The English market model is not fit for export

Morris Bernadt FRCPsych

Consultant Psychiatrist, South London and Maudsley NHS Foundation Trust, London, UK, email mbernadt@hotmail.com

Commissioning of health services has become an intensely political issue in the UK and there is no reason to believe that the conflicts that have arisen domestically would not be mirrored overseas. A key ideological issue in the UK concerns the relative merits of public and private provision of services. In their guest editorial in this issue, 'Governance, choice and the global market for mental health', Sugarman & Kakabadse take a particular ideological stance: they write on the one hand of commercial-style efficiency and on the other of monopoly state provision risking inefficiency and ineffectiveness. This perspective is addressed here.

Inefficiency

Commissioning itself has the underlying assumption that there is a market in which there are buyers and sellers. It was introduced into the National Health Service (NHS) between 1999 and 2003. Before that, the state provided and paid for health services. How well has commissioning performed? The report of the House of Commons Health Committee (2010) on commissioning stated that whatever the benefits of the purchaser/provider split, there had been an increase in transaction costs, notably management and administration costs. Research commissioned by the Department of Health, but not published by it, estimated these costs to be 14% of total NHS spending. That is, 14% of total expenditure is spent on the process of buying services! The Committee was suspicious that the Department of Health did not want the full story to be revealed and was appalled that four of the most senior civil servants in the Department were unable to give accurate figures for staffing levels and costs dedicated to commissioning and billing in primary care trusts (PCTs) and provider NHS trusts.

Other problems identified by the Committee were:

- the PCTs' belief that they were working effectively, whereas in many cases they were not
- the expensive and inefficient use of outside management consultants by PCTs to fill skills gaps in commissioning
- tensions between purchasers and providers.

The Committee concluded that, if reliable figures for the costs of commissioning prove that it is uneconomic, after 20 years of costly failure, the purchaser/provider split may need to be abolished.

In Scotland the purchaser/provider split was ended in 2003, in response to pressures from doctors and the public. Direct administration of the NHS in Scotland was restored and the market option was closed off. In 2007 the purchaser/provider split was dropped in Wales, where in 2009 just seven integrated local health boards were established to plan and operate the NHS. These boards have a strong emphasis on linking health and social care. This contrasts with more than 200 general practice consortia that would arise from the Health and Social Care Bill presented to Parliament in 2011.

Fragmentation

Sugarman & Kakabadse write of the great value of having a diversity of providers in mental healthcare. The Health and Social Care Bill has provoked controversy by its promotion of competition arising from 'any willing provider' of services. Are there drawbacks to diversity? Integrated care refers to collaborative working between primary and secondary care, between health and social care, and other forms of care, and is a cornerstone of good practice (Ham *et al*, 2011). In both the UK and the USA, a diversity of providers predisposes to a fragmentation of services (Roland & Rosen, 2011). Organisations with different governance arrangements face difficulties in coordinating services between them, such that patients do not move easily between primary care and secondary care, or between hospital and the community.

European competition law applied to general practice commissioning in England (Dunbar-Rees & McGough, 2011) would, if the Health and Social Care Bill as originally presented to Parliament became law, make it illegal for general practitioners to talk to their secondary care colleagues about commissioning of secondary care services. This is because such collaboration would compromise the fair and transparent process of tendering of the service to 'any willing provider'. The Royal College of Psychiatrists (2011) in considering those mental health services that have been subject to commissioning by 'any willing provider' reports:

- serious problems of service fragmentation
- decisions made on the basis of cost, not quality
- disruption to continuity of care
- loss of integration of care pathways.

The College 'believes it would be a disaster if this experience was repeated across mental health services'. In the English context of 'any willing provider', the Academy of Medical Royal Colleges (2011) has expressed 'serious concerns about possible risks to coherent, equitable healthcare brought about through the proposed market approach'. The Academy states that organisational viability is generally contingent on the interdependencies between services and that removal of a service from a hospital or the community is liable to weaken cross-specialty care.

https://doi.org/10.1192/S174936760000254X Published online by Cambridge University Press

The profit motive

Problems of profit, fraud and morale afflict the commercial sector, which constitutes part of the diversity of providers mentioned by Sugarman & Kakabadse. Making a profit is the *sine qua non* of commercial companies. Every care pathway is governed by the need to make a profit. What lowers profit margins are highly trained, well-paid staff in recommended numbers. For example, it is often the case that the workforce in the UK private home care sector is abysmally paid, is poorly qualified and has a high turnover (Social and Health Care Workforce Group, 2002; Pollock, 2004, p. 183). Cost reductions achieved by outsourcing, and the profits made by outsourcing companies, are largely made by paying workers less. To maximise profit, private treatment centres tend to cherry-pick patients with uncomplicated, easy-to-treat conditions, who are obviously more lucrative on a fixed tariff than those with comorbidity (Woolhandler & Himmelstein, 2004).

The global healthcare industry includes notorious cases of fraud; in fact, such fraud is endemic in the US system (Pollock, 2004, p. 13). According to the Health Policy Network (1996), the FBI estimated that in the years 1990–95 healthcare fraud in the USA totalled no less than $418 billion. Examples of such fraud include overcharging the government, 'upcoding', not rendering a service to insured individuals and not reimbursing them. Huge fines have been levied by the US Department of Justice. In the UK, the medical director of one private health insurer and provider, BUPA, acknowledged that, in a healthcare market, 'conflicts of interest are everywhere' (Leys & Player, 2011, p. 137).

The assumption that staff in private healthcare might be motivated by the 'bonus culture' (i.e. that better performance results from financial incentives) is false (Fleming, 2011). There seems to be an intrinsic difference between doing what one believes to be right and performance based on reward, and this applies with particular emphasis to healthcare. In fact, rewarding people for doing something tends to reduce intrinsic motivation, to stop individuals taking responsibility and in the long run to lead to inferior work (Fleming, 2011). Sharp practice arising from commercial competition has an adverse effect on relationships between individuals in the same organisation and generates tensions between organisations. This contrasts with a system based on trust and common purpose (Woolhandler & Himmelstein, 2004).

Education and training

In keeping with a market philosophy, the Department of Health's 2010 White Paper *Liberating the NHS: Developing the Healthcare Workforce* plans to give employers greater responsibility for planning and developing the healthcare workforce. It states that:

> individual employers are best able to plan and develop their own workforce. Healthcare employers and their staff will agree plans and funding for workforce development and training; their decisions will determine education commissioning plans.

Providers of healthcare will pay to meet the costs of education and training and there is to be a level playing field between providers.

The White Paper itself points to the problems of:

- providers making short-term decisions in response to short-term pressures
- the length of time it can take to correct an undersupply of key healthcare professionals, due to the length of training
- providers having to buy in the educational skills they need
- individual providers not being able to offer the appropriate range of training opportunities and breadth of training required for a complex workforce
- the training needs of particular professional groups needing to be considered across a large area (for example, a diversity of providers impact on the core and specialty training of psychiatrists).

One might add great concern about the stability of training programmes in an inherently unstable business environment, in which the commissioners might tender a service to 'any willing provider'.

Conclusion

The marketisation and privatisation of health services being rolled out in England, which have reached their apotheosis in the Health and Social Care Bill, represent the wrong model for the development of psychiatric services. Middle-income and fast-developing countries should contrast this model with the integration of services and absence of the profit motive that would arise from a national, state-run service.

Declaration of interest

Morris Bernadt is a member of the British Medical Association and of the executive committee of the NHS Consultants' Association. Both organisations have policies supporting the concept of a publicly funded and publicly provided NHS.

References

Academy of Medical Royal Colleges (2011) Academy briefing statement to NHS Bill 2011. At http://www.aomrc.org.uk/component/content/article/38-general-news/213-health-and-social-care-bill-2011.html (accessed May 2011).

Department of Health (2010) *Liberating the NHS: Developing the Healthcare Workforce*. Department of Health.

Dunbar-Rees, R. & McGough, R. (2011) Challenges of EU competition law for general practice commissioning. *BMJ*, **342**, d2071.

Fleming, F. (2011) The bonus myth. *New Scientist*, 9 April, pp. 40–43.

Ham, C., Dixon, J. & Chantler, C. (2011) Clinically integrated systems: the future of NHS reform in England? *BMJ*, **342**, 740–742.

House of Commons Health Committee (2010) *Commissioning. Fourth Report of Sessions 2009–2010*. HC 268-1. House of Commons.

Leys, C. & Player, S. (2011) *The Plot Against the NHS*. Merlin Press.

Health Policy Network (1996) *Health Care – Private Corporations or Public Service? The Americanisation of the NHS*. NHS Consultants' Association.

Pollock, A. (2004) *NHS plc. The Privatisation of Our Health Care*. Verso.

Roland, M. & Rosen, R. (2011) English NHS embarks on controversial and risky market-style reforms in health care. *New England Journal of Medicine*, **364**, 1360–1365.

Royal College of Psychiatrists (2011) Health and Social Care Bill 2011.Royal College of Psychiatrists. Second reading briefing. House of Commons. At http://www.rcpsych.ac.uk/policy/parliamentandpublicaffairs/neilspages/healthandsocialcarebill.aspx (accessed May 2011).

Social and Health Care Workforce Group (2002) *Independent Sector Workforce Survey 2001. Provisional Report.* Employers' Organisation.

Woolhandler, S. & Himmelstein, D. (2004) The high costs of for-profit care. *Canadian Medical Association Journal*, **170**, 184–185.