Should NHS mental health services fear the private sector?

The coalition government wants to open up the market in the NHS. **Allyson Pollock** thinks this will result in an impoverished and inequitable service but **Elaine Murphy** and **Philip Sugarman** believe mental health services have much to gain

MALCOLM WILLETT

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- Independent sector treatment centres: evidence so far (*BMJ* 2008;336:421)
- Independent sector treatment centres: learning from a Scottish case study (*BMJ* 2009;338:b1421)

YES

Soon multinational corporations will control the distribution and supply of mental health provision in England. US healthcare corporations have long been targeting mental health services in the NHS; first by substituting for NHS hospitals and then introducing niche markets in drug and alcohol addiction and other services. A whole swathe of NHS mental health services has been closed or transferred to the for profit private sector from the NHS.[1] We know too little about cost, quality, or value for money as the sector has largely escaped public scrutiny in the UK. But we know enough to question claims of value for money and improved quality.[2]

The English white paper marks the end of market incrementalism and a switch to US style managed care and health maintenance organisations. Under these proposals the NHS will be reduced to government payers funding the private sector to commission and provide care.[3] In the UK, general practice consortiums (many of which are run by private companies) are at the heart of the new deal, filling the role that insurance companies play in the US.

Denying not providing

Scepticism about the merit of the private sector in health care is growing in the US. Last November the Senate Commerce Committee received evidence that less that 66 cents of every dollar raised by insurers is actually spent on health care; the rest goes on administrative expenses, marketing, and company profits. Senator John Rockefeller, chairman of the committee, asked: "Is the money they charge going to profits, to executive salaries, and to figure out how to deny care to people when they really need it?"

Denying, not providing, is the natural logic of the private sector; it must manage financial risk associated with providing mental health care.[4] In England, the government proposes devolving financial risk to general practice consortiums through market competition and a system of reimbursement in which money follows patients through a tariff known as payment by results.

But patients with mental health problems are bad risks because they tend to have higher overall health costs and care is unpredictable.[5] US evidence shows that the commercial response among health maintenance organisations is to discourage people with mental illness from enrolling by placing limits on specialist care or imposing stricter rules on referral to specialists.[6]

NO

This is a fascinating time for the NHS, when funding may finally have peaked and there is a realisation that we can't improve health outcomes further through using even more taxpayers' money, we must do it through healthy competition. Although the marketisation of the NHS has been in progress for 20 years, the policy has meandered rather chaotically in the general direction of competition, for political reasons. The coalition government looks set to speed things up, and we welcome this in mental health services.

There is nothing in the founding principles of the NHS that says "national" means "nationalised" or care has to be delivered by one state owned monopoly provider employing staff on identical terms and conditions across the country. Indeed, there is plenty of evidence of inefficiencies, low productivity, high staff costs, and a shortfall in outcomes in the NHS. Despite unprecedented investment in mental health these past 10 years, improvement has been only modest. Many services, both hospital and community, are stretched. The current president of the Royal College of Psychiatrists declared in his inaugural speech that many inpatient units were unsafe and uninhabitable, and that he wouldn't be happy for himself or his relatives to be treated there.[1]

Competition and quality

Regulatory reforms that introduced competition into UK water and energy markets improved productivity by over 10% a year in the 1990s. New companies challenged the old incumbents to up their game, and quality improved across the board. Is health care so different? Why not allow NHS purchasers to commission care from whichever provider, NHS or not, that can offer the best deal on quality and cost? Why not allow patients to choose where they want to go to keep providers on their toes?

The state has the advantage of being able to regulate the market appropriately and fairly to deliver social goals. This does not mean a competitive market based on price alone, which is where some early market reforms of the 1990s went wrong. Price competition without quality drivers simply reduces quality of care. What is needed is a well regulated market where quality is driven up by the need to compete for contracts, in an open marketplace where pricing is on a level field between providers.

The competitive market of mixed providers has been developing for many years in mental health, why should we fear its expansion now? Recent studies, after all, suggest that existing competition in the NHS is starting to drive up quality and efficiency as measured, for example,

US commissioners manage their risks by restricting access to specialists—substituting social workers with minimal mental health training for psychiatrists—and by "carving out" chronic conditions like mental health into separately funded and tightly controlled disease management programmes.[7] The result is loss of clinical and professional control and training, service integration, service quality, and needs based planning.

Evidence based medicine is also at risk, as is service innovation.[8] Time constraints on consultation time combined with the use of semi-trained and less skilled staff are a recipe for inappropriate and costly prescribing, especially when those costs can be passed to patients. In the US, prescription only medicines are projected to capture 30% of mental health spending by 2014.[9]

Inequity

When risk is devolved to general practitioner commissioners or service providers through a capitation fee or payment per head they must seek to manage the risk. The US shows that they will use three strategies to balance the books.[10] They can reduce eligibility for services or place time limits on care; they can cherry pick low risk patients; or they can levy charges for services no longer offered by the NHS. Most likely they will use a combination of all three.

For the first time in the history of the NHS, general practice consortiums will have an incentive to manage enrolment to their patient list. Where then will substance misusers with chronic conditions and comorbidities, the people with schizophrenia and other complex mental health disorders go? Inevitably relatives, charities, and local authorities will fill the gap, and a system of inequitable care determined by the wealth of local areas and individual ability to pay will evolve.

So patients, practitioners, staff, charities, local government the government, and all those who care about ensuring a universal, rational, fair, and effective system of mental health care have much to fear.

The exclusion of the private sector from health and social care in 1948 was not a mistake; it was by design. Bitter experience necessitated limits on private enterprise. The financial crisis has shaken the belief that international corporations can be tamed and domesticated for the good of society. Margaret Chan, director general of the World Health Organization reflected this recently when she said, "Great waste occurs when health is treated as a commercial commodity, to be bought and sold, assuming that market forces will somehow self-adjust to iron out any problems. This seldom happens. What you see instead is unnecessary tests and procedures, more and longer hospital stays, higher costs, and the exclusion of people who cannot pay."

"US evidence shows that the commercial response . . . is to discourage people with mental illness"

The pity is the vested interests will be too powerful to wrest the NHS back if health care is traded as a commodity or used as a tool for economic growth; as in the US, commercial law and legal property rights of investors will be used to trump public health.[11] The white paper plans to expose the weakest and most vulnerable to global market forces as investors trade away the universal right to health care. For the English citizen, this marks a return to fear.

Allyson M Pollock, professor of international public health policy, Edinburgh University, Edinburgh EH8 9AG, UK **allyson.pollock@ed.ac.uk**

Competing interests: None declared.

Provenance and peer review: Commissioned; not externally peer reviewed.

Cite this as: *BMJ* 2010;341:c5382

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by mortality from acute myocardial infarction and managerial quality.[2 3] Contracting from the independent sector, from both for profit and voluntary organisations, is becoming more common in mental health services. The cost of independent sector services is increasingly competitive, even before the true cost to government of NHS pensions and public capital is factored in. Patients and staff already move between the sectors. Choice enabling mechanisms such as Choose and Book, tariffs, and payment by results may work for mental health, but the real future will be commissioners genuinely free to choose "any willing provider" on the basis of quality and efficiency.

Innovation

The independent sector is now providing most of our medium secure forensic beds; many other specialist and secure services for people with conditions ranging from eating disorders to brain injury; and almost all long term care for dementia. In 2008-9 almost of a third of people in England admitted under the Mental Health Act were in independent hospitals.[4] Provision for some needy groups has been led by independent providers—for example, people with autism, and deaf people in need of secure care. Pluralism permits new ideas to flourish, opens up health care to new ways of doing things, such as responding to the special needs of the homeless, asylum seekers, or minority ethnic groups.

The quality and effectiveness of state and independent services are now increasingly comparable. Independent providers are party to the same inspection, contracting, and professionally led quality schemes as NHS providers—including the Royal College of Psychiatrists accreditation systems. There are of course variations by sector and size. Charities like St Andrew's Healthcare and the Retreat at York are culturally quite close to NHS mental health trusts, whereas commercial providers lead on investment and efficiency. Smaller private and voluntary providers can often be the most innovative and flexible, although quality may be more variable.

When clinicians hear the word "market" they think of interfering primary care trusts; of putting profits before patients; and of jingling cash registers. In contrast we foresee state, public, voluntary, and for profit providers learning from each other and slowly becoming able to challenge each other realistically. As we move from a complementary relationship to a more competitive one, there will be more exchange of staff and patients, ideas and practices, and perhaps whole services. It will take many years more for the market to develop fully, but mental health clinicians above all should know that it is right to embrace challenge and change. Now is the time for the NHS to welcome competition, to secure the best deal for patients in the long term.

Elaine Murphy, secretary, All Party Parliamentary Group on Mental Health, House of Lords, London SW1A OPW, UK **murphyel@parliament.uk**

Philip Sugarman, chief executive and medical director, St Andrew's Healthcare, Northampton, UK

Competing interests: All authors have completed the unified competing interest form at www.icmje.org/coi_disclosure.pdf (available on request from the corresponding author) and declare no support from any organisation for the submitted work; PS is an employee of St Andrew's Healthcare, a provider of charitable services to NHS patients, and trustee of the voluntary sector umbrella group the Mental Health Provider Forum. Both organisations believe the NHS should commission more care from the third sector and stand to benefit accordingly.

Provenance and peer review: Commissioned; not externally peer reviewed.

References are in the version on bmj.com

Cite this as: *BMJ* 2010;341:c5385

The Maudsley Debates are regular events held at the Institute of Psychiatry. Visit www.iop.kcl.ac.uk/events for more details.