King's Fund

Developing the public role in a mixed economy

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Introduction

Nearly all the debate about the role of the private sector within the NHS has taken as its starting point the possibility that the private sector might enlarge its role at the expense of the public sector. Yet the more the UK develops a mixed economy of health and social care provision, the more we may need to see the public sector expanding its role, especially in the regulation of services.

Many of the areas where the Government has sought an expansion in private provision have been traditional areas for private sector involvement. They include building and financing new hospitals, and providing nursing home places and elective care (i.e. operations for people on the waiting list). The changes the Government has introduced in these areas have largely focused on the financial and contractual framework for provision, moving it towards long-term relationships and away from the simple purchase of buildings and their associated services on a one-off or occasional basis.

In the case of the Private Finance Initiative (PFI) in hospitals and NHS LIFT – the new mechanism currently being introduced for the development of community health facilities – a great deal of the controversy turns on whether the long-term contracts (and the long-term relationships implied in the proposed LIFT companies) will allow the NHS to meet its objectives or whether commercial requirements, i.e. profit-making, will prevail.

In both these areas, the Government has plunged ahead without setting out clearly why it believes that new relationships between public and private sectors are desirable. Its public statements emphasise that 'what matters is what works'. Yet that pragmatic stance is only as sound as the evidence on which it is based – and so far there is very little sound evidence which shows that the new longer-term contractual arrangements are proving beneficial. In some cases, such as the use of PFI for new hospitals, evidence of positive outcomes is particularly weak, while concerns about its pitfalls remain strong.

These doubts are part of a growing recognition on the part of the public sector that it must impose itself either as purchaser or regulator on the way that the private sector operates if public–private partnerships (PPPs) are to work in the public interest. Yet this aspect of the debate on public–private partnerships has largely been ignored in the headlong rush to embrace or oppose them following the report of the IPPR Commission on Public Private Partnerships in June of this year.

Managing the private sector

The UK private sector accounts for 16 per cent of all health care funding. This includes private medical insurance, out-of-pocket payments for private treatment and individuals' contributions to NHS prescriptions, dentistry and optometry. There is, however, no clear boundary to be drawn between the NHS and the private sector. Since the NHS began, its consultants have been free to treat private patients in pay beds, and the NHS has bought private services for its patients.

As a new King's Fund book (Keen *et al.*, 2001) shows, the NHS has always relied heavily on the private sector, particularly for the delivery of clinical services outside hospitals, such as those provided by GPs, dentists and pharmacists. In one extreme case, some two-thirds of NHS-funded psychiatric rehabilitation is provided privately. These public–private relationships have been characterised by broadly defined contracts as far as clinical work is concerned, accompanied by very detailed financial and other rules.

The trend now is for these contracts to embody a series of performance requirements and, in some cases, for contractual relationships to be replaced by contracts of employment. This trend is particularly marked for general practice, following the introduction of personal medical service pilots from 1997 onwards and the imposition on all GPs of national requirements relating to speed of access to clinical advice.

Parallel to this development there has been a strengthening of the regulation of private sector hospitals and other health care facilities through, in particular, the creation of the National Care Standards Commission. This has recently published, for consultation, a very detailed set of standards defining how privately owned hospital services should be managed. Whilst this is an important step forward, it is unclear how such a system, separate from that which applies in the NHS, will affect NHS patients being treated by private providers.

In the case of medicines supply, meanwhile, the NHS has traditionally relied on the private sector to supply the drugs and on community

pharmacists to act as efficient purchasers by creating a financial framework that gives them an incentive to 'shop around'. Recent events, in particular the very sharp rises in the prices of some generic drugs in 1999, suggested that these arrangements were not working well. Following a report from OXERA consultants published earlier this year, the Government issued a discussion paper which set out, as one option for the future, the possibility that the Department of Health might have to take over the purchasing role and use its financial muscle to get the best deal for the NHS.

The need to change policies stemmed from changes within the private sector itself. Mergers between producers and wholesale and retail distributors have meant that the workings of the market have become very opaque and, as the OXERA report showed, it is hard to tell whether or not the NHS gets a good deal. To ensure that it does, the Department, it would seem, is being pushed in the direction of being an active 'market manager'. Its role may extend to attempting to ensure that the supply of particular drugs takes place on a competitive basis through, for example, easing the process by which production licences are transferred.

Developing the public role

In some areas, the NHS is exploiting its natural advantage as the largest health care organisation in the world and also as the owner, in some areas, of a unique and valuable knowledge base:

- by developing and marketing worldwide, in conjunction with a private sector company AXA, the clinical decision software used by NHS Direct.
- by creating, through NHS Professionals, a national organisation for ensuring the supply of temporary staff, thereby potentially replacing to some degree existing private sector agencies. The Audit Commission recently concluded in its report *Brief Encounters* that by encouraging collaboration between NHS trusts and using modern call-centre technology, significant improvements could be made in the rostering of staff and hence the standard of care offered to patients.
- by stimulating more entrepreneurship within the public sector. The Secretary of State for Health announced, when presenting the hospital performance tables in September, that best performing trusts would be allowed to create spin-out companies to extend their research strengths, or to sell services to other organisations.

As these examples show, the NHS, by its very size and nature, and through the specialised and sometimes unique knowledge which it holds, possesses great strengths which can be exploited in partnership with the private sector or through the development of 'intrapreneurial' organisations within the NHS itself. This has not always been implemented successfully, however, as the slow and controversial development of information technology within the NHS illustrates.

As its relationships with private companies become ever deeper, the public sector may find itself taking more, not fewer, responsibilities. In some cases, this will require more active regulation of private companies; in others, it may mean reducing the scope of their involvement in the NHS.

Conclusions

The following general points emerge:

- Successful public–private relationships require contracts which successfully reconcile the need for the private sector to make profits with the NHS's own objectives.

- The NHS must understand those markets which it seeks to manage; it cannot sit back and assume that the private sector will deliver what it wants. This is as true of the construction market as it is for drugs.
- The NHS cannot take for granted that the private sector is competitive, nor that it will remain so.
- The NHS may be able to exploit some of its own economic advantages, either in partnership with the private sector or by creating the scope for intrapreneurial behaviour by its own staff.

As a result, the King's Fund recommends that:

- The Government should be prepared either to expand or reduce the role of the private sector in the UK health system, according to such evidence as exists as to which can deliver the best quality service in the fairest way possible.
- New kinds of public–private partnership should be piloted carefully before being used across the health service – to ensure that only those schemes which are proven to benefit patients without harming staff are implemented more widely.
- There should always be a genuinely level playing field between public and private options (perhaps in the mode of Best Value) when decisions about the financing and provision of services are being considered – and that the quality of service to be provided and the costs to the whole of the local health system are central to the process.
- Health care, whether public or private, should be subject to a common system of regulation to ensure that all aspects of funding and provision are overseen by the State, in the interests of both fairness and consumer protection.
- The public sector must understand the markets in which it is intervening, and it should continue to monitor them over time, to put right any distortions that occur.

Reference

Keen J, Light D, Mays N. *Public–Private Relations in Health Care*. London: King's Fund, 2001.