

# Cooperation or competition? Proposed changes in healthcare provision in England<sup>†</sup>

Laurence Mynors-Wallis<sup>1</sup>

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<sup>1</sup>Alderney Hospital, Poole, UK  
Correspondence to Laurence Mynors-Wallis (laurence.mynors-wallis@dhufn.nhs.uk)

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**Summary** The Health and Social Care Bill currently going through the UK Parliament seeks to further increase cooperation in the English National Health Service (NHS). The proposals are controversial in significant part because the benefits of competition in healthcare are uncertain. Will patients benefit from innovation and choice brought about by new providers of care or will the vulnerable be faced by geographically variable, fragmented and non-integrated services? Will there be financial savings to reinvest in patient care or will there be increased administration driven by the transaction costs of market driven care? This editorial advocates a cautious targeted approach for the implementation of competition in those areas where current NHS provision is poor rather than whole scale potentially disruptive change.

**Declaration of interest** L.M-W. is Medical Director of Dorset Healthcare University Foundation Trust, an NHS provider of mental health and community services.

The Health and Social Care Bill currently going through the UK Parliament proposes significant changes to the delivery of healthcare in England. Key proposals of the Bill include a move to clinically led commissioning, with clinical commissioning groups (headed by general practitioners) controlling annual health budgets of £80 billion, increasing the number of providers of healthcare, with ‘any qualified provider’ competing on quality and measures to increase public accountability, and patient involvement. The proposals represent a marked contrast to the healthcare systems being established in the devolved administrations of Scotland, Wales and Northern Ireland, where the desired health outcomes are hoped to be achieved by planning and coordination rather than by competition and market forces. It remains to be seen how the Bill will change as it passes through Westminster, but a fundamental question at the heart of the Bill, whether competition or cooperation is most likely to provide better mental healthcare services, is an important one to consider.

### National planning and the internal market

At the inception of the National Health Service (NHS) in 1948 a nationalised system of healthcare funding was created. Comprehensive care was provided free of charge for all on the basis of need and funded from taxation. Secondary care in the NHS was provided by a national network of NHS-owned hospitals; however, primary care (i.e. general medical, dental, ophthalmic and pharmaceutical services) was the domain of independent practitioners, acting as contractors to the NHS.<sup>1</sup> This structure was

modified but continued in essence in this format for 40 years, until the introduction of the internal market outlined in the 1989 White Paper, *Working for Patients*,<sup>2</sup> passed into law as the NHS and Community Care Act 1990. The purpose of introducing the internal market was to open up healthcare to competition, with hoped-for benefits of innovation, cost reduction and improved quality brought about by market forces.

The 1991 market reforms were based on the purchaser–provider split. It was thought that, whereas in the past providers, usually hospital doctors, had largely determined which services would be delivered, new commissioning bodies would act on behalf of patients to purchase the services which were really needed. ‘Purchasers’ (initially health authorities and some family doctors) were given budgets to buy healthcare from ‘providers’. To become a provider in the internal market, hospitals became NHS trusts, separate organisations with their own management.

The purchaser–provider split in the English healthcare system was retained by the Labour governments of 1997–2010. The commissioning bodies were the primary care trusts and reorganisations and central directives were designed to improve commissioning. The devolved administrations of Scotland, Wales and Northern Ireland have chosen to go down a very different route by doing away with the purchaser–provider split and introducing regional health boards to plan the provision of health services through integration and cooperation between primary and secondary care services. There are, therefore, different health systems in the UK, one in which the approach to improving healthcare is through planning and cooperation and one in which improvement is to be brought about by market forces bringing in the innovation and productivity of new providers.

<sup>†</sup>See commentary, pp. 443–444, this issue.

## NHS mental healthcare – not perfect

Even the most passionate advocates of the NHS accept that significant improvements can be made in how care can be delivered. In mental health, for instance, there remain too many examples of patients undergoing repeated assessments to determine whether they meet somewhat rigid, professionally determined ‘acceptance criteria’ for access to services. There are too many arbitrary transitions of care dictated by geographical boundaries, age and diagnosis rather than a focus on patient need. Finally, there is hugely variable productivity among individuals doing similar jobs.<sup>3</sup>

## Market-driven healthcare in the USA – not a success story

Although the UK healthcare system differs very significantly from that in the USA, there are common problems across both. The summary of the Institute of Medicine about the US healthcare systems applies equally to the NHS: ‘The current US system is characterised by highly variable care, widespread failures to implement best practices, and inability to change patterns of practice’.<sup>4</sup> Market-driven and state-provided healthcare are thus not inherently better or worse than the other. The question then is what is most likely to bring about the improvements in both care and productivity that both professionals and patients desire, the English model (based on US style competition) or that of the devolved nations (based on planning and cooperation).

The Royal College of General Practitioners in their response to the proposed English health reforms<sup>5</sup> describe how the market in healthcare is different from the market in commodities such as cars or utilities. For example:

- there is asymmetry in knowledge and power between patients and doctors
- patients when ill are vulnerable, unlike most consumers
- patients and doctors, particularly in primary care where the diagnosis is not yet clear, often lack the information to make precise, informed choices
- most markets encourage activity to increase profit, but in the NHS, additional activity results in a greater burden on the taxpayer.

The NHS has traditionally had a low cost of administration which until the 1980s amounted to about 5% of health service expenditure. After 1981, the administrative costs rose and in 1997 stood at about 12%. An estimate of administrative costs since 1997 has been made by a team at York University which concluded that management and administration salary costs represented at a very crude approximation about 23% of NHS staff costs and around 13.5% of overall expenditure.<sup>6</sup> The need to create a mixture of public and private provision has created a bureaucracy to meet the demands for tenders, payments and monitoring arrangements.

The USA is the biggest healthcare market in the world. It is salutary to note that it spends US\$7290 per capita on healthcare compared with US\$2992 in the UK while delivering significantly poorer health outcomes for the population.<sup>7</sup> In 1999, health administration costs accounted for 31% of US healthcare expenditure,<sup>8</sup> although the main

reason for increased costs is the cost of hospital and physician care.<sup>9</sup> In the USA, therefore, competition has not been successful either in driving down costs or in improving population outcomes.

## Competition: potential benefits and risks

One of the major concerns about unbridled competition in the health service, and particularly in mental health, is that it will lead to cherry picking of profitable services leaving less money for other areas. In addition, there is a real danger of services becoming fragmented, with different providers delivering different aspects of the service. Could it really be better for patients if in-patient care, the out-patient psychiatrist, community nursing, psychological treatments and additional services were delivered by different organisations? Although it is reasonably straightforward for services to be tendered with clear specifications for non-urgent care and discrete packages of treatment, for example, a course of cognitive-behavioural therapy, it is much more difficult to have competition for emergency work and low-volume complex care cases, particularly in the community. The quality benefits for competition have yet to be seen in mental healthcare. Despite significant private provision in secure in-patient beds, there is no evidence that the range of quality is any different to the NHS provision, and in both cases provision may not be local to where a patient’s family and friends live.

In conclusion, competition offers theoretical benefits of innovation, bringing in new providers with fresh ideas and models of care, but this needs to be offset against the costs of competition transactions and the dangers of fragmented and non-integrated care provision. It would seem sensible that competition should be tested out in areas where services are not delivering the outcomes that patients and clinicians desire and that such competition needs to include integrated and complex services as well as simple, low-volume, low-cost services. If possible, agreed outcome measures<sup>10</sup> should be shared across areas so that, with time, a clearer, less politically driven approach to the benefits of planned v. competitive care can be determined.

## About the author

**Laurence Mynors-Wallis** is Registrar of the Royal College of Psychiatrists and Medical Director of Dorset Healthcare University NHS Foundation Trust.

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## Diversity and choice in mental healthcare

### Commentary on . . . Cooperation or competition?<sup>†</sup>

Philip Sugarman<sup>1</sup>

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<sup>1</sup>St Andrew's Healthcare,  
Northampton, UK

Correspondence to Philip Sugarman  
([psugarman@standrew.co.uk](mailto:psugarman@standrew.co.uk))

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**Summary** Independent sector psychiatrists believe that they work hard for the benefit of vulnerable people. Differences between them and National Health Service colleagues are not clear cut in terms of motivation or quality of care. However, unfair generalisations are made about the diverse 'private sector', with selective comparison such as with the worst of US healthcare. Although there are many examples of excellence in the UK state, commercial and charity sectors, global economic changes are bringing risk of care failures from which no area can be immune. We should all be working together to protect our patients from the mistakes of others.

**Declaration of interest** St Andrew's Healthcare is a charity providing specialist services to the National Health Service.

Laurence Mynors-Wallis's editorial comes at an important time for mental health services, subject as they are to immense political change and economic pressure. He presents a familiar, critical perspective on attempts to further widen the range of providers of National Health Service (NHS) care. I try here to respond, in the spirit of constructive dialogue, with a very different but equally personal viewpoint.

Psychiatrists who care for NHS patients in the private and voluntary sectors naturally work best if they feel they are involved in a widely shared, positive endeavour for the benefit of vulnerable people. It can therefore sometimes be dispiriting when NHS colleagues, despite some inclusive gestures, stigmatise those in the independent sector. Well-meaning professionals working outside the NHS, whether in commercial or charitable organisations, have recently seen the services they work in tarred with the high-profile failures of others, whereas no one would think to associate all NHS teams with the various scandals in similar areas of intellectual disability and elder care within the NHS.

#### Idealists v. mercantilists – not a clear-cut division

For example, in a lead letter in this journal, Dr Alistair Stewart cited specific failures of private equity groups,

<sup>†</sup>See Editorial, pp. 441–443, this issue.

branded the independent sector as 'a polite fiction', and complained of 'the private sector milking the money which most taxpayers think is going to the NHS'.<sup>1</sup> Dr Mynors-Wallis similarly presents state cooperation and market competition as incompatible moral opposites. He references the founding NHS principles of 1948, and quotes a Royal College of General Practitioners report as the authority on how patients are too vulnerable to be consumers in a profit-based market system.<sup>2</sup> Yet fee-for-service programmes delivered by general practitioners are obvious examples of profit-driven healthcare, and of course all NHS professionals are paid for their work.

In reality, the entire provision of NHS care is a human patchwork of cooperation and competition for patients and resources, and surely it always was. Nevertheless, Dr Mynors-Wallis longs for the days before the 1989 purchaser–provider split, arguing that administrative costs have gone up with the internal market. Interestingly, a recent McKinsey analysis found that, despite widespread beliefs to the opposite, NHS management costs remain low by international standards.<sup>3</sup> The point is – the market is not the cause of the NHS's problems.

#### Failing US healthcare – a worn-out comparison

It is disappointing that individual psychiatrists, in line with the British Medical Association and others, should erect