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“Liberating the NHS” — Another Attempt to Implement Market Forces in English Health Care

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Like so many recent British governments, the new Conservative–Liberal Democrat coalition government is making structural changes to the National Health Service (NHS) in England. Such changes are being made despite campaign promises by the Conservative Party that it would not reorganize the NHS and despite a decade of steady improvements: for example, waits for elective surgery have largely disappeared, people with suspected cancers are now seen by specialists within 2 weeks, and survival rates among patients hospitalized in critical care units have increased by more than 2% per year.

Although it supports the founding principles of the NHS — a tax-funded system that is free at the point of use — and has made a commitment to increasing funding by 1 percentage point more than the rate of general inflation over the next 5 years (a more generous increase than those for all other public services), the government asserts in a white paper entitled “Liberating the NHS” that changes are needed. The government’s acknowledgment of past achievements is tempered by claims that England has poorer-

quality care than other countries and that productivity is inadequate. Poor quality, the government contends, has resulted from the previous government’s forcing clinicians to focus on processes (such as waiting times) rather than outcomes, from allowing the interests of secondary care providers to dominate those of patients and primary care practitioners, and from insufficient clinician engagement in management. Productivity is seen as having languished because of too much central-government control and bureaucracy, insufficient use of market forces, and ineffective purchasing practices.

The government’s solution is founded on the conviction that those who know best about health care are not managers, health services researchers, or policy analysts, but rather patients, primary care practitioners, and local elected representatives. It’s therefore necessary, the argument goes, to shift the locus of control and influence from central government to as close to the patient as possible. Such a shift will enable financial responsibility to be linked to clinical responsibility, which will encourage practition-

ers to provide cost-effective care and ensure that the use of resources reflects local needs. When this approach is combined with greater use of market forces, productivity will improve.

To achieve these aims, the government plans to change both players in the NHS’s internal market, the arrangement introduced in 1991 to separate purchasing (or commissioning) of secondary care from its provision. (Previously, secondary care providers had simply received an annual budget from the government.) Currently, 152 primary care trusts are responsible for purchasing secondary care for geographically defined populations. The extent to which general practitioners influence their trust’s purchasing decisions varies. Now, primary care trusts will be replaced by several hundred “general practice commissioning consortia.” Apart from these consortia’s covering smaller populations than the primary care trusts, the main change will be the passing of control from health service managers to general practitioners. Consortia will be accountable for their performance to a new national NHS commissioning board, which will

also be responsible for commissioning tertiary care.

Meanwhile, all NHS providers of secondary care and community care will begin to function as not-for-profit public bodies, if they don't already — either as foundation trusts (semiautonomous but still owned by the NHS) or as social enterprises (organizations owned by their staff). The autonomy of foundation trusts will be extended, allowing them to undertake more privately funded care and giving them greater investment independence to develop new facilities and services.

The proposals essentially represent a continuation of what was arguably the only revolutionary change the NHS has ever undergone: the introduction of the internal market by a Conservative government in 1991.

Competition will be regulated to ensure that private health care providers are not disadvantaged in their bids for contracts to undertake work funded by the NHS. These changes will be supported by improvements in information focused on outcomes.

As a result of these changes, the involvement of the central government can be reduced, with a 30% cut in staffing level, allowing the Department of Health to refocus its attention on public health, led by a new Public Health Service based outside the NHS in local government.

Secretary of State for Health Andrew Lansley presented the proposals as “a bold and exciting vision” of reform, and many observers have suggested that they represent the most dramatic

changes to the NHS since its establishment in 1948. Closer scrutiny, however, suggests otherwise. The proposals essentially represent a continuation of what was arguably the only revolutionary change the NHS has ever undergone: the introduction of the internal market by a Conservative government in 1991. Although the level of governmental support and enthusiasm for that policy has fluctuated, the past two decades have witnessed steady, if somewhat slow, progress toward the vision set out in the late 1980s. Whereas former Prime Minister

Tony Blair's ambitions to make progress were frustrated by resistance from within his own government, Lansley may face no such internal opposition.

Lansley's claim of radical reform is contradicted by the apparent continuity with previous policies: a provider market, improvements in information that focus on outcomes, financial incentives to improve quality, regulation rather than performance management, and patient-centered care. However, the proposals do contain one key change in the way in which the 1991 vision might finally be achieved by shifting responsibility for most purchasing from corporate managers to primary care clinicians. After four decades of governments' wresting control from the

medical profession, this reversal represents a radical change.

Despite their pursuit of the same goals and adherence to the same underlying policies as preceding governments, Lansley's proposals have aroused considerable criticism. Some negative reactions stem from a dislike of any change, some from justifiable worries about personal prospects. More widespread concern has arisen regarding the proposals' lack of detail, particularly since the secretary of state has had several years, while out of government, to prepare and fine-tune his approach. The principal concern focuses on the new general practice commissioning consortia: whereas Lansley sees general practitioners as “knights” who can stand up to the tyranny of hospital specialists, others see his policy as simply transferring control from one type of provider (secondary care) to another (primary care), with little guarantee that patient-centered care will be enhanced. And several practical concerns will need addressing. For instance, most general practitioners want to undertake clinical work, not financial management — and they may not be sufficiently informed to hold any hired managers to account. Of greater concern to the government will be the potential variation among consortia in the services available to patients, as well as the ability of general practitioners to destabilize secondary care providers by choosing to stop purchasing from them. Awareness of this latter risk presumably explains why the government plans to withhold from general practitioners the power to purchase maternity care services, retaining them centrally instead.

Like all policy proposals, Lansley's plans represent only the start of a process that may ultimately lead to the implementation of policies that look very different. For advocates, after the frustrations of two decades of governments that only toyed with implementation of an internal market, this initiative represents an opportunity to fulfill that goal. In the view of critics, it is the latest attempt to impose an inappropriate and flawed policy. Critics' greater fear, however, is that the government shares that view and would be happy to see the NHS buckle under the strain, thereby justifying the need for really radical change to health care in England, including changes to its mode of financing. In all likelihood, both the hopes of advocates and the fears of critics

will prove to be exaggerated, and once again changes will be slight.

Disclosure forms provided by the author are available with the full text of this article at NEJM.org.

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