



## **‘Competition: the solution to the NHS’s problems?’**

*House of Commons, 19 February 2008*

The ‘NHS Next Stage Review’ being conducted by Lord Darzi has been billed as a ‘once in a generation’ opportunity to reinvigorate the health service.

The scope of the review is all-encompassing, from the reconfiguration of services to constitutional arrangements for the NHS, but one thing is clear: it *must* get buy-in from a disillusioned medical profession and empower them to work for patients once more.

Consonant with the review, Civitas will be hosting a number of high-profile debates to explore the potential for consensus on some of the key themes and milestones. The aim is to bring together the grassroots of the medical profession, along with key stakeholders in the NHS, private sector and politics, in healthy, open and unassuming discussion, independent of government.

The first in the series, chaired by **Professor Aidan Halligan**, looks at the role of competition. Engaging an audience of around one hundred interested parties were **Mr Nick Boyle** (p.1), **Professor Parveen Kumar** (p.4), **Nick Seddon** (p.6) and **Professor Chris Ham** (p.10).

Comments (p.12) were also heard from: Professor Nick Bosanquet, Massoud Faloudi, Mr Christoph Lees, Norman Lamb MP, Philip Brown, Professor Steve Smith, Dr Rodney Burnham and Andy Cowper.

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**Mr Nick Boyle**

**Consultant General Surgeon, Maidstone & Tunbridge Wells NHS Trust**

**Managing Partner, Circle**

The way health care is currently delivered in the NHS is unsustainable:

- *The aging population.* Every day average life expectancy goes up 5 hours. We now have more pensioners in the UK than children.
- *Technological advances.* There have been massive advances that are expensive. To treat a heart attack now we have, for example, CT scans, angiograms, angioplasty and thrombolysis to name but a few. A CT scan done in Tunbridge Wells can be viewed in Vietnam.

- *Consumer expectations.* People have choice in so many facets of life and are not willing to put up with an NHS service that doesn't provide this.
- *Sustainability.* Investec recently predicted that unless we change the modes of delivery we'll be spending 15 per cent on GDP by 2025; by 2050 this could easily be 25 per cent.
- *A medical profession highly discontented* over the way we are able to provide our services. In a recent survey by *Hospital Doctor* of c.3,000 doctors; over 80 per cent said they wouldn't encourage their children to go into medicine.

The common thread is lack of ownership; the ability to practice, to treat our patients in the way we want to and think best. Healthcare in the UK is not managed from the bottom-up, but from the top-down. As an ex-clinical director I can testify to this first-hand. This is bizarre when you consider what a scarce resource we are and that our decisions influence 80-90 per cent of healthcare costs.

In other industries, we have been in this situation before; in the 1950s with food delivery and retail, in the 1970s-1980s with manufacturing and services, in the 1990s with financial services, airlines and telecoms.

Every time – with the exception of manufacturing – we have seen a solution in competition. Positive restructuring has happened and competition has been the driver. And every time the customer (patient) has got better access, better quality, better value for their money and more choice.

But a defining feature has been that incumbents resist change; as both the existing private and NHS organisations have done. Yet where these incumbents have overcome the barriers to exit, they end up providing much better services and thrive; like BA and BT.

The stimulus has always come from newcomers who innovate, change and challenge incumbents. The same solution can apply in health care.

Patients need more access to information about outcomes; how good is their hospital, their doctor? At the moment they just don't have access to this. Now innovative companies are developing this data to drive change.

Our government has to make a choice – are we going to allow the talents and entrepreneurial skills of this country to thrive and push change; or are we going to try to protect incumbents, like with manufacturing? And we all know what happened to the UK car industry.

But I would argue we don't have a choice here. The government has increased NHS spending from £30bn in 1997 to £100bn now, yet the government is still waiting to yield the political dividend it hoped might be seen. Why? Because consumer expectations have not been met; and will not be met in the current system.

The debate is not between private and public, but between progress and protectionism.

I'm a clinician, I'm really not interested in philosophical ideology at all; I just want to treat my patients better, as with every other. But I believe an environment where you encourage competition will best enable clinicians to achieve this. You can let a thousand flowers bloom.

Take Nations, an ISTC company, that was failing. It was only because of the market that we, as a clinician-led organisation in Circle, were able to acquire it and give the clinicians, nurses and the porters ownership. We empowered them. That small unit has transformed its output, the number of patients it sees, along with quality and patient satisfaction. It is providing value to taxpayers.

Competition offers a solution.

### **In discussion:**

It's simply not true to say the NHS is the envy of the world. All international comparisons show that we're not delivering as good health care as in Europe.

And even if we disregard all the comparative data – if you think our data is better or you simply can't compare it – in absolute terms you can say this: I work at Maidstone & Tunbridge Wells NHS Trust, the experience there is not unique, and there's no way you can say this is the envy of the world.

The structure of the NHS doesn't work, it needs to be reformed, and it needs to be based more on information than 'reputation'. It's all very well talking about reputation, but people have reputations for all sorts of reasons – it could be because they're a great clinician or because they have a good golf handicap and happen to play at the weekend with the local GP. That's not good enough. One of the reasons why the poor have such bad access is because they don't have access to a clinician's 'reputation'; they don't have access to unbiased information. It is our responsibility as clinicians to measure our performance and make it public.

I also take issue with training being disrupted by increased private provision. We as doctors have a responsibility for training the next generation – there's no reason, from a surgeons perspective, why joined-up training can't be improved in a centre where elective surgery is ring-fenced and medical students have the opportunity to do the same surgery over and over again.

Everybody recognises now that clinical leadership has been lost from the NHS and needs to be reinvigorated. There's never an easy answer or one-size-fits-all. I'm sure that competition within electives and diagnostics would be more effective than in more complex systems such as mental health. But the fact of the matter is that, as a principle, in other facets or human life competition is a tool that leads to better value and better quality in the provision of services.

It's not absolute, not black and white, but a principle we shouldn't forget.

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**Professor Parveen Kumar, CBE**  
**Hon. Consultant Physician and Gastroenterologist, St. Bartholomews, The Royal  
 London & Homerton Hospitals**

I believe in a public system and I think we have to be very careful about where the public and private divide occurs. The NHS is 60 years old and we should be celebrating its future.

I speak as a clinician who has worked in the NHS for 42 years in one of the most deprived areas in the UK.

The NHS has declined while I've been in it; repeated policy change with little or no evidence base has left us as an exhausted and bewildered workforce and no-one really knows how these changes will impact on the future delivery of health care.

Forty-two years ago patients wherever they lived had good clinical care and could actually see any clinician in the land. The profession had a high morale and it was working. But over the years this has been dismantled; we've got increasing bureaucracy, increasing management and we're inundated with administrative paperwork and emails. We've been fettered into immobility.

Why? You can talk about central control being far from local needs; you can talk about lack of funding; poor management and inefficiencies; you can talk about the huge pressure, targets and guidelines the NHS has been subject to. All must be addressed, as must the changing society and greater expectations that have gone alongside this.

But is plurality of provision and competition the way to do it? Money follows the patients; so if we have increased independent provision money will be bled away from the NHS and there will be increased destabilisation of an already threatened service.

Is this what we want? Over the last 20 years 'competition' has been brought into the NHS. The introduction of the internal market in the 1990s represented a shift of power from the providers to the purchasers (the health authorities, GP fundholders); then 9 years later fundholding was abolished, but purchasing was given to PCTs; 4 years later Foundation Trusts were developed. Now there's even more initiatives; payment-by-results, patient choice and practice-based commissioning. Change for the sake of immediate expediency is costing the taxpayer millions.

The competition that's being brought into the NHS is often more about money and driving off competitors; with the patient forgotten.

Patient choice seems an excellent idea on paper, but does it really work? A *Which?* survey showed a huge range of opinions, from those wanting it, to those who were actually intimidated by it.

And is *informed* choice really possible in health care? Last week I tried to buy an iron; and I managed to short-list it to six. All had what I wanted, but I couldn't see the difference between the one that was £7 and the one that was £10; so I just chose what was on the shelf. What the *Which?* survey, actually showed was that people wanted proximity of care, prompt treatment, cleanliness and a good clinical outcome: i.e. a good local service that obviated the need for choice.

The benefits of choice also depend on how old you are and the condition you have. If you're young and working, you want medicine tailored to your needs; an immediate, one-stop clinic and at a time you can get there. But older people with chronic ill health want local services and continuity of care that'll be lacking in the one-stop scenario. Who's looking after these patients?

Diversity of provision and competition will only exacerbate inequalities. Foundation Trusts, for example, sound a great idea, but some may well choose to do some procedures and not others.

Equally private providers may cherry-pick and leave the complicated patients with co-morbidities, heart conditions and diabetes to the NHS. The NHS is there to pick it all up, but the NHS and private providers are not competing on a level playing-field; using competition will signal a return to a postcode service, which is the last thing we want to do.

The training of health care professionals for the future will also be disrupted. Even if private institutions do take training on, who will set the standards, do the teaching, the auditing, and provide the funding?

There's no simple solution, but I believe in the original tenants of the health service: a publically funded service that delivers equality of care, good medicine, free at the point of need, without people having to worry whether they can or can't pay or afford the medicine we have.

But we do need to change with the times; we should have a 'collaborative competition' within the NHS, joining up primary and secondary care. Competition can raise barriers, but it's never really been shown to drive up quality and lower costs in health care; it's about money.

The NHS is a fantastic institution, it's envied worldwide. Let's not lose this; instead let's do something to help our patients.

### **In discussion:**

If we look at the NHS you may be tempted to say why did we start from here, but the fact is we've got this system – a fantastic one if allowed to work – and we also have patients and a public that are attached to it. We can't just transpose a system from another country onto ours.

If you do so, you will perpetuate the inequality of care. Of course, inequality does exist in the NHS. I know this from having worked in the east-end of London – perhaps because ethnic minorities and the poor aren't as articulate as the middle class they do not get what they want, or are frightened of getting it or don't know it's there.

We as doctors can broker, say this is the best person to go to, but not all the public can. I wish we could have such evidence-based practice along the lines of NICE for everything, but we can't.

But then do we want an alternative such as the US, with 49 million people uninsured? And nor is there as much choice in other systems as people think. In Switzerland, for example, you don't always

have the provision you want, you're in cantons and the insurance company often says where you can go within a canton.

I do believe the NHS, as a system, is the envy of the world, as they say in the States. Our training is certainly world-class. Maybe they don't know how bad the NHS has got and, ok, we don't compare very well in many of the international disease 'league-tables', but where do these comparisons come from? We can do much better than we are currently, but the real problem is not a lack of competition rather that the health care we provide is just not joined-up enough.

In fact I feel we are somewhat debating the wrong question. It's crazy we don't have integration between primary and secondary care; on one occasion I remember being told I couldn't talk to a patient's GP! Often I can't discharge a patient into a nursing home because there isn't a place; or I can't discharge them home because there's no budget to put a hand rail in their house.

We need an integrated system, led from the ground, by clinicians, clinicians who are managers, with the focus on the patient.

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**Nick Seddon**

***Author of 'Quite like heaven? Options for the NHS in a consumer age'***

You're all familiar with the litany of complaints. Productivity has remained pretty much static; inefficiency and inflation are chronic, there's too much waste, innovation is stymied; the service isn't comprehensive, with the gap between supply and demand growing daily, and the historic rationing – contrary to other sectors – becoming more, not less, acute as medical technology has advanced; international comparisons across a range of indicators are less than favourable; unexplained and unacceptable variations in performance persist; socio-economic inequities are widespread and growing; and the most important asset in the system, its human capital, the healthcare profession, is alienated and dispirited.

And all for just £100 billion. Now the cry goes up, not 'Show me the money', but 'Show me where the money's gone.'

To say the NHS isn't working is obviously rubbish; but it isn't working as well as it should be. And it's my belief that it's precisely out of respect for its founding principles, and in response to consumer demand in a globalised society, that the NHS must embrace fundamental, market-based reforms.

Again, you know the mantras. If there are alternative providers, then hospitals can't ignore patient criticisms with impunity. By giving patients a choice – the freedom, that is, to take their business from one hospital to another – providers will be given a powerful incentive to improve.

But, clamour the sceptics, there you go: the government's noble efforts haven't worked. Competition hasn't worked. Nor will it work.

But it's no good saying competition hasn't worked when it's been so marginal. The majority of PCTs haven't embraced competition. Many don't seem to have the capacity to do so. Practice-based commissioning is far from being universal. Payment-by-results only covers a very small percentage of operations. The proportion of patients being offered a choice of providers is at 43 per cent and *falling*. The proportion of independent provision needed to drive competition is nowhere near being achieved, and the government is retreating on the ISTC programme. Likewise, the procurement of new privately run primary care practices is too small to have any meaningful impact.

The causal nexus of this failing is that government has control of the purse strings. That's why it's all so politicised; why clinical decisions end up on ministers' desks; why reforms have been mangled by bureaucracy, targets and, to pilfer Alan Maynard's lovely coinage, 're-disorganisation'; and why there's such a peculiar relationship between supply and demand, namely that the supplier would like less demand.

All over the world the debate is not *whether* competition will improve performance, but *why* it hasn't always done so, and *how* to organise systems that make it more effective. Here, I'd like to linger with the Dutch system for a moment.

They have achieved what's been called 'a National Health Insurance system based on Managed Competition in the private sector'.

There are two key rules: all adults must buy insurance, and all insurers must offer a policy to anyone who applies, no matter how old or how sick. Those who can't afford to pay the premiums get help from the state. To prevent insurers from selecting only young, healthy people, the government compensates them for taking on higher risk patients – such as the elderly and those with chronic conditions – with payments drawn from the risk-equalization or solidarity fund.

Using individuals' money to cover both their own expectations and the needs of the poor, they've made private insurance arrangements function for public benefit.

The system hinges on competition between insurers, who are expected to cut premiums, persuade consumers to live more healthy lives, and push hospitals to provide cheaper, better care.

Sure, it's too early to proclaim the reforms a success. Still, waiting lists are shrinking; last year the costs of generic drugs fell by some 40 per cent, leading to falling expenditure on prescription medication; and overall cost growth fell to about 3 per cent from 4.5 per cent in 2006. Twenty per cent of patients have switched insurer and, in both 2006 and 2007, insurers have on average priced the annual mandatory premium below the health ministry predictions.

They are proving innovative, too. One has started opening its own primary care centres to serve its patients, for instance, while another is offering financial incentives to enrolees to eat healthily and do more exercise. The next step will be to see if competing insurers can get traction with the delivery system and lead it in the direction of higher quality and value for money. It has more than a fighting chance.

But please don't think me so simple as to want to *transplant* a foreign system into ours. Were it possible, it would almost certainly be a disaster. But the principles may be *translated*; and the fact that the current Dutch system is the result of a 20 year process of reform should inspire us.

A growing body of commentators is beginning to conceptualise the NHS 'in effect, as largely an insurance-purchasing organisation'. Yet it remains a monopoly. With our eyes on the prize, it isn't difficult to envisage a time when purchasing is carried out by a wide range of bodies. Patients could choose PCTs without geographical restriction, ending postcode lotteries. Money could go straight from the patient to the PCT. PCTs could be like HMOs, charged with optimising the balance between current spend and future liability. Insurers could do the purchasing for PCTs, or in competition with them.

Government, removed from day to day micromanagement, would be freed to play a reconstituted role in regulation and public health policy.

But we also need to think about the organisation of provision in a competitive world. There needs to be new approaches to measurement. Measurement would have to be of the quality of outcomes per unit cost across the whole care cycle; as opposed to the NHS, where payment by results, which is really payment for activity, only addresses a single intervention. Both purchasers and providers should stop thinking of a *procedure*, and instead regard the patient's *health* as the product of healthcare.

Publication of results must be mandatory. If providers and insurers compete on results, those who achieve excellence will be rewarded with more business, while those who don't won't.

With such measurement systems, providers may increasingly organise themselves around specific medical conditions. They'd do so in integrated practice units housing all the services needed to deliver joined-up care for the duration of the patient's condition: right through from monitoring and prevention, to diagnosis, treatment, rehab and ongoing management.

Alternatively they may develop multi-specialty teams to provide continuous coordinated care for those with co-morbidities. This would mean that a diabetic patient who also has heart disease and depression can receive care from a team of cardiologists, endocrinologists, and GPs – routinely sharing medical records and practice guidelines. This is why attention has been given to the Kaiser Permanente model, where purchasing is integrated into provision.

Competition, properly organised need not come at the expense of collaboration, and should indeed make integration of care financially, as well as clinically, desirable.

By liberalising demand and supply we should be able to liberate the system to be more flexible, efficient and innovative, creating an environment where healthcare professionals feel respected and are proud to work. With a proper framework for competition, we will get better quality without corroding equality. Indeed, compared with our two-tier system, universal mandatory insurance would *promote* social solidarity.

Our goal has to be the best care possible for the patient. The patient deserves nothing less.

### **In discussion:**

It's always said that local people want really great local services, that proximity is the most important thing. But my point is that wanting a perfect local service is a false distinction; because it's about how we get that service. The best way is by embracing competition.

It will also help with reducing inequalities. For a long time we've been saying, well we're not actually that good, but at least we're fair. I don't think you can use this argument anymore. Looking at the OECD, of course there are some systems that are much less equitable, but there are others that are equivalent or better. In the UK we have an increasingly two-tier system. I don't see any reason why we wouldn't get a greater degree of solidarity through changing at least some of the finances.

When the British Social Attitudes Survey asked people whether they would value choice, there were more from lower-socio-economic groups who said they want it. This is completely obvious; in the current system only the middle-classes have choice and voice. The London Patient Choice Survey found this played out in practice too.

People say collaboration and competition are mutually exclusive, but collaboration should improve with competition properly designed. Unless we have integrated services, we may as well go home; but our current system isn't providing this, people are constantly complaining of getting lost in the system. Kaiser Permanente does this much better.

We need a longer-term view. One of the reasons I think other countries have succeeded in this more than the UK is because health care is less politicised and therefore less susceptible to the vicissitudes of government and party political campaigning on the NHS. The only way you can disentangle government, or reduce its role in the day-to-day management of the service, is to reduce its financial connection.

We're all talking about collaboration and integrated systems. But I still ask the question: how do we get there in a system which is sclerotic, not because of the doctors, but because of the constant political 're-organisation' that goes on. I'd take Michael Moore no more seriously on his comments on the NHS than Borat on Kazakhstan.

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**Professor Chris Ham, CBE**  
**Health Services Management Centre, University of Birmingham**

Extending the benefits of markets, choice and competition that have been realised in other sectors into public services is quite a persuasive argument, but if we do then two crucial conditions have to be met:

- Firstly, we have to get the design of the market right. How do we organise the provision, purchasing, regulation and payment systems to the best effect?

There certainly needs to be a rough balance of power between the providers of care and the commissioners. 'World-class' commissioning doesn't actually exist anywhere in the world, yet if we don't get this right, the market won't work.

- Secondly, the political environment has to be conducive to market conditions in health care. It hasn't been as yet.

For a market to work there has to be the real possibility of exit. If we wind back to the 1990s when the internal market began to bite in London, the government appointed Sir Bernard Tomlinson to introduce a planned approach to avoid the negative effects of competition.

And if government isn't prepared to allow a private bank to go bankrupt, what will it do when a hospital gets into difficulty?

The conceptual benefits of competition are likely to be difficult to realise in practice.

Instead, I think we need to have a better balance between competition and collaboration. There are areas where we can achieve greater efficiency and responsiveness through competition, such as primary care and planned, elective, care. Take my son for example; a 25-year-old investment banker, who works incredibly long-hours and can never find a time when a GP is open. When I ask him what he thinks of the NHS he thinks it's 'crap' because of this and ends up paying £75 to see a private doctor. Competition could be beneficial here.

But contrast that with my mother-in-law, who had a TIA (transient ischaemic attack) back in September. The ambulance arrived very quickly – a wonderful, professional response – took her into Charing Cross, where the quality of care was excellent; she was scanned, operated on and discharged in 3-4 days. But some bits didn't work so well. There were difficulties after discharge in terms of a break-down in communication between the community nursing service and the GP and hospital. A strong chance of inappropriate re-admission arose because the health professionals weren't talking to each other in the way they should have done. But she didn't want to shop around and choose which hospital to go to etc.

Unplanned, emergency and long-term care is the bulk of health care; the bulk of what we do. It deals with complex patterns of demand and need in an increasingly elderly population, which aren't amenable to quick, acute, procedures. In this area we need much more collaboration, much more service integration.

We need to build on cancer and cardiac networks. We need primary and secondary care to work much closer together; and health and social care to work much closer together.

On market design. Nick Seddon referred to Porter and Teisberg, who point to the 'wrong kind of competition' in the US, which hasn't led to increased value and efficiency; and highlighted the benefits of Kaiser Permanente or Health Partners as alternatives. In both of these US systems there's a high level of integration.

But crucially they don't have the division between the commissioners on one hand and providers on the other, as we do in the NHS, but bring them together within the same organisation. They recognise how difficult it is to commission care well separately from those who are providing it on a day-to-day basis. This will come as no surprise to transaction-cost economists in the audience tonight, because years ago the difficulties of applying market principles in health care were identified. It's often more sensible to make what you are concerned with, than to buy it.

I'll give you a domestic analogy. I wanted to build an extension recently to my house, but found going into the market of plumbers, electricians, builders etc. almost impossible. So I took advice from friends and neighbours and commissioned an architect who both designed and project managed the build. Because the architect was in this market and had lots of networks and contacts, he was able to provide a much more integrated house-building service than I could hope to have commissioned. The same applies to health care.

In essence, we need to explore how we can develop choice between integrated systems, rather than the fragmented model we have now.

### **In discussion:**

We might all agree on the importance of different parts of the system working better together; the problem is that with the way the reform programme is going forward, there are no incentives to encourage people to come together in networks and integrate care. Patient choice, competition, payment-by-results and Foundation Trusts tend to work against this.

Anyone who's running a Foundation Trust would, quite rightly, do what's in the interests of that Foundation Trust to maximise income, which may mean pulling back from some networks to look after self-interest.

The reforms have to be reformed to create the payment systems and regulation that facilitate collaboration and not just competition.

The big step will be moving towards competing HMOs (Health Maintenance Organisations). We should build on the strengths of primary care. Practices collaborating with others in primary care networks could act as a foundation stone for specialists to move out of hospitals to multi-specialty medical practice, particularly where chronic conditions are concerned.

Of course, the way such networks develop should depend on where you are in the country. If you are in inner-London where the quality of primary care is lower than other areas of the country then specialist hospitals reaching out into primary care may be the right way to go instead.

I don't think the government should dictate this. If we believe there's a better way of doing health care based on integrated systems and choice between them, we should identify some simple principles and rules, articulate them and say there's far more brains out there in NHS Trusts, PCTs, GP practices etc. to take the framework and find the local solutions.

As the frameworks develop, you'd have the capacity to make a choice between such networks. In urban environments there may be two or three competing clinically integrated systems and money would follow your choice through a person-based capitation, alongside regulation to guard against cream-skimming and risk selection (the US problems).

I don't see a problem with public and private provision working through this. We already have a mixed economy of health care provision up to a point. GPs are already, and have always, been run as small businesses, and elective and diagnostics are increasingly being opened up to independent providers. As long as we maintain taxation as the core funder of health care to ensure equity I think it's an entirely pragmatic problem as to whether it's public or private provision that delivers the care. The mix will change over time.

One would hope that by June, with the Darzi review, there will be a commitment not just to going towards more clinically-led, integrated services where appropriate, but also be some of the means to give us greater confidence it could work in practice.

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### Comments:

**Nick Bosanquet, Imperial College:** I believe there's a surprisingly simple solution; an economic constitution to ultimately conceptualise competition in HMO terms and to make a reality of the reform programme the government has set out.

This would include: informed choice of commissioner and provider, stronger independent commissioning, provider pluralism, flexible labour markets, a clear success and failure regime, flexible prices based on quality and cost, and a separation of regulatory and political/strategic responsibilities.

See: <http://www.reform.co.uk/>

**Massoud Faloudi, Circle:** I believe in HMO-based competition, but it's such a big step, is this really possible with such short-term perspectives in government?

**Philip Brown:** A reality check is needed here. I'm a pharmacist, 80 per cent of the prescriptions we dispense are repeat prescriptions, many of which are reissued without even seeing a doctor. The vast majority of patients are not seeing their doctors, have no motivation to do so, and don't want to. The problem is to get them to see you. I'm not sure that choice and competition is that relevant in a context where the vast majority of health care is unseen in primary care.

**Norman Lamb, MP:** Lib Dem proposals embrace the principles of competition and empowering patients, but also of real local accountability for commissioners through locally elected health boards. I think we have a command and control approach to health care in this country, which will ultimately fail.

My problem with Parveen's analysis is with accentuating inequalities in health care and the dangers of going back to a postcode health care service. The problem is that both exist now with a vengeance. There is unequal access to health care. Ethnic minorities and the poorest are severely disadvantaged under our current bureaucratic system. The articulate middle classes will always get what they need, but the disadvantaged do not. All the indicators of health outcomes we have indicate a widening gap.

And postcode lotteries exist without any local accountability for the variations in service, which depend on the decision-making and performance of local PCTs, not the people who may or may not have access to a particular service.

I also think there is enormous potential for developing direct payments and individual budgets, particularly in mental health, where service users have no power and are often waiting scandalously long – sometimes 2 years for therapy recommended by NICE. Giving such patients budgets to access services they need, outside the NHS if needed, could start to transform outcomes.

**Mr Christoph Lees, Addenbrooke's NHS Foundation Trust:** I think Nick Seddon was talking about social insurance, which I'm in favour of, but is a word that gets people wound up when they hear it, despite the fact it maintains universal health care, with the additional benefit that it enables everyone to access the best standards of care.

It hinges on both public and private provision. My question is why we can't have both competition and collaboration between the private and public sector as happens in other countries?

**Professor Steve Smith, Imperial Healthcare NHS Trust:** I think the issue over what the right type of competition is, is a key area.

It's clearly not appropriate for a car crash victim; they don't want to have three different drip providers to choose from etc. Here there must be collaboration, as there must be across health care.

For a large trust such as my own, strategy must be vertical. It must encompass the work done by generalists and by very, very, specialist consultants. Unless you can bring the two – primary and secondary care – together you cannot provide integrated health care.

But then the chances of me creating a monopoly with Imperial is obviously quite high, therefore there needs to be an element of competition between integrated health systems and I think this, in the long-term, is the way in which we should be going. Creating competition, the wrong type of competition, does detract value from a health care system.

The problem is how you can get integrated systems, and get them to compete, within a system where the vast majority of health care comes from taxation.

**Dr Rodney Burnham, Royal College of Physicians:** Clinical integration is happening already; we issued a circular to fellows and members of RCP and have over 300 examples of integration, of specialists and generalists working together.

Policy needs to back up clinical innovation and leadership. I'm not convinced that competition helps at all. Doctors are by nature competitive, but they need to be competing among themselves on the basis of accurate data. One of the problems of NHS data is that it's simply not accurate. If people audit their activity, share it and compare it with each other, that will drive performance.

People will say this hasn't worked, but this is only because people have used NHS data rather than data that is properly collected and reliable.

**Andy Cowper, British Journal of Healthcare Management:** We shouldn't keep our minds aside from our brains here. If we have competition in some areas, then it should be competition based on outcomes. The latest operating framework realised this; patient reported outcome measures will be brought in for a range of procedures. I don't want competition based on providers who can bang them out, but leave people worse off afterwards. I want competition on the basis that people are in a better state than when they went in.

As Chris Ham pointed out, we allegedly have competition in general practice, but what kind of competition is this? How much market exit is there, let alone entry? You have to be killing patients before you lose your contract in general practice! And do we genuinely choose between GPs based on one providing a much better service than another?

We should also learn from the Connecting for Health, NPfIT initiative. This was a beautiful theoretical model of competition in procurement. Actually, it was ok as a procurement exercise – diverse suppliers won the contracts – but now the 'market' has consolidated to three or four providers and we have a virtual monopoly situation. I don't suggest competition is always the answer and we should review where the question applies.

**James Gubb**

**Director, Civitas Health Unit**

**4 March 2008**

[www.civitas.org.uk/nhs/index.php](http://www.civitas.org.uk/nhs/index.php)