The NHS revolution: health care in the market place

Should the NHS follow the American way?

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Managed care and patient choice have many good points, but the NHS needs to adapt US methods if it is to be efficient, free, and fair

This article is part of a series examining the government's planned market reforms to healthcare provision

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The UK government seems to draw much of its inspiration for health policy from the United States. Hence the recent love affair with Kaiser Permanente's care pathways and the recent affirmation of the belief that choice and payment by results will move England towards a patient led NHS.[1] Using evidence from the US and Canada, we question this source of inspiration, raise the possibility that the current policy trajectory will lead to greater private financing of health care, and outline why the United Kingdom should be wary of this. We then suggest a solution to financing that retains some aspects of managed care and current policy but rejects others. Our solution recognises the cash limits of the NHS and its twin goals of equity and efficiency.

Did managed care work in the US?

It is easy to interpret managed care in the US as having led to greater efficiency in terms of outcomes and cost.[2] However, managed care organisations like Kaiser Permanente have essential differences from the NHS. Crucially, they operate in a free market without universal coverage. They are not obliged to take all comers; patients who represent the "best risk" can be creamed off by targeting groups who make low use of health services. This practice is reinforced by relatively healthy consumers self selecting into the lower cost plans offered by managed care with little threat to their health. Controlling for income or socioeconomic group when comparing Kaiser with the NHS[2] does not adequately remove this source of bias.[3–5] The best risk people from high (or low) income groups will somehow select into Kaiser, whereas the NHS has to look after everybody.

Furthermore, Kaiser has developed a unique culture in which doctors take corporate responsibility for use of resources and give up a considerable degree of clinical freedom. Only a certain type of doctor would choose to work in such a culture, and Kaiser's recruitment process is careful to screen out those who would not fit. Once again, a universal system such as the NHS cannot afford to be so selective.

Thus, comparisons between Kaiser and the NHS are difficult, and the relative inefficiency of the NHS is likely to be more apparent than real. This also explains why, at the whole system level, managed care in the US has failed to control the nation's overall health costs.[6–8] With managed care offering lower cost plans to people with low health costs and with higher risk (and thus higher cost) people tending to remain in their established plan, the costs at the level of the whole system are not reduced. As regards quality of care and outcomes, the detailed works of Miller and Luft have shown, at best, mixed results from managed care.[9 10] The NHS needs to consider carefully adoption of Kaiser-type methods for chronic diseases. Although some diseases may be suitable for a more integrated approach, others may not.

RICK BOWMER/AP/EMPICS

Treatment at a US managed care organisation: patients seem to have low risk of ill health

From patient led NHS to user charges

The recent publication outlining the way to a patient led NHS raises many questions about the extent to which market forces and consumer demand will shape health care and about the future role of commissioning.[1] Patients will be offered a choice of secondary care provider, with the supply side of the market freed up through the independent sector and semi-independent foundation trusts, in an attempt to make health care more patient focused and more efficient.

The prerequisites for market driven efficiency, however, are that price is determined by supply and demand and that consumers' ability and willingness to pay, from their finite resources, in turn determines demand. Yet price will be predetermined in the NHS through a national tariff, and patients do not incur any costs at the point of use. Competition, therefore, can occur only through quality, which will be inflationary unless an effective counterbalance to the power of foundation trusts can be found. This counterbalance is required to prevent more resources falling into the black hole of the acute sector and may even be required to divert resources from the acute sector to primary and community care as well as public health initiatives. It is also unclear how the effects of competing on quality will fit with a fixed tariff.

Another major failure of recent policy has been a lack of recognition of cash limits and scarcity of resources. Up to now, little serious attention has been paid to encouraging primary care trusts to act as the counterbalance and thus set priorities and control the expenditure incurred by patient demand. Further evidence of this comes from the fact that, despite the NHS having received extra money to bring spending up to the European average, many provider and primary care trusts are running large, and perhaps unrecoverable, deficits.[11]

Without further policy developments, the government's current scenario for a patient led NHS, whether by accident or design, suggests a policy roadmap that can only lead to user charges.[1] We face the prospect of an NHS led totally by patients, with supply responding purely to consumer demand without any recognised cap on expenditure and with a tariff system that undermines the market's ability to achieve efficiency. The result is a system that does not seem to stack up financially. With consumers bearing no financial responsibility for their actions and primary care trusts simply paying the bills, already strapped commissioners will be pushed even further into deficit.

As little will exists to raise taxes, we foresee the emergence of a new policy spin intended to ease the way for user charges. Phrases such as the need to "diversify the revenue stream" and for "new sources of revenue," each of which have been used recently in the Canadian context,[12 13] will be heard in the NHS policy debate. Patient charges will quickly follow, either in the form of compulsory charges applicable across all services or as an optional premium charge for additional services.

To see why we should not go down the road of user charges we have only to look at the US system again.[6] The healthcare system that has the greatest problems controlling cost also has the greatest amount of user charges. Although charges may choke off individual demand among certain groups (those who are poorer or not as healthy), they do not do so at the system level because doctors will naturally provide even more services for those who access them (the wealthier or less needy). The demand that is choked off is not necessarily trivial in health terms either. The seminal RAND study of user charges which took place in the US during the 1980s showed that clinically needed care is just as likely to be cut back as care that is not needed.[6] Charges simply lead to the system being as costly as before but meeting less need. The bureaucracy required to avoid such adverse effects, by creating exemptions, is unlikely to be justified in terms of revenue earned.

Although to some extent we already have a multitiered system, the more services that are opened up to private payment, the more diverse will be the quality of those services, in both clinical and hotel terms. The most vulnerable in society would inevitably receive services at the lower end of the market, which would no longer be accessed by the vocal middle class. And it is the middle class who currently win improvements for all NHS patients by being locked into the same system of financing services.

Of course, society may be comfortable with a system of user charges. If so, the NHS could be in deeper trouble than even we suggest. There is little evidence of what would be acceptable to the population in this regard, although it has been claimed that those who advocate user charges tend to be those who stand to gain most from their introduction—in this case, the healthy and wealthy.[14]

Is there an alternative?

On the assumption that the public wants to avoid user charges, we propose a system that retains some elements of managed care and recent policy but rejects others. Our starting point is evidence that the advent of the purchaser-provider split in the UK led to greater awareness of standards and costs.[15] Fundholding resulted in an important change in the role of general practitioners, increasing their involvement in many decisions about service provision. Recent evidence suggests that fundholding had a positive effect on waiting times.[16] Such effects probably arose because general practitioners were able to negotiate from a position of strength, not just financially but because of their professional status. If we want a patient led NHS that remains free at the point of use, but with some handle on the purse strings, then practice based commissioning with genuine responsibility for financial management is the way forward. It would be similar to fundholding, which was modelled on managed care but more explicitly recognised the cash limits of the NHS. This is how we can realise the potential benefits of US managed care models but avoid their pitfalls.

More specifically, we believe that the concept of an integrated primary and secondary health and social care organisation, or superpractice, holds out the greatest promise for a 21st century NHS. Superpractices would receive public funding for and serve populations of 25 000-30 000. As well as primary care professionals with the appropriate skill mix, they would also provide ambulatory secondary care specialists, who could be employed, partners, or contracted in from hospitals.

Such organisations could provide their own inpatient secondary care, perhaps through the development of community hospitals, or operate a mixed arrangement of leased beds (staffed by their own clinicians) and commissioned secondary care from other providers. They would be free to commission more specialised secondary and tertiary care and diagnostic and other services from foundation trusts or independent sector providers. National tariffs and guaranteed throughput in the independent sector would be abandoned to allow superpractices to negotiate the best possible price and quality within their finite budgets. Patients would be

Summary points

Current UK health reforms could end up with patients paying privately for more of their care

A managed care approach is unlikely to increase NHS efficiency without explicit recognition of cash limits and selective adoption of models for specific diseases

An integrated system of care with a focus on general practice based commissioning would prevent too much emphasis on acute care

To make competition work the national tariff needs to be scrapped

Patient choice should be shifted from secondary care organisations to new community based integrated care organisations which provide or commission all services for their patients

encouraged to exercise choice and consumer power by moving between these integrated care organisations, rather than through their choice of secondary or tertiary care providers.

To prevent superpractices creaming off low risk, low cost patients, the NHS would need to develop a more sophisticated risk adjusted resource allocation formula. This could use the data now routinely collected at practice level by the new quality outcomes framework—for example, smoking status, body mass index, and blood pressure. National bodies will still be required to assess performance and conduct other monitoring, and both national and regional bodies would provide the technical and infrastructure support for assessing needs and setting priorities. Methods and criteria for managing scarcity and improving services could also be developed at this level but adapted locally with community and partnership agencies.[17]

Conclusion

Current government policy and US managed care have many good points. Building on these, our proposed model of integrated care, rooted in genuine practice based commissioning, would make it much easier to control overall NHS costs and manage scarcity without compromising clinical standards or equity. If foundation trusts take over and develop these roles, more emphasis is likely to be placed on acute care and demand would be supply rather than patient and primary care led. Our proposals bring the counterbalance that is needed, while recognising cash limits. They would safeguard the founding principles of the NHS and guarantee its continuation as an asset for the twin goals of economic efficiency and social justice in Britain.

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Corrections and clarifications

The parents' journey: continuing a pregnancy after a diagnosis of Patau's syndrome
An editorial oversight led to the names of two authors being left out of this clinical review by Locock (*BMJ* 2005;331:1186-9, 19 Nov). Jane Crawford and Jon Crawford should have appeared as coauthors under the article title. We apologise to all three authors.

Self management of oral coagulation: randomised trial
A observant rapid respondent spotted that the abstract of this paper by Fitzmaurice and colleagues (*BMJ* 2005;331:1057-9, 5 Nov) should say that intervention patients used a point of care device to measure international normalised ratio every two weeks, rather than twice a week.

Height and mortality from cancer among men: prospective observational study
When preparing an update to this analysis by Davey Smith and colleagues (*BMJ* 1998;317: 1351-2), the authors realised that a computer program miscoding had occurred for cancers related or unrelated to smoking. They had originally reported that greater height was associated with increased risk of cancers unrelated to smoking, but not cancers related to smoking. They have now found that, although the overall association between height and cancer mortality remains, there is no material difference in the strength of the association with cancers related to smoking or those unrelated to smoking. Full details of the reanalysis are available in the report of the updated analysis (Batty GD, Shipley MJ, Langenberg C, Marmot MG, Davey Smith G. Adult height in relation to mortality from 14 cancer sites in men in London (UK): evidence from the original Whitehall study. *Ann Oncol* 2005 Oct 25 [epub ahead of print]).