

# Markets in health care: taking a tiger by the tail?

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AS THE UNITED KINGDOM National Health Service (NHS) moves towards structural reorganisation once again, both “contestability” and “choice” reflect the underlying theme of the current reforms: that is, an open market in health care. This paper describes how this reform has come into being and the implications for the UK, but also for the wider developed world.

The NHS was established on the wave of altruistic community spirit that followed the end of the Second World War, when the new Labour government introduced publicly funded education and social care as well as health services. In what may be characterised as a “socialist” model of care, individual needs were often subsumed into the needs of society at large, and egalitarianism and perceived fairness trumped any sense of consumerism.

Paternalistic professionals “knew best”, and grateful patients joined the queues that ensured that there was a steady “header tank” of users to keep expensive hospitals running at a set capacity, and hence a set efficiency. The NHS was perceived as the envy of the world because it seemed to manage to squeeze a quart of activity out of every meagre pint of funding.

Moreover, in this model of planned health care (a local hospital in every district, and general practitioners distributed to ensure a fair population coverage), public services were funded through general taxation and were all delivered by public organisations employing public servants, working alongside each other for the common good.

What a contrast to the more “capitalist” models of health care, such as those of the United States, where services developed largely in response to market forces, and where there was no real sense of central planning, equity, or fair play. Instead, the needs of the individual consumer took precedence over those of society, and the “haves” asked for the moon and got it, while the “have-nots” took the crumbs of charitable care if they were available. The US system was initially paid for on a personal basis, and later through workplace insurance, and services waxed and waned on a commercial footing. Overhead costs were high, and the efficiency of the system (in terms of population benefit) was low. Given these problems with a market-based system, one has to wonder why the original British model was modified at all: maximum bang for minimum bucks; high efficiency and low overheads — what was wrong?

The answer is hard to distil into a few simple causes. One important factor was the inexorable and almost exponential rise in medical technology: what was becoming medically possible was ceasing to be economically feasible as the exchequer’s predictions about public spending on health failed to keep up with the public’s expectations. These expectations were largely led by hospital consultants, busy developing ideas and technologies with little incentive to consider their financial consequences. In economic jargon, the system was beginning to be driven by the supply side, something that did not fit with the “corporate altruism” of the welfare state.

In addition, the days of professional paternalism determining the public’s actions were passing, and consumerism was creeping into every aspect of British life: the conscription, rationing, and utility furniture that had epitomised Britain at the inception of the NHS had long gone, and, as the decades passed, there was more choice in the supermarket aisles, a wider range of channels on the television, and people were constantly being encouraged to

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take control of their own destinies, to “do” rather than “be done to”. Such a culture inevitably started leaking into health care.

Under a traditional Labour government, the drift away from social models of care might have happened more slowly, but in 1979, the advent of a Conservative government with an enthusiasm for commercialism meant that when financial crisis hit the NHS in the late 1980s, it was a quasi-commercial solution that was developed.

Through government eyes, one of the problems inherent in the NHS was the closeness and apparent collusion between health authorities, supposed to control the system, and the hospitals, providers of the most visible aspects of care. There was no “grit” in the relationship, something that Conservative doctrine attributed to the lack of a transparent contracting system: providers were simply paid for being in place, usually on the basis of historical funding, with little if any link between input (funding) and output (effectiveness, or even simple activity levels). Instead, there were intangible professional “understandings” whose effectiveness was not easily amenable to external scrutiny.

So the “purchaser/provider split” was introduced in 1990, to distance those who procured services from those who provided them. Under the auspices of an “internal market”, purchasers (health authorities and, later on, GP budget holders) were intended to be able to buy services from competing NHS organisations (hence “internal”) on the basis of quality, availability, and volume. With “money following the patients”, the notion of contestability was introduced to the planned world of the NHS for the first time.

As a first attempt to marry the planning psyche of the original NHS with the flexibility of a true market, the Conservatives’ internal market could never have really succeeded; the political fallout from a genuine NHS Trust failure would have been too great, as demonstrated by the survival of a major London Teaching Hospital when market forces all conspired to close it down. It was probably the fact that the NHS was not considered “safe in their [the Tory government’s] hands” (Margaret Thatcher, speaking at the Conservative Party Conference, 1983) that prevented the completion of this radical

internal market project. It was to take a nominally more left-wing Government, in the shape of Tony Blair’s Labour administration, to begin the real experiment: an *external* market in health care.

So what appeals about a market model of care? Commercial markets work in a biphasic way: when new “products” first appear, potential customers are prepared to pay high prices to get what they want, and suppliers work to develop the market. As long as demand for a product exceeds the supply, the price and availability will remain at a premium. Once suppliers have caught up with the demand they will want to demonstrate that their version of the product is better/cheaper/quicker in some way; it is at this stage that the purchasers may reap benefit.

In a health care context, demand is channelled through the commissioning process, and supply is largely determined by the availability of hospital staff and technical equipment (beds, diagnostic tools, operating theatres, etc). In an efficient, planned health economy these usually exist at or slightly below the level needed to meet demand (to ensure that “header tank” effect). This means that there has not been the flexibility for hospitals to offer any form of “better/cheaper/quicker”. In market theory terms, shortage of supply has largely held the purchasers over a barrel, keeping prices high and inventiveness a rare and largely unnecessary commodity.

The public sector market enthusiasts wanted to change that, and their first step has been to increase supply. Already in the UK we can see the manifestations of this: there are Foundation Trusts, which are still public sector organisations, but with the freedom to increase capacity, take financial risks, and increase their “market share”. Private companies are being encouraged (with highly favourable contracts, at least in the short term) to take on certain low-risk clinical activities, such as routine elective surgery or the provision of community services. Professional boundaries are being opened up to allow clinical monopolies (particularly among the well unionised medical groupings) to be challenged. And the whole notion of “contestability” is being developed through the mechanism of compulsory choice (a real oxymoron!) for patients, who *must* be given a choice from several different providers whenever

they are referred from general practice into the secondary sector for elective care.

The theory is that once the number and range of suppliers has grown, commissioners will start to regulate the market, driving up the quality and pushing down the price of services. However, we are moving into the realm of hypothesis here, since market regulation in this sort of setting is something new: two systems with values that appear to be mutually exclusive, trying to reach a mutually advantageous position.

On one side is the pressure to run an efficient, egalitarian, public service. The NHS core business is still to deliver equitable care locally, free at the point of delivery, and to that end there still has to be a planned, centralising approach to commissioning.

On the other side, markets have no coherent sense of direction. They evolve and, as with all evolution, they respond to the evolutionary pressure of the moment, with the fittest thriving and growing while the less successful wither and die. Evolution works through random variation, and this is both the strength and the weakness of the market model: variation offers the innovation and creativity that is lacking in the monolithic, risk-averse climate of the public sector, but randomness makes markets hard to corral and control.

Other countries seem to work with one side or the other. Despite the emergence of managed care, the US still largely comprises a primeval market swamp of evolving models that have no population coherence but offer pockets of brilliance in a morass of expensive and inefficient mediocrity.

The Australian system has private hospitals but little headroom (in terms of money or capacity) for real experimentation, while the dissonance between the elements of health care run by the states and the Federal government overlies a climate of cost shifting that mitigates against imaginative models of delivery.

The Scandinavian systems probably err more on the social, altruistic end of the spectrum, but no country seems to have genuinely combined the rigour and equity of central planning with the freedom and innovation of a real market economy.

If the British system is to achieve this aim, then a number of prerequisites need to be in place. First, the central political agenda has to be broad and simple, defining *what* is required without being too

prescriptive about *how* it is delivered. Second, the organisations doing the actual commissioning (currently the Primary Care Trusts [PCTs], but which are presently being enlarged and reconfigured to gain much needed capacity) need to be allowed to develop commissioning mechanisms and relationships that are open and flexible. Detailed contracts, however tightly they are policed, will not succeed in this highly complex environment unless there are established relationships between the players, any more than excellent relationships will work without mature and rigorous contracting arrangements to back them up.

Third, there need to be enough resources in the system to lubricate its running — extra capacity means more people and higher costs, and this is inevitable in an open market system. There has to be room (in terms of human and financial resources) for commissioners to nurture and develop their providers, and room for those providers to grow, thrive and sometimes fail. Moreover, development has to be an ongoing process — so the fourth prerequisite is time. A mature market needs time for the relationships between commissioners and providers to ripen, for trust without collusion to develop, and for the sophisticated risk-sharing mechanisms that ensure joint “ownership” of problems and their solutions to evolve and be fully understood by all concerned.

These are all great leaps, and if they happen, then the UK may have created a new paradigm of health care that would resonate throughout the developed world: a universally available service whose equity and standards are determined and funded centrally, while being delivered by a range of providers whose self-serving interests can be harnessed and orchestrated to the mutual benefit of all.

The risk is that the prerequisites will not be put in place. In that case, we might anticipate underdeveloped commissioners using short-term, mechanical models of contracting that encourage perverse behaviour among the immature and equally short-term-thinking providers. The “win-win” of aligned incentives in a mature market could rapidly degenerate into the classic “win-lose” of traditional public-private relationships, leading to an irreversible “lose-lose” for the whole population.

At the moment, the jury is still out ...

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