Choice in Healthcare

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Abstract

A coalition government has the challenge of rationalising spending on the public services. Health care spending is reported to be protected however the potential for considerable savings exists within the Agenda of Choice that costs 14% of the annual cost of the NHS.

1 A History of Choice in Health Care

John Major’s Conservative government introduced some notional gifts to the electorate in the late 1990’s. In addition to rights concerning the performance standards of public services he entrenched the idea of choice in areas such as education and health care. In part, the policy represented a logical step following the neoliberal strategy[1] of using market forces to deliver a desired improvement in the delivery of public services in terms of value for money and quality initiated in the Thatcher years.

Whether the last 25 years of marketisation of health care, continued by New Labour, has delivered quality benefits is debatable. The expansion of competition from within the NHS to private contractors has accelerated under the Blair government and seems set to continue for the next five years if Conservative and Liberal Democrat manifestos remain unaltered in coalition.

The cost of running an internal market has however been counted by the House of Commons Health Select Committee and stands at 14% of the annual budget of the NHS[2]. Now that the National coffers are declared empty it is timely to ask whether the £14Bn spent on maintaining an internal market represents good value for money. The effect of choice on equity of service provision is difficult to estimate because of confounding environmental and societal factors however the North - South divide has steadily widened since the implementation of the Choice Agenda under New Labour[3].

A more fundamental objection comes from the challenge to the founding ethos of the NHS, neatly summarised by Ali as ”The US health care system is driven by the desire for choice whereas the NHS is driven by the desire for equality”[4].
2 Features of Markets

- Competition drives quality
- Competition drives innovation
- Competition improves productivity
- Choice is a right for the elector

Table 1: Possible Benefits of Market Forces

To operate, free markets depend upon an excess of supply and good information to allow consumers to make good choices. An additional feature of free markets is the constant creation and dissolution of businesses as innovation and failure are rewarded. Constraints on business behaviour are imposed by legislation with ethical issues influencing the best firms that display a strategic commitment to remain in the market in the long term.

3 The National Health Service and Market Forces

Examination of the possible areas of benefit arising from the application of market forces to health care often fails to isolate the other changes that have occurred within the National Health Service over the past 25 years. Setting clinical activity as the driver for financial reward has worked against the delivery of quality health care leading to Lord Darzi’s report and the issuing of the QIPP challenge as a corrective.

Services that have innovated have thrived but there appears to be no market force driver within the NHS underpinning this. Trusts with a strong academic pedigree are more sensitive to the benefits of encouraging innovation and are likely to have strongly motivated thinkers in their workforce anyway.

Whilst activity has risen as a result of the Payment by Results regime clinician productivity has actually fallen. Most front line clinicians would refute the notion that they are less busy than a decade ago however their activity is directed away from clinical productivity as a result of the regulatory processes that have flourished over the past 25 years in reflex response to adverse events. Over the last 9 years it is estimated that public employees in the specification and inspection “industry” has burgeoned by 800,000[5].

Finally, choice is desirable but the information and time needed to make a satisfactory choice are often in short supply. Choices over health care are complex compared with deciding what car to buy or even what stock to pick. The data available from health care providers is usually not sufficient to give a real understanding of the consequences of making one choice compared with another. When taken ill, the tax payer should expect good care automatically[6]. The events at Stafford Hospital would lead to the failure of that Trust if an
excess of local supply, adequate information and the political resolve to allow a hospital to close were present. As with our armed forces, the state should not be seduced into providing duplication for the sake of a notional benefit that does not in reality exist[5]. A recent King’s Fund study has examined the issue of choice in health care, finding that while 75% of citizens value choice only 5% actually exercise choice[7].

For the voter, choice concerning health services should occur at election time. Localisation of choice through local commissioning has a chequered history. When local decisions are taken, one patient’s world Class Commissioning is another’s postcode lottery. The pendulum has swung back with the establishment of a central decision making advisory body in the form of NICE leading to evidential constraint to the freedom enjoyed by commissioners. Devolution of commissioning to family doctors will create an interesting push away from central agreed standards for provision of care[8].

4 So Where Now?

In a state run system where a £20Bn gap due to a freeze in funding looms over the next 5 years, saving £70Bn looks quite attractive. What would the NHS look like under such a monolithic regimen?

The £14Bn identified annually as being required to run an internal market could probably not be fully recovered. Certainly the duplication of supply and transaction processing necessary to create and maintain a pseudo-market would be lost but a strong commissioning function would be needed. Because market forces are no longer acting, some incentives are needed to prevent poor performance. Political resolve will be needed to deal decisively with management and senior clinical teams that occupy the tail of poor performance, an essential - pour encourager les autres.

Change seems to be the only constant in the NHS with an acceleration over the past decade with what Professor Alan Maynard termed "wheeze of the week"[9]. To enable change to occur more easily, single budgets to cover health economies would be an enabler of reconfiguration. The move towards care in the community championed by Kaiser Permanente in California requires, as a first step, integration of community services with the primary and secondary care sector[10]. The removal of competition and choice from the NHS would facilitate such a drive.

5 A New Direction or More of the Same?

Both the Conservatives and Liberal democrats have declared their strong support for choice in health care. Perhaps it is now time to ask the public whether they would choose to spend £14Bn in other ways such as maintaining adequate equipment for our soldiers, funding science adequately or reducing our taxes. Health care choice outside the NHS could be supported through tax incentives
and would potentially ease the burden of care remaining for the NHS. Abandoning such a cherished shibboleth would be traumatic for the Government but the fundamental question has to be posed - can we really afford to expand an unproven £14Bn programme?

References


