation trusts have both expanded out into primary and community care, and/or formed joint ventures with the private sector. This, in the best examples, helps provide a pretty seamless service for patients. But it is producing local monopolies that are starting to make it hard for PCTs to test value for money and bring in alternative suppliers. Suppliers, both public and private, struggle with their statutory duty to co-operate, and the requirement to compete. SHAs and PCTs do not find that easy to police or operate either.

The plus side is that all this has produced considerable gains in productivity and quality. The minus side is that there is still more dislocation of services, as they open and close, than in the past. Put another way, patients enjoy choice and don't want to give it up, but they resent some of the by-products that their exercise of choice has produced. And they miss access to 'their' doctor.

### **INDEPENDENT SECTOR PROVIDERS**

Independent sector organisations on the whole are doing quite well. The best operators are making money, the worst losing. There have been a few scandals over poor-quality treatment and charges for services not provided. But the quality of the data about standards of care and costs is now so much better, and so openly published, that the risk of either of these happening is diminishing.

There is a reasonable amount of merger and acquisition activity. Private medical insurance, having dipped up to 2008, is growing again, but relatively slowly. Companies, rather than subsidising private health insurance, have become much more active in occupational health.

Individual premiums for private medical insurance have fallen in real terms as the reform of the NHS has delivered reform in the private hospital sector too. But there is now a much more clearly discernible split between a 'top end' private hospital sector, with prices (and thus premiums) to match, and a more workaday one for elective treatment that resembles NHS provision far more than that of the private sector, but is a little quicker.

### **PROFESSIONAL AND PUBLIC OPINIONS OF THE HEALTH CARE SYSTEM**

The whole system, however, does not feel entirely stable. There is a continuing rump of NHS-run organisations that look unlikely ever to make it to free-standing status. There remain muddles and compromises. And while politicians are doing a far better job than in

the past of standing back and letting the NHS purchaser manage and run her side of the organisation, there are complaints that she is unaccountable locally and she stills feels exposed.

The public is not happy with the NHS. But then it never is. It is, however, happier (and certainly getting a better service) than it was a decade before, and it remains attached to the model.

There are rows about closures or mergers of services, and there is a continual battle over funding. But the voices that can make a convincing case that the answer lies in changing the funding mechanism are few and far between. A continuous argument rages, however, about how to make the supply-side market work better.

## Appendix B: Participants in workshop

Chair of Working Group – Greg Parston, Chairman, OPM and Director,  
Priory Group

Report editor – Nicholas Timmins, Public Policy Editor, *Financial Times*

Secretary – Tabitha Brufal, King’s Fund

Facilitators – Nicholas Bradbury and Val Martin, Leadership  
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*Working group members are in bold*

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**Neil Goodwin, Chief Executive, Greater Manchester SHA**

Anne Heast, Director of Health, Tribal Group plc

**Tom Hughes-Hallett, Chief Executive, Marie Curie**

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Tommy MacDonald Miller, Director, Capio Nightingale Hospitals

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Laurie McMahon, Co-founder, OPM

Monica McSharry, Chief Executive, North East London SHA

Alison Norman, Director of Nursing, Marie Curie

**Keith Palmer, Senior Associate, King's Fund**

Ali Parsaa, Clinical Centres of Excellence

Sylvie Pearce, Building Better Health

John Proctor, Pfizer

**Carolyn Regan, Chief Executive, North East London SHA**

Rebecca Rosen, Senior Fellow, King's Fund and General Practitioner

Stephen Sears, Chief Executive, Ealing Community Transport

Fay Selvan, Chair, Trafford PCT and Chief Executive, Big Life Group

**Michael Shaw, Chief Executive, John Grooms**

**Ian Smith, Chief Executive, General Healthcare Group**

Matthew Young, Public Policy Projects, Adam Smith Institute

## Notes

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THE KING'S FUND IS AN INDEPENDENT CHARITABLE FOUNDATION WORKING FOR BETTER HEALTH, ESPECIALLY IN LONDON. WE CARRY OUT RESEARCH, POLICY ANALYSIS AND DEVELOPMENT ACTIVITIES, WORKING ON OUR OWN, IN PARTNERSHIPS, AND THROUGH FUNDING. WE ARE A MAJOR RESOURCE TO PEOPLE WORKING IN HEALTH AND SOCIAL CARE, OFFERING LEADERSHIP DEVELOPMENT PROGRAMMES; SEMINARS AND WORKSHOPS; PUBLICATIONS; INFORMATION AND LIBRARY SERVICES; AND CONFERENCE AND MEETING FACILITIES.

Recent changes in the NHS have triggered significant expansion in the involvement of independent and voluntary sectors in the delivery of services. How can this involvement be developed to ensure quality of care for patients and to enrich choice? This question was addressed by a small independent working group, commissioned by the King's Fund. This report is based on discussions within the group and on a one-day workshop that highlights many of the issues that need to be addressed by government and by people providing health services in all three sectors.

