Internal markets for surgical services: opportunity for trade in orthopaedics

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This article and the one that follows by Andrew Harris are the ninth and tenth in a series of articles on the white paper *Working for Patients* and its accompanying working papers. The series started on 18 February (p 437).

The white paper *Working for Patients* represents the cumulative achievement of the most radical free market proposals for the NHS since the government came into office in 1979.² Change has occurred in a step wise fashion through several measures designed to alter the cultural norms of the health service. Increased local accountability, quicker decision making,³ the identification of key decision makers,⁴ contracting out of non-clinical services, cost improvement schemes and efficiency through the resource management initiative have all played a part in preparing the NHS for these latest reforms. The government has stopped short, however, of full privatisation in the face of continued overwhelming public and professional support for a tax based, zero priced health care system.⁵

The NHS review has instead introduced several free market principles, such as greater consumer sovereignty and increased competition among producers, while remaining within a state run framework. Greater choice and diversity of services in primary and secondary care are to be encouraged, with value for money and efficient use of resources being the ultimate goals.

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District health authorities will become the procurers rather than providers of the most cost effective health provision for their population. The larger general practices will be able to shop around on behalf of patients for the services they require from the hospitals of their choice. Similarly, enterprising hospitals will be able to extend their role to the provision of services for a wider population unconstrained by arbitrary administrative boundaries. The cash following the patients is to be the new NHS maxim lending greater financial flexibility to health care delivery than could ever be envisaged (or coped with) under the rules of the Resources Allocation Working Party formula.⁶

Implications for orthopaedic surgery

Orthopaedic departments will be fundamentally affected by the proposed changes and particularly by the concept of trade between districts. Trade may occur between units in different authorities as well as directly between orthopaedic surgeons and general practitioners. These trading relationships are known as internal markets and will affect both the so called core hospital services outlined in the review—for example, accident and emergency—as well as other hospital services—for example, elective surgery. The volume of demand for both acute and elective orthopaedic surgery is such that we can expect to see the early establishment of such trading.

Elective orthopaedic surgery lends itself to the internal market business. Waiting lists and waiting times vary greatly between districts while the most common surgical procedures required are small in number and similar in most hospitals. The procedures

This paper is based on discussions held at a recent conference for general managers in the Yorkshire Regional Health Authority on developments arising from the NHS review. The innovation of internal health service markets—that is, trade in medical and surgical workload between health authorities—was considered and the clinical and economic consequences of such markets for orthopaedic surgery in particular were examined.¹

and outcomes are generally well defined and trade in this area will be seen by hospital authorities as a means of getting more out of existing resources, improving efficiency, and reducing waiting lists. It is also a policy that will probably win public support because it may be seen as a potential panacea for perhaps the biggest shortcoming within the NHS—long waiting lists for non-urgent conditions. Under what circumstances will trade take place and what are the practical difficulties?

There are several reasons why orthopaedic units may wish to trade with one another, but the primary reason is likely to be profit or the generation of additional revenue for the seller and savings for the buyer. At the margins of current output some districts may find themselves with the capacity to handle extra cases at little additional cost while charging their customers a price nearer to average cost. As for the buyers some authorities will want to purchase procedures outside their district at the given market price because they can be supplied more cheaply than undertaking them in house. Others may have different incentives to trade such as constraints on local capacity and pressure to cut waiting lists. Profit may not be the only reason for trade and entrepreneurs may have subsidiary goals—for example, to utilise spare capacity in order to retain economies of scale, to attract recognition for training, and to acquire grants to finance costly research.

Historical precedent

From an economic point of view there is a historical precedent dating back at least to Adam Smith's *Wealth of Nations* in 1776, which supports the theory that free trade leads to better allocative efficiency of national resources than can be achieved under a command or heavily regulated economy.⁷ Neoclassical economic theory has strongly influenced all Western economic policies, interrupted only by the post-war Keynesian interventionist era (during which the NHS was created). Vilfredo Pareto's theory that optimal social allocation of resources could be derived only by independently motivated consumers and producers exchanging goods and services in the market has dominated Conservative thinking on social welfare policy since the early part of this century.⁸

The main irony of the market as Adam Smith himself pointed out is that it is inherently unstable. Left to their own devices producers tend to collude against the public interest to attain even higher profits and greater market share. Nearly every market for a particular good therefore requires some form of regu-

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lation. There may be several reasons for this—for example, to prevent customer exploitation, improve consumer sovereignty, or ameliorate the side effects of undesirable productive activities on society. In some markets the scale of production required is so large and barriers to entry become so formidable that a single producer becomes a natural monopoly. In such cases there is little economic evidence as yet that current policy of deregulating these public enterprises promotes greater efficiency.⁹ It is early days yet for this policy in the NHS but much will depend on how and in what spheres competition is introduced. A sensible approach even for the most risk taking hospital would be the introduction of trade on a specialty by specialty basis, monitoring carefully the results of pilot projects.

Internal markets in orthopaedics may initially be restricted to low priority, high volume cases such as minor elective surgery. Subsequently, this may be extended to a trade in sophisticated and specialised procedures which are in the mutual interests of both parties to undertake. Nevertheless, in a more highly deregulated market some hospitals will wish to adopt a more aggressive outlook, undercutting their competitors, reinvesting profits as a means of growth, and expanding productive capacity to reap economies of scale. Units that start with an advantage in size, facilities, and skills are likely to do even better under these reforms. They may also pay higher wages to attract high quality staff by taking advantage of the new regulations on pay and conditions. The decline or extinction of orthopaedics in the range of specialties we have come to expect from most health authorities may even occur as workload is concentrated in fewer centres.

Trade is a two way contract and needs to be considered both from the buyers' and sellers' points of view.

Buyers' point of view

Whatever incentive there may be for buying orthopaedic services the procurers must firstly decide how much they have to spend and what types of surgical procedure are required. Do they want to buy minor or major procedures or achieve a particular balance of case mix? This will depend on the buyers' priorities—for example, are they trying to maximise a reduction in the size of waiting lists, in waiting times, or expenditure? They must also consider that contracting, say, all minor cases may leave their departments with an imbalance of major workload or vice versa. This will have subsequent effects on their own theatres and bed utilisation requirements. Other management responsibilities for the clinicians will be to ascertain much more specifically than may be known at present how much in house services cost for comparative procedures—particularly if greater efficiency is the overriding objective.

In purchasing orthopaedic services from another district or from the private sector health authorities will be concerned with ensuring acceptable standards of surgery and care that must at least meet those of their own department. Again this may not be as straightforward as it seems. To do this objectively requires a detailed audit of in house performance including assessments of operative mortality and morbidity and longer term results. The latter may be relatively easy to decide for minor procedures but for total joint replacement five or even ten year follow up data are required to assess the success or failure of the operation. In order to achieve a regular standard of quality of care it may be necessary to ensure suitability of patients by careful preselection in terms of age group, general health, and stage of the disease process requiring surgery.

Patients' preferences also need to be considered. An

agreement between two authorities 250 miles apart although financially attractive to the hospitals concerned may not be so convenient for the patient or the ambulance services. It will also impose substantial extra costs on patients in terms of travel, time off work, etc, not reflected in the officially agreed price.

There are two other important clinical considerations requiring attention by the purchaser. Firstly, how and for how long will patients be followed up after their operations? Will a formal contract stipulate whether this will be undertaken by the supplier or the originating orthopaedic department? Follow up will probably have to be split into immediate postoperative assessment and longer term review, particularly for major operations. Secondly, what would be the seniority of the surgeon performing the proposed procedure?

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Would it be an experienced consultant or a registrar in training and who would determine this? If the latter was the case would all hospitals be eligible to sell services or only those recognised by the Joint Committee for Higher Surgical Training?

Direct trade between health authorities, especially for elective surgery, may also require consultation with those general practitioners who have not negotiated their own arrangements with a particular hospital. Named referral will obviously be affected by this practice. It may also conflict with the wishes of those general practitioners holding practice budgets who will want to use the hospital departments of their choice.

Sellers' points of view

Those hospitals who see themselves as suppliers of treatment in these new markets will need to develop careful pricing policies. If the suppliers are charging a fixed price per operation in any one period (it will of course fluctuate in the longer term) the major incentive for them will be to minimise costs in order to maximise profit. We hope that because of professional standards this would not jeopardise quality of care but this will need to be monitored routinely both by supplier and purchaser.

Methods of minimising costs when setting a price are to place conditions on the selection of patients or to levy additional charges for unanticipated complications requiring extra care. These precautions minimise the risk of reducing profit or even making a loss by the supplier. Fortunately, the incentive to reduce risk also falls on the buyer who will not wish to incur undue complications in subcontracted patients and who will want to minimise expenditure. But surgery is a high risk business and some allowance for the completely unforeseen complication needs to be made when the supplier is fixing prices. Similarly, should a factor be incorporated for complications which may appear many years after the surgery—for example, low grade sepsis in a total joint replacement? American health insurance organisations who use diagnostic related groups to reimburse hospitals for treatment for standard conditions are trying to overcome the problem of deviation from the mean by more specific definitions of patient groups. Although not a complete solution to the problem, the corollary of internal markets might be the widespread introduction of a diagnostic related group system to enable better pricing and to control costs.¹⁰

The effect on nursing resources of selling substantial

numbers of operations must also be considered since these patients will have to be cared for in addition to local patients being treated simultaneously. This review would have to take place both at the ward and community levels. Hospitals which accept further workload will have to use existing establishments cautiously as many already suffer from low morale and staff shortages. Higher pay might attract additional good quality staff and help to retain existing staff.

Finally, what medicolegal obligations would the sellers assume? Would they be totally responsible or would part of this responsibility still be borne by the buyer? Subcontracting of patients would at least require a legally binding contract specifically setting out these responsibilities. This would be an appropriate role for regional health authorities in addition to the negotiation and administration of contracts.

Challenging times ahead

The NHS review will instigate a radical new free market climate in our health care system. It espouses the principles of consumer choice and value for money. Hospitals are to be encouraged to seek the most cost effective services available and will be free to offer services to their own and other districts in order to attract funds. Finance will follow patients and successful hospitals will thrive while there is a possibility that less successful ones will contract and even cease to exist.

The days of the local hospital having a natural monopoly on the provision of services to its population are numbered, even if that hospital does not choose to opt out of administrative control by the district. Hospitals and individual clinical departments will therefore depend to a varying extent on attracting business from wherever it may be found. In specialties such as orthopaedics where the demand for elective surgery is high fierce competition may be expected.

How smaller district general hospitals will fare against their larger teaching hospital rivals remains to be seen. Competition between hospitals of similar size may take the form of price or non-price wars with departments offering either a cheaper operation or one performed more quickly.

Though the discussion has been directed at orthopaedic surgery the same considerations apply equally to all medical and surgical specialties. When hospital departments begin to trade in internal markets they will be obliged to consider their position as buyer or seller of services (or both in some cases). They will have to face problems, such as the definition of product, pricing, constraints, clinical and legal responsibility, risk, etc.

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A GP's perspective

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The flaw in the white paper is that though the NHS review was set up as a result of political pressure about the NHS cash crisis, it produces no new funds.¹ But pleas for increased funding or protests about the hidden agenda of future privatisation, although justifiable, will be ineffectual. Mr Kenneth Clarke said in the Commons, "We shall, of course, listen particularly to the views of the public and the patients." He will not be negotiating with the medical profession for agreement, only to discuss operational details. The question now is, "Will the government's reforms improve services and choices to patients or not?" We should welcome some of the managerial and efficiency reforms, but highlight our concerns for patient care by urging our patients to speak out.

The proposal for tax relief on private health insurance for the over 60s—even if taken out by a relative—coupled with the Prime Minister's remark that those who can pay for themselves should not take up beds of others, is a clear indication that Mrs Thatcher views the NHS of the future as a safety net rather than a comprehensive service for all. Comprehensive cover for the over 60s with BUPA is about £2900 a year, an amount few can afford. Retired people who have such means should not be made to feel guilty about using the NHS nor should they need to consider private care if the government's proposals for

an internal market are successful. In a Gallup poll published in February 56% of pensioners were against the tax relief proposals intended for them, and I believe we should encourage them and organisations such as Age Concern to voice loud consumer protest.

Fundamental changes eclipsed

So much attention has been focused on the opportunity for hospitals to become self governing trusts that the fundamental changes in funding and provision of all health authority services has been eclipsed. Health authorities will be funded for the populations they serve, hospitals will be funded according to the services they provide, and general practitioners will be free to refer out of the district with the patient's own district health authority paying the hospital that the general practitioner chooses. While this will create increased choice for mobile patients who are not acutely ill, there are two dangers. Firstly, community health services for the chronically ill and elderly will wither. Secondly, the core services to which patients need to be guaranteed local access by the district health authority will be inadequate where the district health authority elects to use non-local hospitals for some services. I doubt that there will be many hospitals that opt to be independent trusts. While in the short term

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