



Mr Andrew Taylor  
Chief Executive  
NHS Cooperation and Competition Panel  
1 Horseguards Road  
London  
SW1A 2HQ

24 June 2009

Dear Mr Taylor,

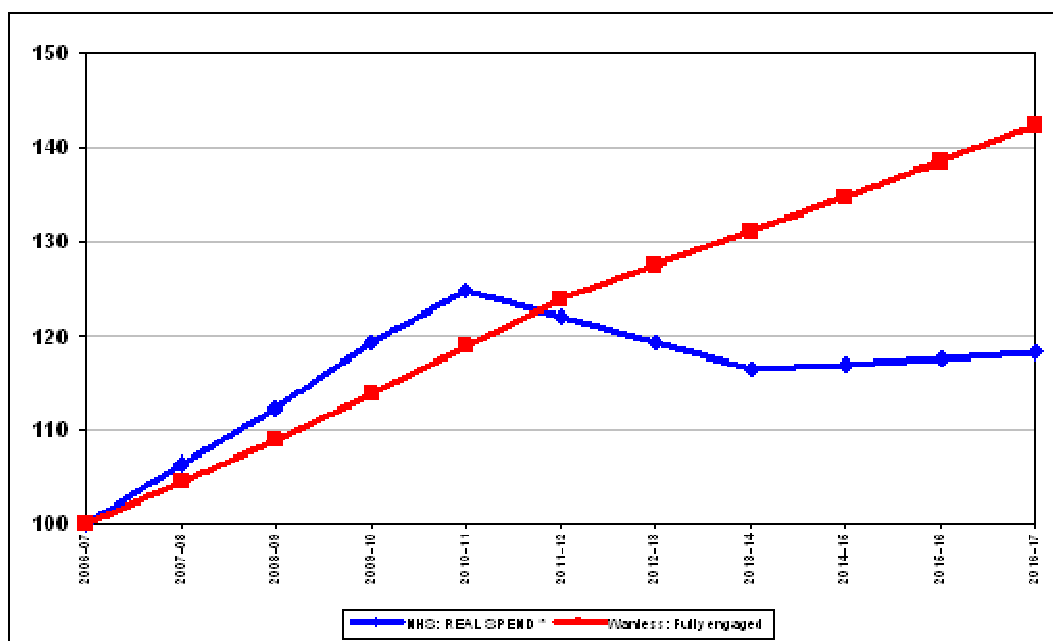
We welcome the opportunity to respond to the Panel's *Discussion Paper No. 2: Initial assessment of the presence and effects of restrictions on consultants' use of their non-contracted hours*.

We believe the Panel has accurately highlighted the principal issues around non-contracted hours (NCH) restrictions, and welcome the Panel's recognition that patient choice is undermined by restrictions on consultants' NCH activities.

We do respectfully however disagree with what we consider to be two fundamentally important conclusions that the Panel has drawn from the evidence it has assessed. As the vast majority of the evidence was provided by the Trusts who may benefit from a potential restriction, we are not concerned that the Panel had to include these in its assessment of the evidence presented to it. However, given the significance of these issues and the role of the Panel in clarifying them, we feel it is important to re-iterate the central arguments against restrictions on any providers to encourage productivity enhancement through workforce mobility, incentivisation and engagement. In the final analysis, it is such productivity enhancement that will lead to competitive advantage of any provider to offer better value to the tax payer and therefore become a more attractive choice.

#### **1. The imperative created by the current financial predicament**

It is important to consider the necessity of freedom of workforce engagement in the context of the NHS's looming funding shortfall. According to figures released by the Institute of Fiscal Studies (IFS), the gap between the current projections for NHS funding, and what Sir Derek Wanless, in his 2002 Treasury review, indicated would be necessary to maintain a world class health service will be annually £25bn by 2016/17 (please see the Kings Fund published graph below). The fundamental question that should concern all of us now is how to avoid such a catastrophic gap?



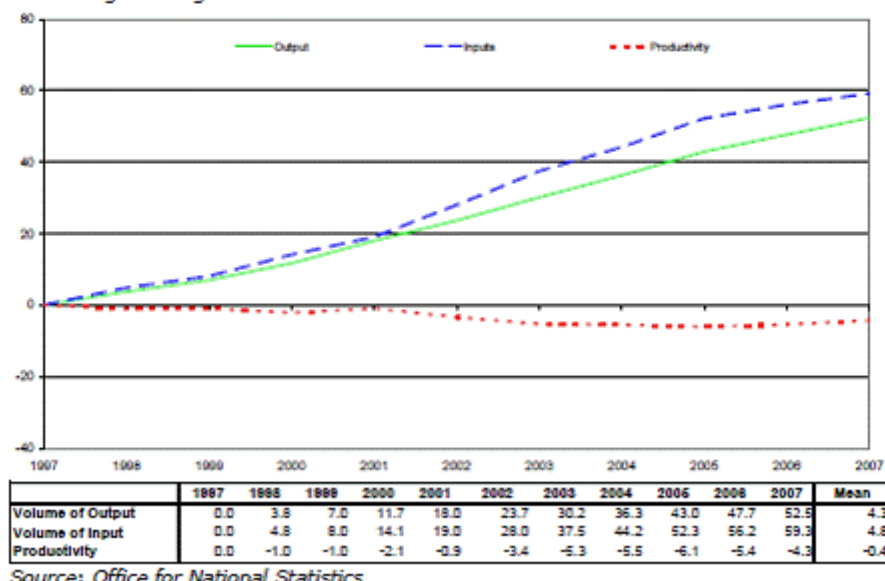
The solution to this gap is unlikely to come from a growth in expenditure. On one hand, it is difficult to foresee increasing public healthcare expenditure at a time of projected sustained and strained public finances. On the other, the incumbent private sector providers have largely lost their ability to access further investment capital. Most incumbent private providers are hindered by difficult debt burdens that resulted from their recent highly leveraged buy-outs and are in no position to invest.

In any case, it is wrong to assume that the gap should be filled by further investment. Value in healthcare should be defined by the following economic equation:

$$\text{Value} = \frac{\text{Quality}}{\text{Price}} = \frac{\text{Clinical Outcomes} + \text{Patient Experience}}{\text{Unit of Cost Expended}}$$

By the end of the current financial review, healthcare spending has risen from £37bn in 1997 to £111bn (ie, the denominator in the above value equation will have grown by almost three folds). Most would agree that during the same period clinical outcome and patient experience, while clearly improved, has not done so by a corresponding three-fold increase. A crucial issue for the 2002 Wanless review was the ability to do more (in both volume and quality terms) with each health care pound. But the unprecedented investment has left productivity almost flat as demonstrated by the report on total public service output and productivity published by the Office for National Statistics in June 2009. Calculating output is not easy, but the ONS thinks the average public sector healthcare productivity output in 2007 was 3.2% lower than in 1998. (please see the graph attached).

Figure 5.1  
**Components of healthcare productivity, 1997-2007**  
 United Kingdom  
 Percentage Change from 1997



An updated report by Wanless and the King's Fund in 2007 clearly found that the additional funding has not produced the necessary improvements. If the money that has been spent has not had the desired effect, the focus now should be on the nominator of the value equation; on cutting waste while improving quality, safety and patient experience.

To overcome the £25bn annual projected gap by 2016, our health services need to achieve almost 20% increase in productivity. While this seems difficult, again over the period between 1997 to 2008 according to Thomson Datastream, private sector productivity rose 22.8%. An analysis of this productivity growth in the private sector demonstrates that much of the gain has been achieved by new entrants. For example, an examination by the University of London of UK manufacturing plants in the 1980s concluded that the entry of new providers and the exit of old ones generated much of the efficiencies, and increased productivity by 50 per cent.

In our view therefore, the imperative duty of our current and future administrations, if we are to avoid such a catastrophic funding gap in our nation's healthcare, is to lower barriers to entry in order to encourage new entrants with new solutions. To this end, we believe the Panel's over-arching objective should be to issue guidance that allows the greatest number of new providers to experiment with new models of delivery that increase productivity. Two primary means of achieving productivity gains are workforce incentivisation and workforce engagement. Any restrictions on incentives offered to consultants or consultant engagement in management would deny emergent providers the tools to realise the productivity gains required to bridge the funding gap facing the NHS – a gap that ultimately will be borne by taxpayers.

## 2. The Role of Financial Incentives in the Healthcare Sector

In paragraphs 61-64, the Panel recites the contention of some Trusts that consultants should be restricted from working for independent providers in which they hold or receive a financial interest because a consultant may have an incentive to treat patients there during his NCH, rather than at his employing Trust.

The reality is that every healthcare provider offers some form of financial incentive to consultants. Whether in the form of cash bonuses, profit-sharing, consulting space and secretarial subsidies, equity, Clinical Excellence Awards, or state subsidised final salary pensions schemes, all providers use financial incentives to encourage consultants to work at their facilities. To bar some incentives but not others would be arbitrary and anti-competitive because it would unduly discriminate against the business model of some providers and deny them their chosen means to attract consultants to work with them. Fairness therefore dictates that financial incentives should be treated equally: either all should be available for providers to use or none at all.

Circle believes that a sense of ownership by all those who contribute to an effort is a powerful tool to enhance performance productivity. This is not purely a financial incentive, but ownership gives the ultimate power to each and every worker to exert control and be empowered to do their best. To this end, together with all its staff, from cleaners to nurses and consultants, Circle is also comprised of more than 1300 consultant partners each of whom holds a small equity interest in the company. Any restriction on NCH activities that arises from consultants simply holding shares would seriously limit our ability to enter new markets.

In our experience indeed, consultants are often equally if not more motivated by other forms of incentives like profit share, incremental additional cash payments or a generous pension scheme. In any case, if against all available data, to the extent that the Panel considers equity ownership to be somehow different than other commonly used incentives, then a proportionality rule should surely apply. Just as a consultant who holds shares in a medical devices company is not restricted from requesting equipment manufactured by that company, neither should a consultant be prevented from treating NHS patients at a provider in which he holds a very small equity interest.

### **3. The Role of Consultants in Management**

In paragraphs 52-54, the Panel distinguishes between clinical management and business management roles within independent providers. It suggests that it may be appropriate for consultants to assume roles in the former but the need for consultants to serve in the latter is “less clear.” Because most independent providers have been able to attract non-clinicians to serve in business management positions, the Panel suggests that restrictions on consultants serving in such capacities during their NCH would not impact patient choice. We respectfully disagree.

First, there is considerable overlap between clinical management and business management functions within healthcare providers such that they are difficult to separate. But the issue is not so much about distinguishing between clinical and business management roles. The issue is whether a consultant’s work at one provider poses a conflict of interest in relation to the consultant’s work at another provider. In our view, consultants should be able to provide clinical services in any facility irrespective of their non-clinical activities elsewhere because there is no inherent conflict of interest between clinical care and management responsibilities. A conflict only arises when a consultant who holds a management role at one provider (e.g., as a Medical Director) seeks to take up a management role at another provider. Of course, the consultant’s access to commercially sensitive information of two different providers would likely make the arrangement undesirable for both. But in such circumstances it should be left to each provider to decide whether to allow a consultant to serve in a managerial capacity. Existing legal and ethical considerations, together with the consultant’s obligation to disclose his activities to all providers for whom he provides services, provide sufficient safeguards and transparency to ensure any conflicts are appropriately addressed.

Second, the Panel’s observation that independent providers have been able so far to fill management roles with non-clinicians ignores the need to engage consultants in the management of care delivery. Although the presence of clinicians in managerial roles with NHS organisations has been limited to date, many within the NHS (including the National Leadership Council headed by David Nicholson) now

recognise the value of promoting clinical leadership in healthcare organisations. As Lord Darzi persuasively argued in his 2008 report, *High Quality Care For All*, greater involvement by clinicians in the management and delivery of healthcare services is key to driving improved standards of care and productivity gains that benefit both patients and taxpayers. Patient choice would be undermined were independent providers deprived of the expertise of consultants serving in management roles.

In closing, it is important to note that NHS consultants are a rare national asset, who irrespective of their channel of payment, in the final analysis, are funded by taxpayers. Indeed their education is paid by the state financed universities and deaneries, their salary is underwritten by the state (even in the case of the FTs, as no Trust has ever been allowed to fail, the consultants are assured that the state is ultimately underwriting their salary) , and their pension is guaranteed by the state irrespective of the future financial health of the institution through which they provide their service. As such, they should be indeed viewed as a national resource and therefore free to provide their services wherever NHS patients chose to be treated and wherever it is judged by patients and commissioners that the highest healthcare value is offered.

Sincerely,

Ali Parsa  
Managing Partner  
Circle

The Panel may make the contents of this letter publicly available.