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Response

Invisible hand? More like post-modern mush

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Some time around 2001, new Labour crossed an ideological rubicon by accepting that provider competition and patient choice were valuable to prod the National Health Service (NHS) towards better performance. Exactly what produced this ideological *volte face* by the then Secretary of State, Alan Milburn (and presumably some time earlier by the Prime Minister), has never been made clear. It may have been as simple as the fact that all other levers had been tried to reduce waiting times for elective treatments without enough effect. Or that extra supply of beds and staff were needed overnight to make progress, and the only source of these was outside of the NHS. Most likely it was both reasons. But no dressing up the need for extra supply or the desire to give more patients choice could hide the raw verdict that competition for resources between institutions – external threat – was a helpful motivator for the staff within them, including even the holiest of men and women in the NHS, the clinical staff. In making this verdict, new Labour had accepted what had been concluded by the Conservatives over ten years previously, which culminated in the policy of the White Paper, *Working for Patients*, in 1990, and the implementation of the NHS internal market in 1991.

What was controversial then remains so today among the social democratic left. Before Blair left office, a coherent set of reforms was crafted which laid the foundations for more provider competition and patient choice in the NHS. Even then, getting enough votes to pass through legislation to set up foundation trusts was hard work. Now, the going seems rougher. The financial settlement for the NHS is less generous (now down to 4% in real terms), and the state of the economy may wipe out real growth in the short term. The direction of reform is less certain with a change of Prime Minister and an election looming. A raft of reports have shown the disappointing pace of progress of key Blairite reforms such as Payment by Results (prospective payment for hospitals), practice-based commissioning, the use of independent treatment centres and patient choice. On the one hand, the confidence of the centre to craft detailed financial incentives effectively has taken a blow with the huge cost and opaque

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benefits of three staff contracts: for consultants, general practitioners and other staff under Agenda for Change. On the other, central diktat has been supremely successful in reducing two glaring problems: waiting times and hospital acquired infections.

What better time then to explore the arguments and evidence for using competition and choice in a public service like the NHS? Le Grand has produced, in *The Other Invisible Hand*, an elegant summary for the rationale as well as an examination of the evidence on impact in health and education to date (as of late 2007).

Le Grand is surely right when he says that a number of models of public service delivery operate within the NHS – targets (command and control), voice (accountability) and trust (in professionals). Before him, Christopher Hood put across a similar and fuller thesis on the public sector in *The Art of the State* (Hood, 1998). And like Hood, Le Grand points out that each model has its own inherent weakness: command and control is crude and demotivating with damaging consequences for quality of service provided; voice models favour the better off and in themselves offer few incentives for providers to improve quality; and relying on trust can produce behaviour by providers that is self-serving rather than quality-enhancing for patients. Each lever by itself, or in combination with the others, is not enough to produce a good quality service – one that is effective, responsive, efficient and equitable. *Ergo* competition and choice are needed also, argues Le Grand. He then explores how competition and choice might improve quality, examines the evidence, and describes the policies needed to ensure that competition and choice can work effectively.

There will be a hard core who simply will not countenance, given any evidence on beneficial impact, the use of what are, in effect, fairly crude financial incentives to shape the behaviour of professionals. But there will be a larger number who will contest the contents of *The Other Invisible Hand* (Le Grand, 2007) on more empirical than philosophical grounds. Here there are several areas to ponder.

First, the evidence on impact of choice and competition on effectiveness and efficiency in health care is pitifully thin. Evidence on the impact from abroad or from other sectors is not easy to translate in the NHS because of the vastly different context in which it operates. Regardless of one's point of view of the policies, is the impact of choice and competition limp, or the methods used by academics to evaluate them poor? How could this be remedied?

Second, Le Grand's argument that competition and choice increases equity (of access to health care), and the evidence cited on impact does not wholly convince. Anyone with even fleeting clinical experience will have seen the obvious lack of confidence of vulnerable groups in making decisions about health care; something that will need huge effort to remedy. In particular, older people with complex chronic diseases simply do not travel far, and prefer local treatment (Propper *et al.*, 2007).

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Third, one yearns for a more complex theory of clinician behaviour than is explored in the book. Arguably, the external challenge on institutions resulting from competition is likely to have more impact on management rather than front-line clinicians (who effectively direct resources). How could the external threat filter down to alter clinical behaviour? What level of external competition (or switching of provider by patients) might be healthy or detrimental regarding the quality of care clinicians provide? What kinds of incentives do which type of clinicians respond to, and why?

Fourth, more fundamentally given where we are in the NHS (in England), what other levers might be important in improving performance, and in what blend, to optimise the impact of competition and choice? Has the power of public reporting of performance through the regulator been exploited fully? If better outcome measures were available and used, with decent regulation, might that be as important a policy to pursue to improve performance in the NHS as competition (for resources) and choice?

In the NHS, at a national level, these kinds of discussions are often thin for several reasons. The subject is complex and the empirical evidence underpinning it weak (and so the guiding principle of 'what counts is what works' is little help). Discussions get caught up in shrill ideological debates between opposing groups, for example, between the role of the centre versus competition, or on the need for financial incentives versus professionalism. Various key tribes in health care have such a strong prevailing worldview that discussion to them is either unnecessary or irritating. To caricature: large tracts of the medical community actually believe that a combination of extra resources, their innate professionalism, along with information on evidence-based pathways of care and leaving them alone will lead to a near perfectly performing health care system; a significant number (if not the majority) of managers still believe that a combination of resources, central guidance and strong performance management is the most effective way to achieve change. In the absence of evidence, there are enthusiasts to support every shade of opinion.

Faced with a long list of must do's, limited time to show impact, and confusion as to how to achieve change, no wonder national policymakers reach for the 'command' lever. This lever works; in fact, it is probably the single most effective lever in the toolkit. But the drawbacks of over-relying on it to run a health system are now well recognised to the point that current political parties are united in saying they will reduce its influence. But what is powerful enough to take its place?

Some, like Le Grand, argue that choice and competition between providers will be that replacement. Others argue equally forcefully that it is only when local people have more influence over services, through some method of involvement, will the NHS improve. Again, precious little evidence. Still more put their faith in improving performance through public reporting of comparative data on outcomes for hospitals or general practitioner GP practices, arguing

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that reputational risk will prod the professionals into appropriate action. Again, the impact of such regulatory or other activity is insufficiently assessed to date. 'Forge partnerships and collaborate' is another recipe for nirvana for some. All these approaches will work to some extent, but do the little fires add up to a bonfire across the NHS transforming performance? Not yet at any rate.

The truth is that, at present, we are peering through a glass darkly. At best we can identify the main potential levers to improve performance, try them, and not rule out any simply on ideological grounds. The narrative in the NHS, and indeed in health care systems across the developed world, is no longer a binary one between those on the political left (believing in state ownership and command) and right (believing in markets), but what is the right blend of levers to take health care where it should be to meet the twenty-first century needs and expectations? This blend may be naturally different by area (for example there is not much scope for competition in Cornwall compared to Tower Hamlets), by service (more likelihood of stimulating competition and choice for elective care than care for people with complex and chronic conditions), or by age group (older, sicker people less likely to travel to alternative providers than the young).

The place we seem to be in health policy is that, at the national level at least, there is no clear path forward on how to achieve improvement in provision other than reducing central command, developing the other levers and trying them out. This may sound like an impasse to politicians anxious to find an administration-defining means for change – but in fact it is a healthy, diverse and almost apolitical state to be in, arrived at in the NHS (in England) after 60 years. This 'post-modern mush' is healthy only if there is a robust and regular appraisal as to its impact on outcomes and efficiency. On the other hand, regarding funding, despite the distracting issue of whether or not to allow top-up payments, there is strong political consensus that public financing of the NHS and universal coverage will remain for the foreseeable future.

As a result, much of the attention now in the service is at the local level. One oversimplified way of looking at it is that until now much of health policy has focused on 'extra-organisational' levers (factors outside providers or commissioners) created nationally to up the performance of local NHS organisations across the country. Now the focus is turning more to allowing NHS organisations to experiment with a wider range of 'intra-organisational' levers, such as a range of financial and non-financial incentives. These are largely focused on clinical and medical staff to engage them with the need to improve quality and efficiency, not just of their own practices but also across whole services and beyond institutions. These incentives simply cannot be crafted well nationally or by people with no clinical experience. Engaging doctors in this way has been an elusive objective of the NHS for decades, not least since the inquiry by Roy Griffiths in the 1980s, even though it has been recognised that to make any

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great strides in improving performance, doctors have to not only be on board but own and lead change.

If the sting of targets and directives is reduced for long enough, there may be space for local NHS trusts and primary care trusts (PCTs) to innovate in this way, and, by doing so, addressing head on some long overdue downsizing of hospitals. The main risks are inertia (David Nicholson likes to quote from the 'Life of Pi' – how the zoo cages are now open but the animals are still inside), or that efforts to improve performance of services are not responsive enough to the individuals using them. This is where external challenge or indeed threat from competition, choice, regulation and public reporting of comparative data and forms of local accountability may have an effect. Or that political patience with slow progress runs out as finances get tight, and there is reversion to diktat.

So while national policymakers are still twiddling the dials of payment by results, GP commissioning, reforming regulation, allowing autonomy for NHS trusts for example, all eyes should be on how local NHS trusts and foundation trusts and PCTs, and GP commissioning groups are using freedoms to 'nudge' themselves, using a range of internally crafted incentives towards improvement. As the policy agenda moves away from reducing waiting times for people needing elective care to the far bigger challenge of improving the health of those with chronic illness, NHS providers will see the need to integrate care (at home, in the community, in GP practices, in hospitals) in a seamless way, and be more proactive and supportive of the individuals when they need health care, and when they do not but may be at risk of ill health in future. This recognition prompted last years' NHS Next Stage Review by Lord Darzi, and the accompanying strategy for primary care, to include in it the recommendation for integrated care pilots. With skilful crafting, and intelligent response from the NHS, these or other pilots could be where the interesting action is over the next few years. But without external challenge of some sort, integrated care sites risk becoming self-serving monopolies.

So the critical question for policymakers must be not whether competition and choice have some role in the NHS, but how much relative to other levers (and how could we tell?). Le Grand's answer is 'still not enough'. The Government's response is probably the same – for the moment. To move ahead we need more understanding from policy makers, and a more intelligent response from researchers.

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