



COMMENT

It takes two

The health service can survive testing times, but only if providers work as a team, argues the NHS Confederation's **Joe Farrington-Douglas**

The health market is used to uncertainty, but June brought a trio of changes that would shake the confidence of the bravest investor. While the government and Prime Minister survived an extraordinary political period, the majority of health ministers were reshuffled, posing a threat to business continuity. The resignation of top reforming mandarin Mark Britnell, while a coup for his new employer KPMG, sent confusing signals about the commitment of the Department of Health to continuing a commissioner-led agenda. And a realisation of the size of impending health budget cuts reached the mainstream media, triggered by an NHS Confederation report asking whether this would be the greatest ever challenge for health service leaders.

Such turbulence in health politics raises questions about the future of reform. There is a risk that politicians and leaders pull their horns in and shy away from radical thinking and difficult decisions, worsening our ability to respond to

the challenge when it arrives. Already some voices, including medical unions, have taken this opportunity to step up campaigns against any competition in healthcare. Others argue that letting the market rip is the panacea.

But NHS leaders know that doing and cutting things in the ways we've always done them will lead to the unravelling of progress and store up health costs for the future. This threatens the principles of the NHS. Setting up false choices between competition and collaboration does not help identify a way forward.

There is a shared understanding in much of the health service, including key influencers, thinkers and practitioners, for the need to examine every corner of the system and ask whether it could be done safer, better or more efficiently. Every commissioning decision will need to be cost-releasing. The ability to soften the impact of changes with extra resources will be limited. While rolling back competition would remove an important stimulus for innovation, in the new reality supply-side and transactional reforms will be more challenging to achieve.

This shift from budget growth to imminent funding squeeze will therefore require a radical adjustment in approaches to public private partnership on both sides. Competition and plurality will have an important part to play in meeting the challenge of post-2011 spending. But the scale of the challenge means that what might have worked for expanding elective capacity and choice – providing equivalent services, at tariff prices or above, with plural providers and spare capacity – cannot be enough for the future. If whole care pathways are to be transformed, NHS and partner leaders will need to collaborate closely across systems, breaking down traditional barriers and experimenting with new service configurations.

Similarly for the private finance initiative, banking on tariff surpluses, racking up off-balance sheet debt with cheap access to capital is not feasible for the future. Co-produced small scale investment, design and construction models are needed to provide flexibility rather than ambitious flagship projects to deliver more of the same for 30 years.



While the practicalities of working in the new world are far from clear, the strategic implications for public private partnership are now emerging.

No business in today's economy needs reminding about the realities of risk taking. NHS organisations are entering a more commercial environment at a time when the business world is in flux. Health service commissioners and providers are no longer guaranteed eternal survival and pay-outs for failure are no longer tolerated, or affordable, in any sector. While the NHS must remain a responsible corporate citizen, sheer mathematics means that partnerships must share real risk.

This represents an exciting opportunity for new forms of more integrated partnership that can innovate and evolve over time. In an uncertain world, 'complete' contracts specifying every eventuality are neither possible nor desirable. Relationships of trust and cultures of arbitration rather than litigation need to be built quickly. Bankrupting your commissioner, or your collaborators along the value chain, should not be in the interests of any partner. In order to align incentives, commissioners and partners will have to offer a long-term transformational relationship, with reward reflecting quality and financial savings.

If commissioning is going to achieve the kind of cross-system transformation that is required, a new financial system will be needed to allow for blends of competition and integration. Payment

by Results has been designed and rolled out (far from completely) in a period of unprecedented growth – and even then contributed to substantial instability. Costs and activity have increased on the basis of doing more of the same things this year as last.

However compelling this critique, it falls down on the lack of an easy solution. Simply allowing competition on price tends to lead to skimping on quality. The development of 'normative' tariffs centrally has always been easier in theory than in practice: Generating historic cost-based prices has proved complicated enough. More fundamentally, Whitehall cannot necessarily tell you today what the price of tomorrow's innovative, transformational pathway will be.

Given that we have only one year to play with before an election, there is no option but for regional and local commercial innovation. With the help of a more enabling central framework and commercial support units, partnerships could develop new contracting and payment models to incentivise redesigned care pathways, for example using a year of care budgets that bundle payments and share savings between commissioners, trusts and partners.

Contrary to the anti-reform critique, competitive pressures can have the potential to be a powerful tool in the reform of health services. They may be an important driver of innovation. When traditional hospital-based elective care service has been 'disrupted' by the introduction of competitors, both NHS

and independent, they have been able to develop more efficient care pathways and provide new services like mobile treatment centres. These competitive pressures can help drive quality, responsiveness and technical efficiency.

However it is also clear that achieving the kinds of improvements in quality and efficiency necessary will require innovation in the way services are designed and delivered. Rigid segmentation of the market and the construction of barriers to inter-organisational collaboration could send contradictory signals about the permission to innovate.

After a generation of health spending growth, if the NHS is to survive as an innovative partnership, it needs new ways of thinking for the new world. The old polarisation of competition versus collaboration needs to be re-thought. New ways of combining both and unleashing clinical leadership and user involvement needs to be sought. This requires an enabling, smart interpretation of rules.

Innovation is the only solution if doing the same more quickly is not sufficient. NHS leaders are cautiously optimistic that there is scope for change on this scale, and the system is in a better state – financially, physically and culturally – than before. But the successful vision for 2011 and beyond can only be achieved if all leaders – including commissioners, providers and professionals – start thinking about how real partnership can transform every corner of the system. ■

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