

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



21 July 2009

Dear Mr Taylor,

Restrictions on Consultants' Use of Their Non-Contracted Hours
 Response to Notice of Possible Policy Recommendations

Further to my previous submission I would like to address the issue of financial incentives, and specifically make two points.

The Cooperation and Competition Panel was established to “help ensure that the Principles and Rules of Co-operation and Competition for the provision of NHS-funded services support the delivery of high quality care for patients and value for money for taxpayers.” The issue of non-contracted consultant hours is the first issue to be considered by the panel because it is accepted that consultant mobility within this market is an essential component for it to work. We argue that while the market is so immature the “normal” considerations of fidelity towards a single employer are inappropriate and would prevent its development particularly as very few consultants will abandon their salaries and pensions and resign from their current NHS employment. Consultants will be rewarded financially for the services they provide in facilities owned both by the NHS and alternative providers. Inevitably, while doctors work in more than one facility these have the potential to provide incentives to doctors to treat patients where they gain the most financially. But these “perverse incentives” have always existed within the NHS and transparency, patient choice and the existing professional regulatory framework are the tools that will ensure patients are treated appropriately.

Identical treatment of all financial incentives

In our view the fundamental issue for the CCPanel in this regard revolves not around these inevitable potential conflicts of interest but rather restrictions on different sorts of financial incentives. We would argue forcibly that all kinds of financial interest should be treated identically. Salaries, payment per item of service or profit share may all provide immediate cash payments for consultants while an equity share holding or discretionary points' contribution to final salary pensions provide delayed payment, but ultimately they **all** provide financial reward for participation in providing services and they **all** potentially offer “perverse incentives”. That some trusts choose to reward clinicians for the volume of work they undertake is undisputed and we can provide evidence that this is the case. As the market develops all providers will use different methods of rewarding consultants that achieve their business goals and these will include the productivity gains that will be so essential to the NHS over the next few years. The new consultant contract has given NHS trusts the tools to achieve these goals. Because of their position as consultants' primary employers and the NHS pension issue the barriers to entry into the UK healthcare market are formidable and we could argue that new providers should be preferentially treated. But we do not ask this, but simply that the panel does not choose to discriminate against any specific forms of financial incentive.

Equity participation and proportionality

Circle's business model is based upon the belief that employee ownership models are most likely to deliver the quality and productivity gains required of the NHS and we have previously submitted

evidence supporting this view (*NHS MUTUAL*, Nuffield Trust). The King's Fund/IFS publication this week "*How Cold Will it Get*" suggests that these will have to be in the order of 3.7-7.7% per year over the next decade, levels never before achieved by the NHS. To discriminate against this particular form of ownership at this time would in our view be deeply counter-productive to the greater needs of the NHS and tax-payers. Circle does not reward equity proportionally to clinicians for volume of work; rather 49.9% of Circle's equity will be rewarded over 10 years to the 3000 individuals who contribute to the company; an average of less than 0.2%. However we do accept that equity participation even at this level is not currently an option open to NHS employers and that they may therefore believe that this provides a competitive advantage to Circle and all the other partnerships in which clinicians have an equity share. In so far as the panel might agree with this argument, we would argue that a degree of proportionality is essential. It is accepted in UK company law that a "declarable and significant" interest in a company constitutes a minimum 5% shareholding. Below this figure a shareholder is considered to be "inactive"; at this level any perverse incentive is likely to be no different than that offered by other forms of financial incentive including salaries, professional fees and profit share. Therefore if the panel did choose to impose restrictions on consultants holding equity in alternative providers, while in principle we believe this would be wrong, we suggest that this is the level that it should be set.

Yours sincerely

Nicholas Boyle BM MS FRCS
Consultant surgeon and Partner