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Response

Peering through a glass: darkly

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Calum Paton's article reads like a howl of pain when faced with the history of the past 20 years of 'market-like' reform to the NHS and the prospect of what is to come. Typically, he makes some powerful points. Not least, he highlights some of the unresolved tensions in current health policy. It does indeed remain pretty much of a mystery quite how patient choice, practice-based commissioning, and commissioning by primary care trusts will knit together, let alone how all NHS Trusts, foundation or not, are meant to make a profit (surplus) within a cash-limited system. But, while his article contains a litany of the problems, both actual and potential, that the 'new NHS' may bring, it is missing a counter factual. It contains an unspoken assumption that these changes are being made, almost willfully, to a system that was functioning, if not perfectly, then pretty well.

But that was not – is not – the case. Up to 2003, on the European data, the UK's five-year survival figures for cancer look pretty poor, even if you retain a fair degree of skepticism over the data. (It seems simply counter-intuitive, for example, to believe that five-year survival figures are better in Poland and Estonia with their much lower expenditure as a share of GDP. So there may be something wrong with the numbers.) Equally, after more than five years of 7% per annum real terms growth, the latest figures on waiting times show that, even now, once the diagnostic wait is included, there remain literally tens of thousands of patients waiting more than two years for an operation. That is not a record to be proud of, or to regard as acceptable. If the Conservative's version of the internal market failed to crack that, so too did the winding down of its potential impact during the Major years, and the further dilution of it during Labour's first three to four years in office. So it is far from clear that more money, plus planning, will alone produce an improvement in performance that is evidently needed.

Second, Paton is, at the simplest level, right to say that full choice requires some excess capacity. But he treats the NHS as though it is entirely static; that there is a given, fixed, and unchangeable amount of capacity within the

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system. In fact, however, the NHS is a dynamic not static organization. It is not just that there are the well-known and wide variations in throughput for a given amount of resources across NHS Trusts – notably in electives where choice will bite first and hardest. And indeed improvements by those below the mean – which the reforms are intended to stimulate – would increase capacity. Equally, however, hospitals already above the mean can and do find better ways to organize services and increase throughput. And while changing technology may sometimes reduce throughput by way of new and more complex procedures, it can also increase it – the arrival first of day case surgery and then of surgical endoscopy, for example. Thus capacity can increase within the system as well as by additions to it and choice and competition – with its threat that the business can go elsewhere – could help drive that. And while the independent treatment centres are adding capacity, they are doing so in a National Health Service that has at the same time received an unprecedented increase in resources – even if, rather predictably, a lot of that has disappeared into rent as expenditure growth outstripped the ability to expand capacity.

It is equally true that the new market, as Paton argues, is unlikely to work in practice in the way it has been designed in theory. Payment by results is wonderfully inappropriately named: it is payment for volume, not for results or quality. And it is highly unlikely that the tariff will hold as a single fixed price, particularly once the rate of growth in expenditure slows. Indeed Primary Care Trusts (PCTs) are already being given the right to vary it where hospitals 'overperform' against contract. In time it is likely to be a benchmark price – one that the NHS will not normally pay more than – rather than a single fixed sum for each procedure or group of procedures.

The fact that the tariff is far from perfect and will need repeated adjustment should hardly be surprising: it is new and it will need amendment in the light of experience. And it may be that attempting to have payment by results cover virtually everything that the NHS does is over ambitious. But we will see.

Equally, the injection of private competition to undertake elective operations at prices somewhat above tariff can arguably be justified on the grounds of the start-up costs that the private operators face to enter the market. The real test will come in the second wave contracts, where above-tariff prices for the sort of routine less complex cases that the Independent Sector Treatment Centres (ISTCs) handle will not be justifiable. As electives are stripped out of existing district general hospitals, the result could well be profound financial instability for the services that remain if the change takes place too rapidly – although that would apply whether the electives go into private sector treatment centres or ones run directly by the NHS.

So the market will indeed end up being a very managed market – health care being too imperfect a model, with too many information asymmetries and other problems, to operate effectively through the invisible hand. And big questions remain – and have remained unanswered for far too long – about how this

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new entity will be regulated. Who will oversee market entry and exit? What does a failure regime for both foundation and NHS Trusts look like? Who loses and who pays when organizations go belly up? How far and how fast will the divorce between PCTs' role as direct providers of care and their role as commissioners be driven? At what point, as competition is introduced, do European competition and procurement rules begin to bite, so that more NHS services have to be put out to tender? When these questions are answered, the nature of the regulation that emerges will dictate the eventual shape of what happens. The fact is, however, that every time the Department of Health has tried to address this over the past two years and more, the issues have been put back into the 'too difficult' basket, which suggests there may yet be a fundamental problem with the whole approach.

Even so, looking at NHS reform over the past 20 years – since 1988 – what is happening can be seen as an attempt to introduce some incentives and penalties into the way care is organized that may make the system more responsive – and more responsive than has proved possible through planning alone, although planning (by way of market management) will remain.

In a sane world, policies will be tried through a process of trial and error, with those that succeed retained and those that produce unwanted outcomes jettisoned. And at any one time the answer to all the questions about what might happen will not be available. But such is the way of the world (even a planned one).

One final thought: debates about the theoretical and practical impact of these changes are crucial. But at the time of writing, the independent surgical treatment centres are treating around 170,000 patients a year. That is less than 3% of the planned – 'elective' – procedures that the NHS performs annually. Even with a second wave of treatment centres that is still under negotiation, the total will amount to barely 5%. And electives remain a small part of what hospitals do, let alone what the NHS as a whole does. To that, diagnostics – X-rays, scans, endoscopies – has to be added. But that too is a small percentage, an even smaller percentage, of what the NHS as a whole currently performs. With patient choice, these numbers may well grow. But even with patient choice, it is hard to see in any near future – by which I mean the next three to five years – the private sector performing the 15% of waiting list operations, or even anywhere near it, that some have predicted. While it has to be true, that small changes at the margins, and locally, can create big problems for NHS Trusts, the private sector, competition, and choice cannot conceivably be blamed for the current ills of the NHS, even if, in a few cases, it has had a significant impact locally. When trying to work out why all is not well at present, analysts need to look beyond current policy.

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