

shaping
the new
NHS

FUTURE DIRECTIONS FOR PRIMARY CARE TRUSTS

Future Directions for Primary Care Trusts

RICHARD LEWIS, JENNIFER DIXON AND STEPHEN GILLAM

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This discussion paper forms part of a wider King's Fund Shaping the New NHS programme of research, seminars, debates and publications, running throughout 2003. It builds on earlier work carried out in 2001, which brought together a group of professionals, commentators and academics from health care and beyond, chaired by Lord Haskins, to consider key issues facing the NHS, culminating in the publication of *The Future of the NHS: A framework for debate* in January 2002.

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Summary

Primary care trusts (PCTs) are struggling to deliver the demanding modernisation agenda set for them by ministers. In consequence, two new policy themes – stronger market incentives and the decentralisation of budgetary power – have been introduced to strengthen the commissioning role of PCTs. This discussion paper looks at how PCTs could adapt to the new policies and considers some alternative futures for them.

The goal is a National Health Service where providers are more responsive to patients, and where market excesses are curbed through better regulation and new models of social ownership. We discuss potential problems arising from the Government's proposals: these include inconsistencies in the approach to elective and non-elective care and concerns about whether PCTs can sustain 'virtual integration' in a competitive market place. The skewed nature of the policy on foundation trusts could impair the influence of PCTs. Further experiment may be needed to determine the best direction of travel. Suggestions include the testing of foundation 'whole systems' that include PCTs as well as foundation primary and integrated care teams.

We offer three different scenarios for debate. The first ('the consumer is sovereign') maximises the use of competition within new structures of social ownership. The second ('equity first') emphasises integration, and makes little use of competition outside elective care. The third ('an ethical market') proposes that market incentives should be used only where they are consistent with the wider social mission of the PCT. The various elements of these scenarios are not mutually exclusive. They may help to create a distinctive form of managed care in the UK.

Introduction: the modernisation of the NHS

The NHS, now more than half a century old, is struggling to meet the challenges of a consumerist society. Although the public is generally satisfied with the services it provides,¹ politicians of all parties have accepted that the NHS cannot remain as a centrally managed public bureaucracy, because in this form it is unlikely to adapt fast enough to meet public expectations of care in the twenty-first century.

The Government set out its vision of a modern NHS in the NHS Plan.² The modernisation agenda addresses both ends and means. The ends are to offer prompt and convenient care: rapid access to diagnosis and treatment in modern facilities, with patients having choice over the time, place and personnel involved. The means include new incentives to encourage efficiency and quality, greater supply (of staff and facilities) and diversity of provision (particularly from the private sector) and more choice for patients, backed up by better information and a new system of financing providers that gives more substance to these choices.

Competition and decentralisation

The NHS Plan was published in 2000, together with many national targets. Since then, the 'centre' – the Department of Health and the NHS Executive – has been heavily involved in meeting these targets. Perhaps inevitably, fulfilling such an ambitious agenda – particularly after so many years of under-investment – has taken longer than ministers would have liked. This has prompted a review of the mechanisms by which the health service is managed to deliver policy goals. As a result, two new themes have emerged:

The use of stronger market incentives. For example: new financial flows (cost-per-case funding encourages providers to offer rapid access to high-quality care); new rights for patients to choose alternative providers if waiting time targets are exceeded (the Patient Choice initiative); a 'mixed economy' of public and private providers, including the recruitment of healthcare providers from abroad.

The decentralisation of power. For example: a slimmed-down Department of Health; the transformation of NHS trusts into 'foundation trusts', a new type of public benefit organisation mutually owned by, and accountable to, local communities, patients and staff; the transfer of 75 per cent of NHS resources to the direct control of PCTs.

Yet at the same time, older imperatives persist. NHS organisations still have a 'duty of collaboration'. Equity of health status and access to high-quality services is still a policy objective. And there is still a requirement to develop integrated care between all parts of the NHS and between the NHS and local authority and voluntary services, crucial to the achievement of national service frameworks. The tensions between these older policies and the new themes of market incentives and decentralisation will need to be resolved as implementation progresses.

PCTs are crucial to modernisation

Why look at PCTs now? Because they are crucial to modernisation – they are responsible for leading local strategic change across the country, in particular commissioning secondary and other care. Yet policy makers have paid them relatively little attention. The ‘centre’ has been preoccupied with the supply side (that is, hospitals and other providers) and, in particular, waiting times for elective hospital treatment. More worryingly, there is a feeling in many quarters – not least the Delivery Unit at 10 Downing Street – that PCTs are struggling to fulfil their potential.³

If modernisation of the NHS is to accelerate, much will depend on the capacity of PCTs to deliver the strategic change needed. In this discussion paper we look at how PCTs might adapt to the new policy environment, and we propose some alternative futures for PCTs and the wider NHS.

The rapid evolution of PCTs

PCTs have evolved rapidly. Their precursors were the primary care groups (PCGs) introduced in 1997, which in turn had their origins in the policies of the preceding Conservative government. GP fundholding, GP commissioning pilots and total purchasing pilots (TPPs) were all attempts to engage primary care clinicians more formally in the allocation of NHS resources, in recognition of the fact that GPs already effectively controlled many of these resources through their referrals.

A broader remit

The early priorities of PCGs were to develop primary care services and clinical governance, to use information and peer pressure to reduce unexplained variations in primary care clinical practice, and to advise health authority commissioners. However, current PCTs have a broader remit. They are now expected to maintain an overview of local health services, to control directly 75 per cent of NHS resources, and to take the lead in redesigning NHS services locally.

*Shifting the Balance of Power*⁴ lists the main roles of PCTs as:

- improving the health of the community
- securing the provision of high quality services
- integrating health and social care locally.

PCTs are therefore more than just 'grown-up' PCGs. They have already taken over roles from other NHS bodies. From health authorities they have acquired responsibility for: commissioning; developing and holding to account primary care contractors; improving public health; and increasing public engagement. From NHS providers they have acquired direct service provision roles for, among other things, community health services, intermediate care and pilots in primary care (traditionally the role of independent contractors).

Importantly, PCTs will soon become the key link between government and the provision of NHS services, as acute providers (increasingly foundation trusts and private healthcare companies) lie beyond the direct influence of the Secretary of State.

The problems of PCTs

How successfully PCTs take on these roles will determine how effectively power can be devolved within the NHS. Evidence suggests that PCTs are struggling to achieve all that is expected of them and are disappointing the expectations of politicians. This might have been expected, given the performance of their predecessors: TPPs, for example, were not notably effective in their commissioning role even after two or three years.⁵

Centrally funded evaluations of the early years of PCG/PCTs have suggested why progress might be slower than intended.⁶⁷ PCTs have been preoccupied with organisational development, and have been hampered by shortages of managerial capacity in such basic areas as finance and public health. The inadequacy of existing information systems has prevented PCTs from generating the data they need to carry out their core functions and other important roles such as the peer review of clinical activity. The registered populations covered by PCTs range from 57,000 to 334,000: some trusts are seen as 'too small to make a difference' and others are merging key functions to create critical managerial mass and thus improve progress.

More parochial concerns, such as deficits in the secondary sector and the influence of strategic health authorities, are hampering the capacity of PCTs to reconfigure services using their commissioning power. Central policy imperatives – such as waiting list initiatives, National Service Frameworks and guidance from the National Institute of Clinical Excellence – have absorbed most of the money allocated to developing local services. Although PCTs are making progress in commissioning community and intermediate care, few feel that they have enough leverage over acute hospital providers.

The PCGs were most effective in promoting services that improved access and reduced variations in the quality of primary care: that is, the services they could most directly influence. The change to trust status seems to have reduced the influence of general practitioners on the governance of PCTs and therefore the priority attached to developing primary care. This may explain the waning of support for PCTs among formerly enthusiastic frontline clinicians and the dysfunctional nature of some overstretched professional executive committees.⁸

Applying the new policy framework to PCTs

If the new directions for the NHS are stronger market incentives and greater decentralisation, what are the implications for PCTs?

Stronger market incentives

Various strategies are adopted by organisations in other sectors to overcome discrimination against older workers at the point of recruitment.

Commissioning

The commissioning role of PCTs is fundamental to any policy to strengthen market incentives in the NHS. An effective market requires an appropriate balance of power between commissioner and provider, and the new market-orientated policies are intended to strengthen the historically weak hand of commissioners. Yet research suggests that, so far, PCTs are still ineffective commissioners of hospital care, and thus have failed to improve care in this sector.

The new system of financial flows within the NHS⁹ will give providers more incentive to respond to the demands of commissioners and fewer opportunities to cross-subsidise services. This, plus better quality information and audit, should make it easier for PCTs to shift resources between providers (assuming there is sufficient supply to permit choice) as part of their search for faster access and higher quality.

Yet there is a contradiction here. As consumers are increasingly offered choice of secondary care providers (for example, through the Patient Choice initiative), the commissioning role of PCTs diminishes. For elective care, the commissioning will increasingly take place in the GP's consulting room or through discussions between patients and those employed to support their decision making. This raises an important question: can coherent development of the NHS emerge from the simple aggregation of decisions made on a patient-by-patient basis? The dilemma for PCTs is how to support 'bottom-up' decision making to suit individual patients, while ensuring the degree of 'top-down' planning needed to represent the collective interest.

However, elective care is but a small part of total NHS provision – although it has always attracted a disproportionate amount of the Government's attention. Emergency care and the management of patients with chronic diseases are less amenable to simple market based solutions. Here, the emphasis must be on commissioning care packages that cross-organisational boundaries and on creating seamless pathways of care. This integration must be both horizontal (for example, between general practice, community specialists and social services) and vertical (between community services, general practice and hospital specialists).

Arrangements for the care of complex or rare conditions – or catastrophic emergency conditions such as trauma or burns – often cover large populations and may involve tertiary centres. Designing and commissioning this type of care is beyond the capacity of individual PCTs, who will need to collaborate with neighbouring PCTs (for example, in cancer networks).

Strengthening the role of PCTs in commissioning hospital services, to help the trusts to operate in a more market-orientated way, will therefore require different strategies for different types of care:

- For **elective care**, PCTs must give patients high-quality information about the various treatment options and providers, and perhaps employ ‘navigators’ (staff who help patients to make appropriate choices about their care). PCTs must also work with primary care clinicians to influence their preferences for treatment and referral, again through high-quality information and peer review mediated by sensitive clinical leadership.
- For **complex** and **chronic care**, PCTs must take a more developmental approach, creating alliances between commissioners and providers: in particular, networks of clinicians. Here, patient choice will be more about the power to shape long-term care (for example, through influencing commissioning and clinical teams) than about the ability to select from a range of providers. Were they more developed, initiatives such as the Expert Patient Programme could be helpful to PCTs in this respect.

The provision of primary care

As already pointed out, there is no real market where primary care is concerned. Most PCTs have to work with a stable number of GP practices that exercise a near-monopoly on the provision of care. As a result, patient choice of provider has always been limited. In theory, patients are free to choose their general practitioner, but in practice, lack of availability limits this choice – and in many parts of the country, changing GPs can be difficult. Rather than exercising choice, many patients fear that they will be forcibly removed from a doctor’s list if they are seen as a troublemaker.

Over the last five years, however, government policy has explicitly set out to increase patient choice by improving access to primary care. New initiatives such as NHS Direct/24 and NHS ‘walk-in centres’ provide an alternative locus of primary care. Opportunities for local contracting, through personal medical and dental services (PMS/PDS) pilots and local pharmaceutical services (LPS) schemes, have allowed PCTs to commission new services to increase patient choice or to provide additional services directly. If implemented, the new general medical services (GMS) contract will increase the commissioning power of PCTs, as they will be able to create a market for ‘enhanced’ and ‘additional’ services and to develop new forms of out-of-hours care.

PCTs thus face the classic ‘make or buy’ dilemma: do they wish to be service providers or commissioners? For its part, the Government must decide whether to relax the current regulations governing the primary care market: for example, should private providers be allowed to bid on equal terms for primary care contracts, and should ‘control of entry’ be relaxed to stimulate competition among suppliers?

One area of patient choice so far ignored by policy makers is choice of the PCT itself. Currently, the user's choice of GP, and to a lesser extent where the user lives, will determine which PCT commissions their care. Few patients are aware of this – and since PCTs usually cover all general practices within a geographical area, it is a matter beyond the patient's control. Creating a competitive environment for PCTs may make them more responsive to consumer demand and more ready to innovate. In the United States, managed care organisations (MCOs) routinely compete for patients. King's Fund research into Kaiser Permanente in California¹⁰ suggests that the need to compete for enrollees improved the quality of service, the involvement of clinicians in decision making and the shared sense of mission within the organisation.

However, increasing consumer choice in this way has its drawbacks. For example, US experience suggests that it can lead to 'adverse selection', where MCOs attempt to attract 'healthy' patients and to avoid high-cost ones.¹¹ Incentives to avoid this practice, coupled with scrutiny by a regulator, might be needed. Similarly, the need to compete for patients could hinder the efforts of PCTs to improve public health and reduce inequalities, because it would oblige them to focus on improving health care.

Whether competition between PCTs is seen as desirable or not, now is decidedly not the time to introduce it. PCTs are new organisations already coping with many new roles. Furthermore, the NHS is currently preoccupied with increasing the supply of acute providers of elective care and encouraging competition among them; while this is happening, allowing competition among PCTs as well may be an innovation too far.

Even so, PCTs will have to take on new roles: for example, in operating legally binding contracts with foundation trusts. Introducing competition between PCTs for registered patients might be worth considering in the medium to longer term, although we first need to look at how competing PCTs might be able to lever improved quality from primary or secondary care providers.

Decentralisation

The Government has announced its intention to reduce central control over NHS care in order to liberate local innovation and to make health care more responsive to local communities. However, NHS bodies will still have to work within the constraints of a national policy framework, centrally mandated targets and a centralised system of performance management, assessment and regulation.

The proposal to introduce foundation status for acute NHS trusts is a bold step by the Government, and the most convincing evidence so far that it is serious about decentralisation. With their mutual-based model of social ownership and their new lines of accountability (to an independent regulator, to PCTs as commissioners and to the Commission for Healthcare Audit and Inspection, rather than to ministers), foundation trusts represent a potentially important shift in the balance of power between the 'centre' of the NHS and its periphery.¹² At the time of writing, the freedoms proposed for the new trusts are limited – and subject to scrutiny by a new independent regulator – but in time they may be expanded.

Whether PCTs will be allowed to adopt foundation status is not yet clear, but nothing is likely to happen immediately, for the reasons given above. The arrival of foundations in the acute sector may also shift the balance of power between PCTs and the acute providers from which they commission care. The ‘democratic deficit’ in PCTs, which have only limited and indirect input from patients, will be thrown into even starker relief when they negotiate with foundation hospitals, which can claim a new (and arguably higher) authority derived from social ownership.

A decision not to give PCTs foundation status in the medium term could therefore be problematic. The new market incentives designed to strengthen commissioning by PCTs may be undermined by any shift in the balance of authority away from PCTs and towards acute providers, who may claim to have a deeper understanding of the needs of the local community. In the short term, the first group of foundation trusts will be drawn from those trusts that are currently the best performers. Whether or not the local PCTs that commission from these new trusts are similarly well developed will be a matter of luck rather than design (although the PCTs connected to the first foundation trusts are promised support in developing their commissioning role, particularly zero-star PCTs).¹³

Perhaps more significantly, many PCTs are themselves major providers of services, including community health, learning disability and mental health services, as well as a range of intermediate care. If foundation PCTs are not created, those services will remain outside the local ownership and control required by recent government policy. Indeed, it is the commissioning role, with its focus on assessing local needs and prioritising scarce resources, that could be said to need local ownership most of all.

And what of the independent regulator of foundation trusts? This new body will determine, among other things, whether trusts are complying with their licences, or whether amending the terms of the licence is appropriate (for example, to change the range of services provided). It will also arbitrate in disputes over service reconfigurations. In time, this independent regulator is likely to wield considerable influence over the planning and delivery of health care. A difficult balance will therefore have to be struck between the power and scope of the regulator and the freedom of the PCT to act according to local priorities.

Mutual models of social ownership are becoming common in other sectors.¹⁴ Whether foundation trusts will succeed in attracting a membership is hard to predict, as is the extent to which members will be involved in the business of the trust. Similarly, the eventual impact of mutual ownership on the NHS must be a matter for speculation. In the short term, however, the Government may feel unhappy about relaxing its control over PCTs as well as acute providers. After all, PCTs are currently a major channel for ‘top-down’ control, via strategic health authorities and published priorities and planning guidance.

The ‘semi-detached’ nature of foundation trusts will mean that, in time, PCTs will be the only means by which the hand of government can reach directly into the health service. But the Government’s stated reason for introducing the policy – to allow NHS bodies more freedom to innovate and respond to local needs – applies just as much to PCTs as it does to acute providers.

The success of the strategy to decentralise the NHS will depend upon the skill of those who manage foundation trusts, plus the ability of players other than the Government (that is, the independent regulators) to ensure that foundations are continuing to improve care according to broad national priorities. Too many national priorities and targets will be counterproductive, as would too much direct performance management via strategic health authorities.

The management of chronic disease

So it seems clear that, in the short term, PCTs will need to strengthen their commissioning function across a range of providers (primary, secondary, tertiary and social care); that in the medium term they may achieve foundation status; and that in the medium to long term they may be able to compete for patients.

Yet whatever the scope and pace of change, PCTs face one major challenge: they must improve the care of patients with complex and often multiple chronic conditions, particularly older people.

Chronic diseases – such as diabetes, asthma, congestive heart failure, chronic obstructive pulmonary disease and depression – impose a huge burden of ill health in the UK, which is borne not only by patients but by their relatives, carers, friends and employers as well. These are also the costliest conditions for the NHS to treat. The key to managing these diseases is to centre care around the patient and to provide a clear pathway of care. This pathway requires effective integration of the many different services and staff who may be providing care.

Yet policies designed to increase diversity and competition among providers, and to give greater autonomy to NHS bodies, will inevitably complicate the task of delivering integrated care. This vision of a multitude of NHS and private providers, each given incentives to pursue its own goals, presents a formidable challenge to PCTs, whose task is to create coherence for individual patients out of this diversity. At present, NHS policy says nothing about how stronger market incentives or greater decentralisation can help to improve the management of patients with chronic diseases.

In fact, there is a conflict here: at the point of service, hospitals and primary care are subject to different incentives, despite the welcome introduction of unified budgets at PCT level. For example, the new system of financial flows in the NHS may reinforce the tendency of hospitals to focus on elective care, rather than on developing integrated care pathways that cross into primary care. The new policy of foundation trusts may harden institutional boundaries rather than, for example, encouraging the integration of care across secondary and primary providers.

Therefore the Government should perhaps pursue stronger market incentives for elective care only, where the ‘business units’ in the market could be well-defined specialties carrying out elective and generally uncomplicated procedures, competing with the private sector on similar territory. New incentives to improve quality of care and responsiveness to patients would need to be designed for non-elective services, perhaps using a unified budget, vertically integrated networks of clinicians and clinical leadership in managing resources.

There may be lessons here from the United States, the world's most developed market for exclusive illness management. Here, to improve management of chronic disease, managed care organisations adopt models of 'real' integration (in which primary and secondary care providers are managed and owned by the commissioning body – the managed care 'Plan'), 'virtual' integration (in which primary and secondary care providers operate as one organisation but contract with a separate commissioning body) or a combination of the two.

Examples include Kaiser Permanente, a vertically integrated organisation, and United Healthcare, a 'virtually' integrated model. It is not yet clear which of these models is the most effective. Significantly, the Department of Health has invited both Kaiser Permanente and United Healthcare to work with PCTs to improve their management of chronic disease.

To achieve service integration, PCTs may choose to employ their own specialists and provide integrated care in-house. PMS 'plus' pilots have already begun to present an alternative approach. Some pilots have brought together primary and specialist services into a single organisation. Here, the task of integration falls to the clinicians directly involved in the care, unencumbered by superimposed organisational boundaries. The unified budget of the pilot offers the clinicians a financial incentive to manage the primary-secondary boundary efficiently.¹⁵ While Health Act flexibilities offered opportunities for virtual integration, the few care trusts and the proposed children's trusts will lead to further dissolution of the boundaries between health and social care.

Some future options for PCTs

The twin policies of market incentives and decentralisation are designed to create a new NHS where responsiveness of providers to patients is paramount and market excesses are curbed by better regulation and new models of social ownership. Yet there are major tensions within this approach.

First, as already mentioned, the Government's commitment to stronger market incentives reveals an inconsistency in its approach to elective and non-elective care. Policies designed to support patient choice and responsiveness of services in relation to elective care may undermine attempts to deliver non-elective care. The question is: will PCTs be able to create effective models of 'virtual integration' within a broadly competitive marketplace? Or will the policy environment offer unforeseen opportunities for greater vertical integration between providers?

Second, the policy on foundation trusts seems curiously skewed. Foundation status will not (in the immediate future, at least) be applied to primary care, which accounts for 90 per cent of patient contacts. But surely social ownership and control of the commissioning and public health roles of PCTs is just as important as over the provision of hospital services? Moreover, the decision to increase the involvement of the private sector is inconsistent with a movement towards social ownership. As private provision increases, the rights of stakeholders give way to the needs of shareholders.

Third, an important element of patient choice has so far been ignored: choice of the PCT itself.

The NHS is in transition. We suggest that further experiment would help to determine its future direction of travel. In particular, we propose that the following initiatives be developed and tested:

- **'Foundation systems'**. Foundation trusts focused on individual organisations may have the unintended effect of disintegrating, rather than integrating, health care. This is a particular danger while PCTs are immature and their commissioning role is underdeveloped. Instead, 'foundation systems' could bring the principles of mutuality and social ownership to the collective health assets of a community.

A single foundation board, backed by locally elected governors, could bind together hospital, primary and out-of-hours care and even diagnostic and treatment centres. The board would oversee the modernisation of the local health services and ensure that they met the needs of the community, rather than the needs of individual institutions. This structure would provide incentives to deliver integrated and preventative care within a public health framework. However, direct patient choice over elective and primary care could still be possible.

- **Foundation PCTs** in some areas, particularly where local health communities are complex and have unclear boundaries, foundation systems may not be feasible. Instead, the creation of foundation PCTs may offer an opportunity to correct the imbalance between provider and purchaser by strengthening the commissioning role of PCTs. Furthermore, foundation PCTs may increase public involvement in the PCT role of modernising local services. Foundation status may also encourage more clinicians to become involved in management: they currently see PCT professional executive committees being trumped by stronger management teams and publicly appointed boards and therefore feel disengaged.
- **Foundation clinical networks (primary or integrated care teams).** As PCTs get larger and more remote from their clinical constituents, some may encourage the development of clinical networks. Building on early initiatives in PMS, these teams may include primary care providers only or a combination of specialist, intermediate and community providers, perhaps focusing on the care of patients with chronic conditions or with multiple co-morbidities. In time, these vertically integrated clinical networks may secede from PCTs, which will retain a commissioning role only.

The first two proposals could severely test the Government's willingness to devolve power, since local decisions could conflict with national priorities. If devolution is to be genuine, the 'centre' would have to rely on other organisations to influence the direction taken by PCTs rather than imposing its will directly: for example, a central regulator via inspection and assessment, and perhaps the local strategic health authority via (light) performance management.

How might these developments combine in the future and how might the role of PCTs be adapted to the new policy framework? In the box on p 13 we describe three different scenarios in order to stimulate debate. These have been constructed as theoretical options, and their components are not mutually exclusive.

Some future options for primary care trusts and the NHS

'The consumer is sovereign': maximum use of competition within a new social ownership structure

- Foundation status is freely bestowed on PCTs, hospital providers and primary care.
- Maximum patient choice of hospital provider from public or private sector, including niche providers (for example, diagnostic and treatment centres, 'chambers' of specialists, third party disease management companies, and so on).
- Deregulation of primary care to provide consumers with more choice. Rules inhibiting the entry of private companies into primary care market are abandoned.
- Patients choose from among competing PCTs, based on freely available performance indicators.
- PCTs determine their own balance between commissioning others ('virtual integration') and providing services themselves, and develop sophisticated ways of measuring patient satisfaction.
- Patient 'navigators' are used to support patient choice.
- PCTs licensed to remain in market place according to their ability to deliver central targets. Inspection and assessment by central regulatory bodies and minimal performance management by strategic health authorities.

'Equity first': an emphasis on integration, with little use of competition except for elective care

- 'Foundation systems' ensure that service integration is based on collaboration.
- PCTs increase the proportion of primary care currently provided, incorporating existing independent GPs where possible.
- PCTs directly employ a range of specialists, particularly for chronic diseases.
- Non-elective care commissioned via long-term collaborative arrangements with hospitals under the umbrella of the foundation system.
- No choice of PCT for patients and limited choice over primary and non-elective care.
- Patient 'navigators' used to empower patients.

'An ethical market': more market incentives are used, where these are consistent with the wider social mission of the PCT

- 'Foundation systems' link local health resources at strategic level, with agreed autonomy for component organisations. There is support for patient choice and competition within this overall framework, mainly for elective care.
- 'Ethical commissioning' by PCT, where strong set of social priorities are identified and protected from competition (for example, additional support for primary care businesses in economically deprived communities).
- PCTs choose between in-house and commissioned services, leading to a rise in the number of independent integrated care organisations within the foundation system.
- Emphasis on long-term relationships between provider and commissioner for non-elective care, rather than the shifting relationships determined by commercial criteria. Shorter-term relationships for elective care.
- Patient 'navigators' used to empower patients in clinical care.

Where next?

A crucial balance has to be preserved between the rights of individual healthcare consumers, the priorities of the public at large and the interests of care providers themselves. This balance is shifting, and patient power is quite rightly coming to the fore. However, providing patients with genuine choice involves far more than simply enabling them to select a preferred hospital from a number of alternatives. There is a further dimension to patient choice: the ability to become meaningfully involved in the care process itself (or, in fact, to decide whether or not to have treatment at all).

But offering this sort of choice requires a significant shift in the balance of power between professionals and patients. Indeed, it implies a new concept of what professionalism within health care means – one that sees patients as ‘co-producers’ of their own health rather than simply the passive recipients of care. Which of the models described in the box on p 14 will best meet these new demands?

Should the consumer be sovereign? Over time, and if properly supported, patients should expect to acquire far more control over when, where and how they receive their care. This could include offering them choice over their PCT as well as their treatment options. In this scenario, the future NHS bears some resemblance to the managed care market in the United States.

However, managed care US-style has many critics: it succeeds in being unpopular with both consumers and providers, compared with traditional indemnity insurance coupled with fee-for-service medicine. There are concerns over the restrictions on choice, the unsavoury behaviour of MCOs (for example, adverse selection) and the fragmented view of public health it embodies. However, a key difference between our model and the US situation is the greater accountability of health care to the local community, to a national inspectorate and regulator to ensure the delivery of broad national and locally specific policies.

By contrast, the ‘equity first’ model appears to lack the dynamism needed for change. While it is crucial for the public to engage with health care organisations at the macro level, this is rarely enough to guarantee that services to individual patients will be responsive. For this, patients need the ultimate power of choice.

What of the shorter term? The last thing the NHS needs is more reorganisation. The ‘ethical market’ approach is broadly feasible within existing structures (or with the same degree of change as currently proposed for foundation trusts). While encouraging patient choice and innovation through diversity where appropriate, it secures integrated care through collaboration across health and social care.

Endnotes

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