It is a very great pleasure to be here this morning with this traditional institution of Gresham College.

As Wynand said, we have known each other a very long time. We have had the pleasure of working together for a couple of years now, thinking about how the NHS might learn from the Dutch reforms. Basically, there are two big ideas behind this. One is looking back to the movement of Governments in all developed countries, apart from the United States, to introduce universal coverage. Wynand has emphasised that the problem is that if you have unregulated insurer competition, you end up with the uninsured, as in the United States, and insurers will put a huge amount of effort into assessing risk of individuals.

There is a highly skewed distribution in use of healthcare: the most expensive 5% of the population use 60% of healthcare costs. If you allow unregulated competition, insurers will put all their effort into identifying high risk individuals and either making them pay a huge amount or getting them out of the system, and that creates inequity in healthcare. Hence, the standard response to that is to remove competition between insurers. You either have a single payer scheme, as in Britain, or multiple insurers, as in the Netherlands, twenty years ago, when you had no choice between insurers. Wynand has spent his life working on how we can work out a method of risk adjustment, which is fundamental to the Dutch reforms. That means we can have competition between insurers, and you do not have insurers putting effort into identifying high-risk individuals and screening them out, but rather working out how they can become effective purchasers and achieve a higher quality of care, at reduced cost.

One of the sad things that happens to the English NHS every few years is a major structural reorganisation, and the NHS needs another structural reorganisation like it needs a hole in the head! The problem we have, if you compare what Governments do to the NHS, with well-regulated markets, is enterprises in well-regulated markets work out the optimal form or organisation, and the trouble with the NHS is that it has, imposed on it, major structural reforms, on a regular basis, and it is not surprising that these purchasers, our local insurers, do not compete. They do not do risk rating and they have been very poor at working out the best way of purchasing care from providers.

Now, the idea of learning from the Dutch system is, as Wynand has described, that we could transform these local purchasers, currently Primary Care Trusts, to become GP consortia, into organisations that compete, and they would then be free to work out the optimal form of delivery within that system. I am going to review the issues that we have had in the English NHS and to say what might happen if we were to look to lessons from the Dutch reforms.

As Wynand said, this is David Cutler’s analysis of issues that all systems of healthcare have to confront, and as Lord Warner mentioned right at the start, and Stephen Dorrell and his Select Committee have emphasised, the big issue we have now, over the next four years, is severe cost control. In the 1990s, under the Conservative Government, and then the Labour Government, we had very good systems for equity – there were no barriers according to ability to pay. I am a member of advisory groups that work out how to allocate money according to need of populations, on a fair basis, across England. The issue that we have are inequities in outcome, which, unfortunately, have been widening. We have been supremely good at cost control compared to other countries, and there is no doubt we will do that very well over the next few years. The big problem we have is how we achieve high performance. The worrying thing is, after the Labour Government improved performance in many respects – the elimination of waiting time as a problem, better outcomes, better experience of quality of care – if we do not deliver the efficiency saving in the Nicholson challenge, we will have cost control and equity but we might go back to the way the NHS was in the 1990s.

Now, if you want to achieve these three goals, there is a theorem in cybernetics, the law of requisite variety that says that if you want to control a very complex system, you need to have a complex regulatory system. Broadly speaking, if you want to achieve cost control, equity, and performance, you need to have three instruments.

In the 1980s, the last time we were actually dealing with another fiscal crisis and there were severe constraints on NHS expenditure we tried to achieve these three goals, but only had two instruments. Health authorities, at that time, ran providers, and the Conservative Government imposed severe cost controls on the NHS, with no growth over much of the 1980s. The idea was that, through this severe cost control, the NHS would deliver efficiency savings. That took place alongside the system to redistribute money to achieve greater equity across the health authorities, so money was taken out of the London health authorities and put into the health authorities along the South Coast. This completely messed up the idea of delivering efficiency savings through a squeeze, because the authorities on the South Coast, below their target fair share, were getting more money and did not have to make any efficiency savings, and those in London had not only to make the efficiency savings as planned in the national budget, but had to make cuts because money was being taken away from them through a process of redistribution, so neither of these authorities actually achieved efficiency savings.

The attraction of the purchaser/provider split, as introduced from 1991, is that we would then have these three
The conclusion, looking at both markets, both the one introduced by Margaret Thatcher and by Tony Blair, and reorganisations.

very small and had very limited impact on the market, there were changing policies all the time, and multiple exit from the market did not happen, there was limited entry, the independent sector treatment centres were This came out last year. Again, there is this problem of political interference. Purchasing remained very weak, sympathetic to market-driven reforms, but they found that the evidence said this was not working terribly well.

met Wynand at a conference, and wondered whether we could look at an alternative from the Dutch system. Treatment Working?” and, briefly summed up, it seems to me the answer was no. It was at this point actually I A few years later, this was evaluated by the Audit Commission, Healthcare Commission, with its report, “Is introduce greater plurality with providers, with foundation trusts and with independent sector treatment centres.

The Conservative Government introduced a very different model, although it was called an internal market with a purchaser/provider split and competition being provided. Money followed the patients, with this idea of selective contracting, with two purchasers, health authorities and GP funders, who could opt to buy a small subset of hospital community health service, particularly elective and diagnostic care. This did not work terribly well.

Julian Le Grand, my colleague at LSE, did a systematic review of the literature and pointed out despite all the sound and fury and concerns people had about this radical reform, very little happened on the ground, and said the incentives were too weak and the constraints too strong. Carolyn Tuohy wrote a wonderful book, “Accidental Logics”, comparing health reform in three countries, Canada, the United States, and Britain, and argued that the trouble with the internal market was it contradicted the logic at the NHS at the time of its creation in 1948, which is driven by ministerial accountability for failures. My namesake, Aneurin Bevan - and I have not proved I am related to him, but I am still working on it - famously said that “If a bedpan is dropped, it should echo in the Palace of Westminster.” I am sure Secretaries of State ever since have been grateful for him saying that.

The problem with markets is that they work through exit of failing providers, and the pressure for Ministers, as Lord Warner knows very well, is when a hospital is failing it is politically difficult to let it fail. Even closing an A&E Department was something that became politically difficult. The other issue is that there were these health authorities that did not have GPs as part of them, and they contracted with hospitals. Her argument was that these were administrative artefacts making contracts, but the real decisions are made between GPs and hospital doctors, who are remote from this process. Thus, the contracting process was ineffective, and the rhetoric of these were administrative artefacts making contracts, but the real decisions are made between GPs and hospital doctors, who are remote from this process. Thus, the contracting process was ineffective, and the rhetoric of the internal market was that hospitals would compete on price and quality, and we had very poor information on either, so it was very difficult for that to happen.

There was an intervening period under the Labour Government, which abolished the idea of competition on being elected in 1997, and then introduced a thing I was involved with, which was the star rating process regime of targets, which actually dramatically reduced hospital waiting times and improved things in various ways. Following this, the view was taken by Julian Le Grand, with Tony Blair and Alan Milburn that the target-driven system - this is not something I agree with, and I have continued discussions with Julian about this - could move the NHS from being appalling to mediocre, but if you wanted a high performing system, you should move towards competition, patient choice, with money following the patient. So they went back to the ideas of the internal market of the 1990s, with various refinements. They wanted money to follow the patient, but they introduced a standard price for same types of cases, known as payment by results. The idea is that you have competition on quality, not on price. Selective contracting would be by Primary Care Trusts, who would contract with GPs and with providers of community health services.

To try and improve the purchasing, they set the standards of world-class commissioning, very ambitious sets of things, which articulated what they were supposed to do with this emphasis on patient choice, and to try and introduce greater plurality with providers, with foundation trusts and with independent sector treatment centres. A few years later, this was evaluated by the Audit Commission, Healthcare Commission, with its report, “Is Treatment Working?” and, briefly summed up, it seems to me the answer was no. It was at this point actually I met Wynand at a conference, and wondered whether we could look at an alternative from the Dutch system. There was a systematic review by Civitas which came out last year - Stephen Dorrell spoke, and they would be sympathetic to market-driven reforms, but they found that the evidence said this was not working terribly well.

This came out last year. Again, there is this problem of political interference. Purchasing remained very weak, exit from the market did not happen, there was limited entry, the independent sector treatment centres were very small and had very limited impact on the market, there were changing policies all the time, and multiple reorganisations.

The conclusion, looking at both markets, both the one introduced by Margaret Thatcher and by Tony Blair, and
continued, in a way, by Gordon Brown, is that this did not achieve what the theory says you should achieve. They raised this question of whether the NHS was incurring the transaction costs of the market but not the benefits. The Coalition Government, in laying out their programme as to how the future might be - this is a point highlighted by the report of the Health Select Committee – promised, and this was a welcome sigh of relief to all of us in the NHS, that it would stop the top-down re-organising that got in the way of patient care, and of course, they have done no such thing!

If reorganisation of purchase is the answer, my feeling is that you are asking the wrong question. We have tried this many times since the 1990s. We started out, first of all, with GP fund-holders looking after a very small population of about 10,000. There were then 200 district health authorities. We continued with fund-holding. We thought the health authorities were too small so we created bigger organisations - 100 health authorities. We then thought the 100 health authorities could be supplemented by bigger GP-led organisations, through primary care groups. We then thought that was not working we created 300 Primary Care Trusts.

We then thought the Primary Care Trusts were too small, so they created 150 Primary Care Trusts. The idea now is to try and introduce GP-led purchasing through practice-based commissioning. In the reforms that are going on, the PCTs are being required to move into bigger clusters, and then we are going to move into GP consortia, which are supposed to come into place from 2013. The most depressing thing about this is that I am very confident that, within five years, we will have another structural reorganisation of the National Health Service. It seems that Andrew Lansley, our Secretary of State, spoke to nobody about these reforms and they are very much his own idea.

The objectives behind the key ideas are very attractive. The creation of the NHS Commissioning Board is intended to free the Secretary of State from the day-to-day interference of the NHS. We would like to see a system whereby the Government is steering, not running, the NHS. It is attractive, through GP consortia, to have GPs involved in shaping services. The idea of freeing up the providers is an attractive choice of managed competition. He actually says that he sees this change as evolution, not revolution, although the Chief Executive of the NHS, Sir David Nicholson, says this is such a big change you would actually see it from space.

If you compare the account that Wynand has given of twenty years of market reforms in the Netherlands with the reforms in the UK there is one basic point. It goes back to the DECA report of the 1980s. There is a process of corporatism in the Netherlands, where the insurers, the doctors, the hospitals, the governments, get together, and through a slow process, they work out how they are going to change things. Wynand describes this as a Dutch procession that is a dance in which you do three steps forward and two steps back. However, the key thing is: it is in one direction.

In Britain, it is more like a March hare running in all sorts of directions. We have competition between mutual healthcare purchases. The reason why we use this phrase is that insurers would normally put a lot of effort into risk rating. These do not do that. They are insurers without the common function, so we think that ‘mutual healthcare purchasers’ is a much better description of their role. As he pointed out, there is very little development, as yet, in selective contracting, but the model has been exported to other countries with social insurance systems – Germany and Switzerland. Morris Shock made this point in the 1990s, that in England we have a blitzkrieg, and Stephen Dorrell talked about this as SW1 policymaking. There is a radical reform put together in Downing Street, then imposed on an NHS where hearts and minds have not been won, and the phrase he used in the 1990s was “This is like an army of occupation in hostile territory”, and this has much greater resonance now than it has twenty years ago. It is true to say there is not overwhelming enthusiasm for the Government’s latest reforms in the NHS.

We know providers of competition have very little impact, and although in the 1990s, other countries tried this model, some of them abandoned it – New Zealand, Scotland and Wales. In Italy, as I understand, there is only one region, Lombardy, which continues to do that. In Sweden, only Stockholm continues to do this. It seems to have become a relatively unpopular model. So whereas the Dutch model has been imported, this idea of purchaser/provider split is in retreat. So the question is how we might use the Dutch model, given where we are now. We have a system of cost control, with the fixed total budget, with this very severe constraint that lies ahead. We have had a very sophisticated programme formula for allocating money to geographically defined populations. That has been developed by people at the Nuffield Trust to use the Dutch model of an individual-based risk adjustment mechanism. This is the big technical obstacle to insurer competition, and we have actually largely solved that problem in England, and that is the basis under which the PCT clusters will actually be funded.

So the question is: could we go back to what Alan Eindhoven thought we should have done in the 1980s, to a system of purchaser competition, in which the third arm of driving efficiency would be you would have competition between these mutual healthcare purchasers and PCT clusters, in which these purchasers would decide to what extent they want to do selective contracting and to what extent they would integrate. The argument for this was that we could achieve material savings and efficiency by better integration between primary and secondary care, and there are questions as to the extent to which we will actually do that through hospital competition.

In terms of what these mutual healthcare purchasers might look like, there would be a plurality there. Obviously,
you would begin with Primary Care Trusts, and we are looking towards GP consortia. The worry with the GP consortia is that we know, from evaluations of GP fund holding and when they extended that to total purchasing, a small number of them do things really well. So the outcome of this transformation, the abolition of Primary Care Trusts and move to GP consortia, will mean that some of these GP consortia will do a fantastic job - much better than the PCTs have ever done. However, that will be a small minority. Most will not do this very well at all.

It would be attractive to have a regulatory system here, in which, if the GP consortia are to take over from the PCT, they have to demonstrate to the regulator that they have greater competence and indicate that they will do a better job. That would be one process of better managing the transition and the risks that lie ahead. When you have that process in place and you allow PCTs and GP consortia to open up to competition where people can switch between them on the margins of geographical areas, the question is whether could we move towards a more radical system, as in the Netherlands, in which insurers, like BUPA, or foundation trusts could come in and integrate with primary care and offer coverage for the local population.

For that to happen, the lessons from the Netherlands are that these new insurers have to define the area in which they would offer coverage. They would guarantee duty of care, primary and secondary care and they would be allowed to selectively contract and integrate. Then, another refinement we might think about, as Wynand described, is a move towards explicit insurance contract. One issue has come up because the Government has said they are going to stop NICE recommending to the NHS what drugs could and could not be provided. There was a controversy a few years in the high-cost cancer drugs at the end of life. We are going to move back to these GP consortia making different decisions; we are going to move back to postcode rationing. It is very difficult to do that. The insurance company could say that it is up to individuals to decide themselves.

If you want high-cost cancer drugs at the end of life there is a choice between various things you might do. You might do that if you were allowed to pay, as Wynand said, a deductible, a charge. If you are prepared, for example, to pay £5 to see a GP, a trade-off for that was you would have cancer drugs at the end of life, but there are all sorts of ways in which these insurance packages might develop. In terms of the Commissioning Board, as Wynand emphasised, if you move towards insurance companies, they need to be regulated. It would be very important that they regulate entry into this market in terms of competencies and the ability to guarantee a duty of quality. You would need to maintain competition through the existence of a sufficient number of insurers and to provide detailed information that is available, as Wynand said. You need to make sure that we do not move to the problems of having uninsured people. We need to maintain equity through a risk-adjusted funding mechanism, and, as Wynand said, to have open enrolments so these new, competing insurers cannot refuse people who want to join them. You need to regulate insurers to make sure that they are solvent, and they are transparent in the packages they offer.

In terms of looking at the objectives that Andrew Lansley wants for the NHS, I think our argument would be that our proposal is more attractive both in the long-term and in minimising the risk. It is unlikely that a single body, the NHS Commissioning Board, will take the heat from Ministers, and it is much more plausible, to think that creating a system of multiple independent regulators, as the Netherlands have, is a much better way of doing that. In that way, the Minister could say, if a hospital gets into financial trouble that he expects the system to sort the problem out. We do not want GPs to be in the driving seat but to be involved in shaping services with insurers. By choice of managed competition, our belief is that, rather than have provider competition, you want to have a system in which people are choosing optimal ways of integrating services, and the way we have described would actually be evolution and not revolution.

Thank you very much.