BRIEFING PAPER

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MANAGED COMPETITION

A NEW APPROACH TO HEALTH CARE IN BRITAIN

KING'S FUND INSTITUTE

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SUMMARY

In *Working for Patients*, its white paper on the reform of the NHS, the government has three main objectives: to improve value for money by strengthening systems and incentives designed to achieve greater efficiency; to make the service more responsive to consumers; and to continue to finance health services so that they are available on the basis of need and largely free to users. To achieve the first two of these aims, the government proposes to transform the NHS by introducing a system of managed competition, in which hospitals and other suppliers of health services will compete for contracts from health authorities and other purchasers of care.

Managed Competition argues that the white paper outlines an ambitious and high-risk strategy. Its success depends on striking a difficult balance between the stimulus of competition and the regulation needed to safeguard fair and accessible service provision.

The paper identifies six main themes underlying the white paper proposals: new institutional arrangements for the health services; the management of clinical activity; responsiveness to patients; greater pluralism among providers; better management; and new financial allocation mechanisms. In analysing them, it concludes that although the government proposals could help improve the use of resources and make services more responsive to users, there is a risk that they will result in greater inequities and reductions in accessibility if implementation is mishandled. Some of the NHS' strengths, such as low administration costs and comprehensive planning, may also be jeopardised.

Managed Competition lists a number of modifications which could avoid these dangers, including additional resources for implementation of the white paper changes and improvements to the capital stock; a slower implementation timetable; careful monitoring of the proposals in action; and safeguards for quality, including experiments with an accreditation agency. However, the briefing paper sees the changes outlined in *Working for Patients* as only one part of the wider health strategy that Britain must develop for the 1990s and beyond. By concentrating on management of the acute hospital sector and primary health care, the proposals leave many questions about public health, health services outside hospitals and the care of priority groups unaddressed.

1 INTRODUCTION

Debate about health policy in Britain in the 1980s has been dominated by three issues: how to determine the method and level of financing health care; how to improve the delivery of health services to make them more accessible, efficient and responsive to consumers; and how to take account of the wide range of economic, environmental and social factors which influence variations in individual health status.

The future financing of health services was actively discussed during the first part of the Prime Minister's Review of the NHS. A range of ideas were advocated, including a much bigger role for private insurance and a switch from general taxation to social insurance . In the event, the government decided to retain the existing method of financing the NHS, a decision that was widely supported by independent analysts. This decision, however, does nothing by itself to resolve longstanding issues about the adequacy of funding for the NHS; the very question which gave rise to the establishment of the Prime Minister's Review.

The delivery of health services dominated the second part of the Prime Minister's Review and formed the basis of the key proposals in the white paper, *Working for Patients*. As we discuss below, the government intends to introduce competition between providers in order to increase the efficiency of health care delivery. In practice, the proposals contained in the white paper mainly affect acute hospital services, in particular non-emergency admissions, and family practitioner services. A crucial omission in the proposals so far is any decision about the organisation of community care services for the growing sections of the population with long-term and chronic disabilities.

The role of public health was addressed in part in the Acheson Report (1988). But this issue has been relatively neglected in recent debates on the future of health services. In particular, there is little evidence that the government is seriously committed to a broadly-based multi-sectoral approach to improving the general health status of the population or to tackling the persistent inequalities between different sections of the community.

Any assessment of the government's overall response to the key issues in contemporary health policy debate, therefore, has to conclude that they have fudged one issue, ignored a second and half-dealt with a third.

Nevertheless, *Working for Patients* does merit detailed attention because, partial as it is, it still signals the most far-reaching programme of change for the NHS since its foundation in 1948. The government appears to be in the business of transforming health services to promote three principal objectives.

- To improve value for money in the supply of health services by strengthening systems and incentives designed to achieve greater productive efficiency.
- To improve the capacity of the health care system to respond to the needs and preferences of consumers.
- To maintain the principle of financing health services so that they are available on the basis of need and largely free at the point of delivery.

The model of health care chosen by the government to achieve these aims is a system of *managed competition*. The government intends to increase efficiency in the use of resources by making hospitals compete for contracts from health authorities and GP budget holders. At the same time, the reforms aim to make services better managed, more responsive to patients, and to improve the quality of care provided.

Although the government supports the further development of the mixed economy of health, it is intended that public finance will continue to supply the major portion of health service funding for the foreseeable future. Tax relief on private health insurance is to be made available to those aged over 60 who want to take advantage of it, but for the majority of the population access to health services will be based on need and not ability to pay. The NHS will continue to be funded mainly out of general taxation and there are no new plans to extend user charges.

As the outcome of a wide-ranging review of the NHS, *Working for Patients* is significant in endorsing the basic principles of the service and acknowledging its considerable achievements during the last forty years. In particular, it is intended that the NHS should continue to be available to all on the basis of need and largely free at the point of delivery.

This conclusion will disappoint those who wish to see much higher levels of private finance and provision in health care. On the other hand, by proposing far-reaching changes within the NHS, the government has provoked opposition, particularly from organisations representing staff and patients. In short, the reform of the NHS has become an issue of intense political debate. This is dangerous territory for an Institute which prides itself on its independence and impartiality. But we are convinced that despite the plethora of comment so far – partly because so much of it is from vested interests – an independent assessment of the pros and cons of the government's proposals remains necessary. Our commentary takes the form of a constructive appraisal of how the proposals may be implemented.

Our starting point in examining *Working for Patients* is that the NHS has a number of significant strengths which should be preserved. Of fundamental importance is the provision of comprehensive services to the whole population on the basis of need. At the moment the majority of these services are of a high standard and are provided at low cost when viewed in the international context. Furthermore, only a small proportion of the budget is allocated to administration, enabling the bulk of resources to be used for direct patient care. A particular strength of the NHS is its well-developed system of primary health care. Many health problems are handled by GPs and their support staff and this reduces demands on more expensive hospital services.

Set against these strengths, the NHS has some obvious weaknesses. These include long periods of waiting in some parts of the country for elective surgery, the poor quality of care for people with a mental handicap, mental illness and physical disabilities, and a lack of responsiveness to patients and the public. The NHS also contains few incentives

for resources to be used efficiently at the micro-level within global budgets. There are wide variations between hospitals in terms of such variables as length of stay of patients in hospital and costs per case. In addition, GPs differ significantly in their prescribing habits and referral rates. Although the available statistics should be interpreted with caution, there is *prima facie* evidence that performance could be improved.

Against this background, the test to be applied to the government's strategy is will it result in the weaknesses of the NHS being tackled whilst preserving its strengths? Potentially, a number of the white paper's proposals could help to improve the use of resources, and stimulate greater responsiveness to patients. On the other hand, the use of incentives to change the behaviour of doctors and hospitals could result in greater inequities and a reduced access to some services. Nearly everything depends on the way in which the white paper is implemented and the safeguards that are built in to the new arrangements. In view of the magnitude of the changes proposed, and the corresponding uncertainty about their impact, it will be important to monitor carefully the operation of these arrangements to ensure that equity and access do not suffer in the quest for efficiency.

The most radical element of the white paper is the introduction of managed competition. By separating responsibility for funding services from their provision, the government hopes that providers will compete for contracts from health authorities, GP practice budget holders and private insurers. The aim is to turn health authorities into discriminating purchasing agencies, seeking the best deal for their residents by buying services from a range of public, private and voluntary providers. GPs who volunteer to hold practice budgets will act in a similar way for those services which they provide or purchase. This process will need to be carefully managed to ensure that appropriate services are available in each locality.

There is no reason in principle why the separation of responsibility for funding and provision should undermine the values on which the NHS is based. Indeed, by redistributing purchasing power, and by creating an arm's length relationship between purchasers and providers of care, it may be possible for health authorities and GPs to offer better services to their residents. At the same time, there is legitimate concern that the strategy of competition may distort priorities. This could happen if hospitals concentrate on providing services that are in demand by purchasers of care from outside their locality, such as elective surgery, at the expense of services that are needed by local people. There may also be a greater divergence in standards of care. For example, those GPs who are well organised and provide a good service to their patients may be able to develop their practices by becoming budget holders while smaller practices and single handed GPs fall behind. A further concern is that it may be difficult to ensure an integrated approach to service delivery if responsibility for hospital services, community health services and primary care becomes increasingly fragmented. This would be particularly harmful to geriatric and maternity services.

There is thus no doubt that the government has embarked on an ambitious, high risk strategy which could bring about real improvements to health services but also carries significant dangers. As the task of implementing change falls to the NHS itself, heavy responsibility rests on regional health authorities and district health authorities, as regulators and purchasers of care respectively, to manage competition in a way which minimises these dangers.

This task will be easier if more resources are made available. The Prime Minister's Review was set up in 1988 in response to a funding "crisis" experienced by health authorities. This crisis was manifested in widespread service cuts and ward closures as authorities sought to maintain expenditure within cash limits. Despite the extra funds allocated to the NHS during the most recent public expenditure negotiations, alleged under-funding of the NHS during the 1980s, in particular in the hospital and community health services, has not been satisfactorily resolved.

In previous work, we have argued that there is a strong case for increasing the resources allocated to the NHS (Robinson *et al.*, 1988). Evidence suggests that public expenditure on health services in the UK is lower than might be expected, both in relation to other developed countries and in terms of the government's own estimates of the cash required to meet the needs generated by new technology, the ageing population and service development. Specific requirements are a major investment in the capital stock, improvements in health services' wages and salaries to overcome labour shortages, and extra expenditure to tackle unmet need in areas such as waiting lists and community care. Moreover, additional transaction costs associated with recording and billing will arise in a system of managed competition. There is also a need for funding to support medical audit, resource management and other key elements in the government's programme. Unless more resources are provided for these purposes, there will be less money available for patient care.

In putting forward these arguments, we do not wish to suggest that there is no scope for using existing resources more efficiently. In view of the tight pressure put on support services' expenditure during the 1980s, the most promising areas for action are clinical practices, given well-established variations in performance between doctors and hospitals. Many of the white paper's proposals should enable progress to be made in these areas. The size of the savings that can be obtained from greater efficiency in clinical practices is difficult to estimate, but is unlikely to be sufficient – certainly in the short term – to overcome the funding shortfall that currently exists.

For this reason, we believe that extra resources are still needed. The minimum requirement is that the volume of resource inputs per head of the population available for patient care be maintained. If this cannot be achieved then it will be difficult to implement the white paper successfully, and the government will be vulnerable to the claim that accountants, lawyers and computer specialists are benefitting at the expense of patients.

2 PROPOSALS

In our view, the central idea in *Working for Patients* is that a system of managed competition should be introduced into the health services. This is to be developed through *new institutional arrangements*, in particular the establishment of district purchasing agencies, GP budget holders and self-governing hospitals. Alongside these changes, a series of measures will be taken to strengthen *the management of clinical activity*, including the extension of resource management, clearer job descriptions for consultants and the introduction of audit into hospitals and general practice. The government also wants to make services *more responsive to patients* by introducing new financial incentives, providing patients with more information, making it easier for patients to change GP, and increasing the consumer orientation of the service.

BOX 1
MAIN THEMES IN THE WHITE PAPER

- New institutional arrangements
- The management of clinical activity
- Responsiveness to patients
- Greater pluralism among providers
- Better management
- New financial allocation mechanisms

Although the main objective of the white paper is not to increase private finance and private provision, a number of the recommendations are likely to result in greater *pluralism among providers*. This is implicit in the expectation that GP practice budget holders and health authorities will purchase care from the private sector as well as the public sector, the encouragement to be given to joint ventures between health authorities and the private sector and the extension of competitive tendering. The white paper also aspires to *clarify and improve the management of services* by a range of changes from the Department of Health through to health authorities and family practitioner committees. Finally, financing for services will be distributed via *new financial allocation mechanisms* including the modification of RAWP to funding based on resident population.

The remainder of this section outlines the government's proposals within this framework. Readers who are familiar with the contents of the white paper may prefer to turn directly to our evaluation of it which begins on p. 13.

New Institutional Arrangements

One of the most important ideas in the white paper is that responsibility for the funding and provision of health services should be separated. This will take some years to achieve. Health authorities will assume the role of purchasing agencies, negotiating contracts with service providers. District health authorities may retain certain responsibilities in areas such as public health but their principal function will be to ensure that their population has access to a comprehensive range of high-quality, cost-effective services delivered through the contracts they place with providers. GPs will take on a similar role in relation to their patients for the services included within practice budgets. These new arrangements should result in greater competition among providers.

BOX 2
NEW INSTITUTIONAL ARRANGEMENTS

- Separation of funding and provision
- Self-governing hospitals
- GP practice budgets

Self Governing Hospitals

Self-governing hospitals will be established as NHS Hospital Trusts. Initially, the white paper specifies that a number of acute hospitals with over 250 beds will be the most suitable candidates. In the longer term, other hospitals and services will become eligible.

> *There will be no rigid definition of what a 'hospital' should be for the purposes of self-government. For example, it will often be sensible for a self-governing hospital to run a range of community-based services and indeed there might be a self-governing community unit. Similarly, neighbouring hospitals with complementary services may wish to combine into a single management unit, where this is consistent with maximising choice for patients and GPs* (Working Paper 1, p. 4).

As an increasing number of hospitals and services become self-governing, it is likely that DHAs will merge to form larger purchasing agencies. The white paper also envisages the possibility that these DHAs might merge with FPCs. Depending on the pace of change, this could result in the creation of a limited number of unified health purchasing agencies by the mid-1990s.

It is intended that there will be a simple, flexible process for achieving self-governing status. Candidates will have to demonstrate that they have effective management, and that senior professional staff, especially consultants, are involved. RHAs have been given responsibility for guiding and supporting hospitals to achieve self-government, including publicising proposals and consulting interested parties. The final decision on an application for self-governing status will be taken by the Secretary of State.

NHS Hospital Trusts will have considerable freedom to manage their own affairs. This includes the ability to employ their own staff, set rates of pay, borrow capital, and dispose of assets. Trusts will be

funded through contracts negotiated with purchasers of care. The government hopes that this will create an incentive for hospitals to provide services which are cost-effective and responsive to consumer needs. Hospitals which prove popular will attract extra resources and will be able to develop their facilities. Equally, hospitals that are unpopular will have to improve performance or risk going out of business.

The government has emphasised that emergency treatment should be available at all acute hospitals including Hospital Trusts. In addition, essential core services must continue to be provided to local people. Each DHA has a responsibility to define the core services to be provided locally and RHAs are responsible for assessing whether appropriate arrangements have been made when applications for self-governing status are put forward.

GP Budget Holders

The other means by which competition is to be stimulated is through the introduction of practice budgets for GPs. Initially, practices with at least 11,000 patients will be able to volunteer to hold budgets for a defined range of hospital services. These services comprise out-patient services, diagnostic tests, and in-patient and day case treatments for which there is some choice over the time and place of treatment. Budgets will also include allowances for practice team staff costs, improvements to practice premises and drugs.

As in the case of self-governing hospitals, RHAs have been given responsibility for considering applications for GP practices to hold budgets and for determining the size of the budget. The element of the budget concerned with the hospital services will be deducted from the relevant DHA allocation.

A key issue will be the determination of practice budgets. The aim is to base budgets on the number of patients on the practice's list, weighted for the health and age distribution of the population. The government has emphasised that an upper limit of £5000 will be placed on the cost of hospital treatment for any individual patient which a practice has to meet from its budget.

As purchasers of care, DHAs and GP practice budget holders will be expected to use their resources to seek the best deal they can for their patients. Contracts will be negotiated with the private sector, NHS Hospital Trusts and directly managed NHS hospitals. These contracts will cover both core services to which patients need guaranteed access and other services where there is some choice over the time and place of treatment.

Three kinds of contracts are envisaged: block contracts, cost and volume contracts, and cost per case contracts. Under block contracts, the GP or DHA will pay a hospital an annual fee to provide a defined range of services. Under cost and volume contracts, hospitals will be funded to provide a given number of treatments or cases at an agreed price. Under cost per case contracts, payments will be on a case by case basis.

The Management of Clinical Activity

A theme that runs throughout the white paper is the need for doctors to become more accountable for their performance. In the case of hospital consultants, considerable emphasis is placed on the closer involvement of consultants in the management of hospital services. The key proposal here is the extension or roll-out of the Resource Management Initiative (RMI). The first stage of this process has already been announced, involving preparation for resource management in 50 acute hospitals during 1989. Later in the year, the government aims to extend the full RMI process to 20 hospitals with the aim of building up coverage to 260 hospitals by 1992.

> *This is an ambitious timetable, but the government remains committed to introducing modern information systems to support both clinical and operational functions in hospitals* (White Paper, p. 16).

BOX 3
THE MANAGEMENT OF CLINICAL ACTIVITY

- Roll out of resource management
- Medical audit
- Managers to be involved in consultant appointments
- Managers to agree job description with consultants
- Managers to participate in decisions on distinction awards
- DHAs to manage the consultant's contract
- New disciplinary procedure for consultants

Linked to the extension of resource management, the government is seeking to establish audit as a routine part of medical practice. To encourage audit, it is proposed that by 1991 a medical audit advisory committee will be in existence in each district, chaired by a senior clinician. The committee will work with the general manager to ensure that an effective system of audit is in place. The general manager will also be able to request an independent professional audit where there is a question of the quality or cost- effectiveness of a service.

Most of the interest in medical audit in recent years has focused on hospital services, but it is no less important in primary health care settings. It is intended that *"a comprehensive system of medical audit covering all general practices (will be) in place within three years"* (Working Paper 6, p. 11). It is recognised that there are important differences between medical audit in hospitals and primary health care, but the government is confident that *"audit in general practice is now a practical proposition"* (Working Paper 6, p. 11). Each FPC will be required to establish a medical audit advisory group to lead, support and encourage peer review and self-audit by individual GPs and practices. In addition, FPCs will

set up small teams of *"doctors and other staff to support and monitor the medical audit procedures of its practices"* (White Paper, p. 56).

One of the aims of these procedures will be to investigate variations in the referral behaviour of GPs. Another important role for the advisory group will be to assist FPCs in developing the proposed new system of indicative prescribing budgets.

As well as encouraging doctors to take action to raise standards, the white paper seeks to involve managers more directly in monitoring clinical activity. General managers will in future take part in the appointment of consultants, they will agree a clear job description with each consultant, and they will participate in decisions about which consultants receive distinction awards. Furthermore, the criteria for distinction awards will be modified to include a commitment to the management of services. In addition, disciplinary procedures will be simplified to enable disciplinary matters concerning consultants to be dealt with expeditiously.

Responsiveness to Patients

A central concern of the government is to make services more responsive to patients. In part, this means giving priority to customer relations strategies to promote better hotel services and appointment systems in hospitals. In addition, GP practices are to be encouraged to make available information about the services they offer, and it will be made easier for patients to change GP. More radically, the government would like the advertising of services offered by practices to become the norm.

BOX 4
RESPONSIVENESS TO PATIENTS

- Customer relations strategies
- Providing patients with more information
- Making it easier to change GP
- Advertising by GPs
- Financial incentives to GPs and hospitals

One of the most important proposals, however, is the use of financial incentives to encourage providers to offer services that patients want. In relation to GPs, the proportion of a GP's income derived from capitation fees is to be raised from 46 per cent to 60 per cent. In parallel, the establishment of a funding system for hospitals in which money travels with patients is intended to create a stronger incentive for hospitals to treat people as consumers.

In at least one area, however, the consumer voice is not being strengthened. Proposed changes to the membership of health authorities involve a reduction in public involvement in the work of authorities. On the other hand, community health councils (CHCs) are to be retained to represent the interests of the local community to health authorities and FPCs. CHCs will be able to visit hospitals which become self-governing, although the access of CHCs and the public to the meetings of Hospital Trusts will be limited.

Promoting Provider Pluralism

The contribution of private finance and private provision to health services has increased significantly in the last decade. This will continue as the government seeks to encourage greater partnership between the NHS and the private sector. Of particular importance is the use of NHS funds to purchase private treatment. A recent NAHA survey demonstrated that the waiting list initiative gave many health authorities experience of negotiating contracts with private hospitals and the white paper anticipates that authorities and GP budget holders will build on this experience in the new arrangements. Alongside these developments, support will be given to the extension of competitive tendering both in the case of support services and clinical services.

BOX 5
PROMOTING PLURALISM AMONG PROVIDERS

- Competitive tendering
- Capital charges
- Joint ventures
- Tax relief on private health insurance

To encourage fair competition between NHS hospitals and private hospitals for contracts, a new system of funding and charging for capital will be introduced. This will require health authorities and NHS Hospital Trusts to pay a charge for the use of their capital assets. As the white paper notes, the aim of capital charges is to *"place NHS hospitals on a more level footing with private hospitals"* (White Paper, p. 18).

A further proposal is that joint ventures between health authorities and the private sector should be encouraged. Examples cited in the white paper include the construction of a new NHS hospital on a green field site by a private developer in return for the site of the hospital it replaces; the shared development of hospital facilities by the public and private sectors; and leasing NHS land to a housing association to provide low cost accommodation for staff. The white paper states that:

> *The government expects all health authorities to consider the opportunities for cooperative ventures as part of their regular reviews of performance* (White Paper, p. 71).

The other main proposal designed to promote pluralism, and one of the most controversial aspects of

the government's strategy, is provision of tax relief on private health insurance premiums for the over-60s. Relief will be available both to older people and to family members who pay premiums on their behalf. This is intended to encourage individuals to continue private insurance after they retire and lose cover which may have been provided by their employer.

Better Management

To support the development of greater competition between providers, the white paper seeks to strengthen and clarify the management of health services. At the centre, this involves the appointment of a new NHS Policy Board, chaired by the Secretary of State, to replace the Health Services Supervisory Board. The Policy Board will be supported by the NHS Management Executive, chaired by the chief executive, which supersedes the NHS Management Board. The aim of these changes,

> *will be to introduce for the first time a clear and effective chain of management command running from Districts through Regions to the Chief Executive and from there to the Secretary of State* (White Paper, p. 13).

BOX 6
BETTER MANAGEMENT

- Policy Board and Management Executive
- New role for RHAs
- Delegation of decision making
- New membership of health authorities and FPCs
- Stronger management in FPCs
- Audit Commission

The role of regions will become much more important. RHAs will play a significant part in managing implementation of the government's strategy by guiding the introduction of self-governing hospitals and GP practice budgets as well as taking responsibility for holding FPCs to account. Regions will focus on the essential tasks of setting performance criteria, monitoring performance, and evaluating the effectiveness of health services. As a result, they will play a more limited role in the direct provision of services. The NHS Management Executive is expected to review all regionally managed services and to approve their retention at RHAs *"only if it is cost-effective to do so"* (White Paper, p. 14).

Throughout the government's proposals, there is a strong emphasis on the delegation of decision-making.

> *The government's objective is to create an organisation in which those who are actually providing the Service are also responsible for day-to-day decisions about operational matters* (White Paper, p. 14).

One example of the new streamlined approach is that the size of the membership of health authorities and family practitioner committees will be much reduced. Also, management in FPCs will be strengthened by the appointment of chief executives on salaries considerably higher than those of the existing administrators.

The other significant change to management arrangements involves new procedures for audit. The Audit Commission will assume responsibility for statutory external audit in order to bring greater independence to the review of health service performance. It will be given a wide brief to encompass value for money studies as well as more traditional forms of audit. The Commission's remit will extend to NHS Hospital Trusts and GP practice budget holders.

New Financial Allocation Mechanisms

The final set of proposals concerns financial allocation mechanisms. The proposal which has attracted most attention is the adoption of indicative drug budgets for GPs. In addition, RAWP will be superseded by a new resource allocation formula, and as part of this provision will be made for teaching and research.

BOX 7
NEW FINANCIAL ALLOCATION MECHANISMS

- Drug budgets
- A new approach to RAWP
- SIFT

Drug Budgets

Spending on drugs is the largest single element of expenditure on family practitioner services and the government has been concerned about the wide differences in costs – varying by more than 50 per cent per capita from one FPC area to another – and the belief that *"some prescribing is wasteful or unnecessarily expensive"* (Working Paper 4, p. 3). In future, therefore, this spending will be cash-limited and managed through drug budgets allocated to RHAs and FPCs, and indicative prescribing budgets at GP practice level.

> *The objective of the new arrangements is to place downward pressure on expenditure on drugs in order to eliminate this waste and to release resources for other parts of the Health Service. The scheme will be structured in such a way that patients will always get the drugs they need . . . It will ensure that budgets fully reflect these costs and that there will be no disincentive to practices to accept such patients or to begin to prescribe expensive medicine to existing patients, if there is a clinical need to do so* (Working Paper 4, p. 3).

The new proposals mean that the government will set an annual budget for drugs, although this might be adjusted during the course of the year if exceptional

circumstances, such as an influenza epidemic, require such a response. Once the expenditure ceiling has been determined it will be allocated to RHAs, and then to FPCs, on the basis of a weighted capitation formula.

> *This will take account of the age and sex of patients, morbidity, temporary residents, and cross-boundary dispensing. The NHS Management Executive will discuss with interested parties the relative weights to be attached to these factors and any other factors found to be of general application* (Working Paper 4, p. 6).

In addition to determining the basis on which allocations are made to RHAs, the Management Executive will develop guidance for FPCs *"on how to establish a policy for assigning indicative budgets to practices"* (Working Paper 4, p. 7). It is recognised that some factors which influence prescribing by GPs – such as referral rates and the needs of patients for unusually expensive drugs – cannot be incorporated into a FPC-wide approach, and that a sensitive and flexible policy will have to be developed.

It will take some years to develop both the technology and the expertise fully to implement indicative drug budgets. But eventually it is intended that GPs should face incentives and sanctions in relation to their prescribing behaviour. Fifty per cent of achieved *"savings"* in drug spending will be retained by FPCs to help improve primary health care in their areas. On the other hand, if GPs fail to modify extravagant or wasteful prescribing behaviour – *"and where discussion/education/peer review has no effect"* (Working Paper 4, p. 14). – they will face financial penalties.

Post – RAWP

Another significant proposal is that the RAWP system should be modified so that allocations to health authorities are based on the size of the population weighted for health and age. Cross boundary flow adjustments will end and health authorities will eventually pay for their residents to be treated in hospitals outside their boundaries through negotiated contracts. Under the new system, however, purchasing districts will be encouraged to rethink where they place service contracts.

Allocations to RHAs will be made on this new basis from April 1990. For cross boundary flows, adjustments will be made to regional allocations from the financial year 1990-91 by agreement on the basis of current patient flows. This will be followed by direct cross charging from 1991-92 which will increasingly reflect contract funding of self-governing hospitals and GP practice budgets as well as charging between DHAs. The white paper acknowledges that it may take some time before full charging between DHAs is achieved, allowing them to move fully to a capitation basis, but it is intended that from 1992-93 DHA allocations will take account of cross boundary flows.

Teaching and Research

The new allocation formula does not take account of the services and costs which have hitherto been directly funded by RHAs or the DoH such as the costs associated with teaching, research and training and for specialised health services. The government considers that these should be placed outside pricing decisions made by DHAs and GPs.

For teaching, the government envisages that provision will continue to be made for the additional costs of medical education. Working Paper 2 states that *"ring fencing of an amount related to the continuing cost of medical teaching will be needed in the future"* (White Paper, p. 18). This will involve maintaining the service increment for teaching (SIFT) element of RAWP. In this way, the direct costs of *undergraduate* medical and dental education will be met. However, Working Paper 2 makes it clear that SIFT will not cover the additional costs which result from a more complex case mix required for teaching purposes, and these costs will have to be met by appropriate pricing of service contracts. The working paper also emphasises that hospitals should not cut back on post-graduate training in order to achieve cost reductions.

No decisions have been made on the funding of research but for specialised supraregional health services such as heart and liver transplants and spinal injuries the centre will cover fixed costs leaving variable costs to be met by DHAs.

3 ISSUES AND PROBLEMS

A number of the government's proposals could help to improve the use of resources and stimulate greater responsiveness to patients, but there is a risk that the strategy of managed competition will result in greater inequities and a reduction in the accessibility of some services. This section of the report identifies the key issues and, where appropriate, suggests modifications to the proposed approach.

New Institutional Arrangements

The new institutional arrangements offer the prospect of hospitals competing for service contracts from district health authorities acting as purchasing agents, from general practitioner budget holders, and from private patients and insurance plans. How will this new health care market work?

The rationale underlying the proposed market is that competition will stimulate efficiency and enhance consumer choice. In particular, hospitals which are able to provide high quality, cost-effective services will be expected to obtain funds for expanding workloads. This contrasts with existing allocation arrangements in which cash limits often penalise efficiency by restricting a hospital's ability to use its capacity to the full.

Whether or not these expected advantages materialise will depend on the way in which the proposals are implemented. From the many questions that have been raised, we have selected three issues which merit particular attention. These concern:

- The balance between competition and regulation;
- The impact of competition on NHS wage and salary levels;
- The role of new-style purchasing agents.

Competition and Regulation

Under the right conditions, competition between rival firms is capable of providing an efficient allocation of resources. The main problem within the health care market is that these conditions may not apply. The need to ensure that wider social objectives are met may mean that government regulation will modify the incentive structure upon which competition depends.

The way in which newly introduced capital charges are likely to be dealt with illustrates the problem. The white paper proposes that, from April 1991, health authorities will be charged for their existing capital assets and new investments. This is a sensible decision. It puts NHS hospitals on a level footing with private hospitals and encourages greater awareness of the value of capital assets. At the moment, capital assets are often treated as a "free good" and there is little incentive to utilise them efficiently. By levying capital charges, health authorities will be given an incentive to consider the relative costs of providing different services, including the optimum mix of capital and labour.

In practice, however, if hospitals are required to charge for their capital assets – including rental payments based upon their site values – wide variations in the cost of providing services at different locations will result. Hospitals occupying expensive, inner-city sites – particularly in London – would find their costs considerably above those of hospitals in suburban and/or provincial locations. The logic of the market would point to the relocation of services to less expensive sites in order to reduce costs.

. . . cost minimisation is not the only relevant objective.

But cost minimisation is not the only relevant objective. The need to ensure that certain core services are always made available locally means that market processes cannot solely determine location decisions. For this reason, the government will almost certainly offer subsidies to ensure the continued financial viability of many hospitals occupying high-value sites. Even when relocation is a long-term objective, subsidies may be needed to avoid short-term disruption of services over a transitional period. But the introdution of capital charging at least means that such costs and subsidies are explicit.

The tension between competition and regulation also arises in connection with the prices that hospitals will be allowed to charge for their services. Unlike the private sector, neither directly managed hospitals nor self-governing hospitals will have total freedom over their charges. The white paper states that they will be able to set prices at marginal cost, if they have unused capacity, but they may not cross-subsidise between services in order to engage in price competition. On close scrutiny, however, it becomes clear that this distinction is not at all easy to make either in principle or in practice.

In principle, marginal cost pricing is a way of maximising the benefits derived from the use of a facility by providing services to additional customers as long as they are prepared to meet the extra (marginal) costs involved through their consumption. It is a particularly suitable pricing policy in those industries where there are heavy sunk costs – which will be incurred whatever the level of demand – and a low level of operating costs.

In the case of the NHS, there is no ready way of identifying which users are additional and should not be expected to bear some of the fixed costs. And without the ability to demarcate patients in this way *marginal cost pricing will necessarily involve cross-subsidisation.* But without the flexibility for marginal costing the NHS will be open to predatory underpricing by the private sector.

In practice, it will be difficult to prohibit cross-subsidisation because of the problems of identifying costs accurately. With so many joint costs, the allocation of any cost item to a particular specialty or case-mix group will always involve a large element of judgement. The existence of cross-subsidisation will be a source of legitimate difference of opinion. *In view of all these difficulties, there is a case for arguing that NHS hospitals should be given the same commercial freedom over their pricing policies as private hospitals enjoy and not be subjected to additional forms of price regulation.*

Unfortunately, however, such a laissez-faire policy would also pose problems. Total freedom over charging policy for NHS hospitals that enjoy an element of monopoly power could lead to excessive prices and monopoly profits. A clear policy is needed on how much pricing freedom NHS hospitals will have and how to prevent unfair competition. One possibility is for DoH and RHAs to monitor actual prices charged to ensure that providers do not have an unfair advantage over purchasers.

Similar concerns arise in considering the way in which self-governing hospitals respond to the financial incentives with which they are faced. In a system of workload funding, these hospitals may concentrate on profitable services in demand by purchasers of care outside their locality at the expense of services needed by local people. In addition, competition may result in the concentration of services at a smaller number of hospitals able to provide these services to a higher standard and lower cost. If this happens, who will decide whether the trade off between efficiency and accessibility is worth making? A further risk is that in the absence of reliable data on the outcome of much of the care that is provided, hospitals will focus their attention on reducing the costs of services at the expense of quality.

. . . striking the right balance between competition and regulation will not be easy.

To raise these questions – and others could be added – is to illustrate the potential dangers of introducing market principles into a public service like the NHS. Anticipating possible criticisms, the white paper insists that self-governing hospitals will continue to provide core services to local people where no alternative exists. Ministers have also argued that the quality of care will be safeguarded through medical audit and the power that health authorities and GPs will be able to exert through the contracts they negotiate with hospitals.

But striking the right balance between the competition and regulation will not be easy. Constraining the competitive spirit by introducing too many safeguards may be self-defeating. Equally, allowing competition to be unregulated is likely to produce results which are inconsistent with the aim of providing accessible and comprehensive services. *Where the balance will be struck is unclear, but DHAs as purchasers of care and RHAs as regulators of the relationship between purchasers and providers will have a major responsibility to ensure that the underlying values of the NHS are not eroded in the quest for greater efficiency and enhanced consumer responsiveness.*

Wage and Salary Levels

Under the white paper proposals, self-governing hospitals will be given the freedom to determine their staffing levels, rates of pay and conditions of service. In determining rates of pay, they may use national agreements or they may opt for arrangements that suit their local labour market conditions. The government intends to remove what it sees as restrictive practices on pay and employment and to encourage a more competitive labour market.

Freedom to determine rates of pay can be expected to result in the emergence of wage and salary differentials between hospitals. Those hospitals which are successful in attracting service contracts will be in a position to offer higher rates of pay to attract staff. Hospitals faced with tight local labour markets will have the freedom to offer competitive wages and salaries. Conversely hospitals located in areas of high unemployment may find that existing national wage levels are above the market rate.

While this freedom over pay determination may work to the advantage of some self-governing hospitals, it could lead to worsening staff recruitment and retention problems for other NHS hospitals. Nursing staff, for example, may respond to opportunities to earn higher salaries in self-governing hospitals, especially if salaries in directly managed hospitals continue to be constrained by national agreements. This would exacerbate nursing staff shortages for some hospitals at a time when national recruitment problems are already a source of concern. Similar considerations may arise in connection with administrative and ancillary staff. In short, a competitive labour market may lead to winners and losers among hospitals and NHS staff.

A number of commentators have also pointed out that the greater freedom for individual hospitals to determine their rates of pay may well exert upward pressure on NHS spending levels (Barr *et al.*, 1989). One of the advantages of the NHS is its ability to contain total spending. A major reason for successful cost containment has been the monopoly power of the government as a purchaser of health service labour. If self-governing hospitals are given freedom to determine their own rates of pay this monopoly will be eroded. Of course, the government will still be able to control total spending through cash limits. But it will become susceptible to new pressures for increased funding to accommodate higher wage and salary levels.

Set against this argument, however, it is not entirely clear that the ability of the NHS to hold down wages and salaries has been an entirely favourable feature of its performance in recent years. Poor wage and salary levels have almost certainly affected productivity adversely through staff recruitment, retention and morale problems.

Defenders of the *status quo* have tended to point to the impact they fear the removal of the NHS monopoly as a purchaser of labour will have on doctors' earnings, in view of the fact that the supply of doctors is still tightly governed by the profession itself. The spectre of escalating medical earnings has been raised. But the pay of doctors is not a large part of total NHS expenditure. Moreover, any salary increases that NHS hospitals are likely to offer will probably pale into insignificance alongside doctors' potential for private earnings. To the extent that hospital consultants are

motivated by financial incentives, the opportunity for higher NHS salaries is unlikely to figure particularly prominently in their minds.

On the other hand, the scope for paying nursing, administrative and ancillary staff higher salaries is likely to be a far more important factor. At the moment many hospitals suffer from serious shortages of these staff, especially in areas where they are in competition with non-NHS employers who are able to pay more. These shortages constitute an important source of inefficiency. By offering more freedom over pay, it is at least possible that improved staffing levels and a better rewarded workforce will be a source of increased morale and higher productivity. *Whether or not increased productivity would be sufficient to offset higher costs would be an empirical question to be resolved through careful evaluation of the evidence.*

Purchasing Agents

Separating the responsibility for financing services from their delivery will involve a major change of role for district health authorities and GP budget holders. While the skills needed to negotiate service contracts are not entirely new to the NHS – they have been developed, for example, in the waiting list initiative – the form and scale of contract negotiation now proposed is of a different order. This will require a good deal of learning during a short period of time if health authorities and GPs are to become competent purchasing agents. *A considerable investment in training will be needed to assist staff to acquire relevant skills. The task of specifying contracts in such a way that quality and price standards are achieved is formidable and calls for a new style of management within the NHS. This may well involve recruiting staff from outside the health services as well as appointing individuals who have experience of contract negotiation to serve as non-executive members of DHAs.*

A related issue concerns the way in which health authorities use their budgets. The white paper creates the opportunity for authorities to think radically and imaginatively about what is really in the community's interest. In principle, there is no reason why an authority which has an arm's length relationship with providers should not decide to change significantly its investment in health services. Priority could be given to those surgical services likely to have a major impact on waiting lists; to assessment and rehabilitation of elderly people to achieve optimum use of in-patient services; and to health education and screening programmes to promote healthier lifestyles and prevent ill health. *Much will depend on the ability of authorities to recruit good Directors of Public Health to provide an analytical basis for decision making. Also, executive directors with skills in health services evaluation and technology assessment will be able to encourage a more discriminating approach to the use of resources.*

In the case of GP practice budgets, a number of changes can be anticipated. The more imaginative GPs will consider not just the cost of treatment but also the scope for developing the services they provide to patients. By basing budgets mainly on the number of patients served, the government hopes that GPs will respond more positively to their patients' needs. In much of the debate surrounding these changes, attention has focused on the restricted selection between hospitals likely to face GPs. But for GP budget holders, the proposals also open up the option of choosing alternatives to hospital treatment. Innovation can be expected to increase the variety of GP services and thereby enhance the choice facing some patients.

On the other hand, practice budgets face some obvious pitfalls. The most serious is that they may encourage GPs to be more careful about accepting high risk patients. Scheffler (1989) describes this danger as the "Achilles Heel" of the NHS reforms. He predicts that in a GP practice of 11,000 patients, it would take only 165 high user patients, or 1.5 per cent of the practice list, to cause a GP to overshoot his annual budget by more than 5 per cent – the margin which, if exceeded in two successive years, would place the continuation of his budget holder status in jeopardy.

Recognising this difficulty, the white paper proposes that practice budgets will be based not only on the number of patients served, but that capitation payments will be weighted to reflect, age, health and other characteristics. However, as Scheffler points out, a small number of patients generate a high percentage of practice costs and standard adjustments may fail to pick up these variations. A practice population of 11,000 may be too small to even-out higher and low-risk users. In the US, Health Maintenance Organisations (which also provide care on the basis of capitation payments) have difficulty in surviving if they have fewer than 50,000 enrolees. The white paper provision that any patient incurring more than £5,000 expenditure during a year will be financed from outside the GP budget reduces some of the risk of adverse selection. But it also removes some of the incentive for the efficient management of patient care. A more sophisticated approach would identify high-cost patients by diagnostic-related group and, subject to a confirmatory second opinion, reimburse GP budget-holders for their treatment at the current most cost-effective rate.

A related danger is that GPs will respond to budgetary constraints by under-treating patients or by providing inferior treatment. The government has argued that one of the safeguards against this is the freedom of patients to change GPs if they are dissatisfied. In practice, this freedom will be easier to exercise in some parts of the country than others. And even where a genuine choice of group practice exists, patients may find it difficult to judge the quality of service on offer. It should also be recognised that there

. . . a small number of patients generate a high percentage of practice costs.

appears to be little demand among patients to exercise choice, with *"convenience and tradition rather than an evaluation of available alternatives"* (Leavey, Wilkins and Metcalfe, 1989) being the key considerations in the

selection of a GP.

As in the case of hospitals, medical audit will be used to promote high standards of practice among GPs. This is a step in the right direction, but audit is essentially a form of self-regulation and the results will not be made available to the public. As we argue below, *more information about the quality of care in general practice should be published to enable patients to exercise the informed choice to which the white paper aspires.*

Bevan *et al.* (1989) point to yet another distortion of GPs' behaviour that could arise because of the budget holder proposal. Under the white paper proposals, practice budgets will be charged for elective care but not for emergency care. Often, however, the distinction between these categories is unclear. As a result there may be financial incentives for GPs to shift cases from elective to emergency care, or to delay admission for non-urgent cases (e.g. hernia) that could result in the condition becoming urgent (e.g. strangulated).

Despite vocal opposition to the white paper on the part of many GPs, it is likely that there will be enough volunteers to at least test out the government's proposals for practice budgets. In practice, those GPs who are already well organised and provide a good service for their patients are likely to be among the first to opt for a budget. This will leave smaller practices and single handed GPs operating as at present. This carries the clear danger that standards of care in general practice will diverge even further. And, consistent with the inverse care law, those patients whose needs are greatest will continue to receive a second class service.

The Management of Clinical Activity

Many of the government's proposals for strengthening the management of clinical activity are consistent with our own analysis of this issue (Ham and Hunter, 1988). We therefore welcome the general thrust of the recommendations made in this area. However, there are four substantial issues which give rise to concern.

- The pace at which the Resource Management Initiative (RMI) is to be extended.
- Insufficient emphasis on a broad range of performance indicators.
- The failure to establish independent mechanisms for quality assurance.
- The potential for lack of sensitivity and resources in the development of medical audit.

The decision to roll out RMI in advance of the results of the evaluation currently being conducted is unfortunate. Early reports from the pilot sites are encouraging, but it is premature to draw conclusions about the progress and impact of the initiative as a whole. Even in the experimental hospitals, resource management is far from being an established part of clinical activity, and its progress may be hindered if the approach taken does not recognise the complexities involved in undertaking change of this magnitude.

As experience with clinical budgeting and management budgeting has shown, the process of winning and retaining the support of doctors and nurses takes time. Resource management has so far been confined mainly to a handful of carefully selected demonstration sites where clinicians were in principle supportive. This support may need to be earned elsewhere, particularly if, as seems likely, it takes longer than anticipated to develop information systems to provide staff with reliable and intelligible data about their work.

Despite the clear leadership provided by the Department of Health, and the commitment of significant resources to support implementation, the timetable set out in the white paper for extending RMI throughout the NHS appears ambitious in the extreme. Indeed, by forcing the pace of change, the government risks losing some of the support and goodwill that has been developed in the last three years. The process of carrying people along cannot be rushed. The real value of resource management only accrues when sufficient time is allowed for management and information systems to be put in place in a way that is appropriate for the hospital concerned. Over-hasty expansion is likely to lead to a superficial approach. *We believe more time should be made available both to allow the lessons that emerge from the national evaluation to be assimilated, and to permit the essential groundwork to be done in those hospitals where the case for RMI has to be made rather than assumed.*

A separate concern is that there are insufficient safeguards to promote the quality of care. As we have noted, the government envisages that medical audit will help doctors and nurses to maintain high standards of professional practice. There is also a reference in the white paper to a need:

> *to develop and publish indicators of hospital performance which cover the quality as well as the efficiency of the services provided*
> (White Paper, p. 36).

However, this statement is not elaborated, and it is not clear how information about quality in the hospital service will be gathered and publicised. *Our own view is that high priority should be given to work in this area in order to develop data about the quality of the hotel aspects of hospital performance as well as clinical effectiveness.*

A number of instruments and indicators could be used for this purpose including patient satisfaction surveys, the analysis of complaints, and avoidable deaths. Recent experience in both the UK and the US in publishing mortality data by health authorities and by hospitals suggests the need for caution in using simple mortality rates to compare performance. But work is currently going on at the Freeman Hospital in Newcastle to develop measures of clinical outcome as part of RMI, and this appears to represent a promising approach.

A further issue concerns the absence of any proposals for a national health accreditation agency or inspectorate. In the US, Canada and Australia, the existence of accreditation agencies has provided a focus for the setting and review of standards. Elements of

such an agency already exist, for example, in the form of the HAS, and several organisations have argued for an accreditation agency to be established in the UK.

. . . there are insufficient safeguards to promote the quality of care.

Such an agency could be constituted on a voluntary basis through cooperation between health authorities, the professions and managers. Its principal role would be to use teams of experts to visit and report on the quality of care provided in hospitals and other health care facilities. This would be of assistance both for the purchasers of care, who would be able to call on the judgement of the agency in deciding whether to place service contracts, and for providers, who would be able to demonstrate that they meet specified standards of care through a licence or certificate granted by the agency.

To retain credibility, an accreditation agency would need to be scrupulous in maintaining its independence. It would also need to employ experienced professionals whose judgement is respected in the health services. These professionals might be joined by consumers who could contribute a user's assessment of quality. To examine the case for such an agency, we believe there is merit in a pilot study in two or three regions. The experience of these pilots would enable a judgement to be made about the desirability of a national organisation. *We would urge the government to consider giving support and resources to establish such pilots.*

The government's support for medical audit reflects growing interest in the quality of care on the part of both the professions and managers. In the case of hospital services, there have been several local initiatives, as well as national studies such as the *Confidential Enquiry into Peri-Operative Deaths*. The medical royal colleges have also promoted audit, as in the recent initiative taken by the Royal College of Physicians. The impetus provided by *Working for Patients* should help to maintain this interest but *it will be important to assure that adequate resources are provided by the government. The sum of £250,000 set aside in 1989 – 90 is welcome, and a continuing commitment of funds will be needed in the longer term if the interest and support of the profession is to be retained.*

The introduction of arrangements for audit in the family practitioner services raises rather different kinds of issues. Much of the discussion has so far focused upon "aberrant" prescribing and referral behaviour by GPs, and there is certainly scope for seeking to understand and modify inappropriate variations in these areas. It is crucial, however, not to lose sight of the need to monitor quality in general practice as a whole, especially given the complementarity and substitutability of different aspects of clinical practice. A good deal has been done by the Royal College of General Practitioners through its *What Sort of Doctor?* initiative and it ought to be possible to build on this in future.

A broadly-based approach to audit in general practice is essential if the co-operation and enthusiasm of the medical profession is to be obtained. At present, audit is the only proposal in *Working for Patients* to command widespread support among GPs. Given the potential goodwill which exists, serious attention should be paid to the assessment of quality which transcends simply the analysis of administrative data such as prescribing and referral statistics.

The size and complexity of the task should not be underestimated, but a number of suggestions have been made about how to make a start. One approach advanced by Morell, for example, recommends that:

> *general practitioners should contract with the family practitioner committee to provide services for a defined community of patients to a standard defined by the committee in consultation with the profession and consumer associations* (1989, p. 1006).

Allowances to practices would then depend upon the FPC's audit committee satisfying itself about the quality of care provided. Factors which ought to be taken into account include suitability of premises, availability of essential equipment, evidence of team work, and the range of services provided. The main question we would raise is the ability of FPCs to carry out these functions with the resources at their command. *It will take more than a change in the status of the chief executive and the membership to equip FPCs to deal competently with issues of this complexity in a short space of time. Once again, we are impelled to question not so much the direction but the pace of change.*

Responsiveness to Patients

Many of the proposals for making services more responsive to patients build on initiatives that are already under way. Nevertheless there are a number of questions which merit attention.

- Will the new NHS be sufficiently responsive to the needs and preferences both of individual patients and local communities?
- Will GPs have sufficient time to respond to patients' needs and demands?
- Do the government's plans introduce real choice for patients?

Much has been done since the Griffiths Report on general management to make the NHS more customer orientated. But the performance of health authorities and FPCs is still very variable, and the key challenge in implementing the white paper proposals in this area is to ensure that they are taken seriously throughout the NHS. This depends on the use of management review meetings to hold health authorities and FPCs to account for their performance. As research at York University has shown, the commitment of health authorities, and especially of FPCs, to consumer relations is uneven. The more progressive agencies have appointed senior managers to take responsibility for consumer relations, commissioned surveys of patient satisfaction, invested in staff training and

provided more information to the public. *The clearer line management arrangements for the NHS set out in the white paper should enable the centre to ensure that these practices are adopted more consistently at the local level.*

More fundamentally, the opportunity created by the white paper is for health authorities as purchasing agencies to emerge as a countervailing force to the power of providers. In principle, authorities could use their financial leverage to move the service in a direction that gives priority to consumer demands rather than provider preferences. Whether this happens depends on the ability of the executive and non-executive directors of the new authorities to see their new role as community advocates and to make strenuous efforts to find out what their communities want.

At first sight, the government's proposals appear unlikely to cast health authorities in the role of community advocates. The number of authority members is to be reduced, and those members appointed by local authorities will no longer occupy places as of right. Indeed, the white paper's recommendations have been widely interpreted as leading to a greater involvement by people with business and management experience in the work of health authorities, in place of individuals drawn from community groups.

Against this, the removal of doctors, nurses and other health professionals from authority membership, and the separation of funding and provision, creates a possibility that authorities will be able to avoid provider capture. Whether they will then be able to use their purchasing power to act in the community's interest depends on a number of conditions. *One of the most important is to recruit people to serve on the new authorities who are able to speak for the consumer interest in a professional way. A second is a*

Health authorities should be open and accessible to the community.

commitment on the part of authorities to test public opinion on expenditure priorities through surveys and other means. A third requirement is for authorities to be open and accessible to the community, both through public meetings and by encouraging the contribution of CHCs. Health authorities could use CHCs to help determine community needs and they could commission CHCs to provide an independent assessment of service quality from the patient's perspective.

In the longer term, as health authorities develop their new role and there is a more complete separation of responsibility for funding and provision, it may make sense to incorporate the functions of CHCs into health authorities. But before any decision is taken, some experience of the new arrangements in operation is needed in order to establish whether health authorities really are able to act as the community's advocate. It should be incumbent on health authorities to demonstrate that they are in touch with their communities and have made real progress in reflecting the public's views in their decisions. Unless this can be demonstrated, any suggestion that CHCs or their equivalents in the rest of the UK are redundant should be resisted.

Given the traditional weakness of the public's voice in the NHS, a case can be made for clarifying and strengthening the role of CHCs, at least during the period in which the new authorities are brought into being. At present, the performance of CHCs varies considerably, and they are not subject to any kind of formal review. As the bodies responsible for establishing and funding CHCs, RHAs could be given the job of appraising the performance of CHCs, perhaps with the assistance of experts in community participation from outside the region concerned. Those CHCs doing effective work could be rewarded with budget increases above the rate of inflation, while those CHCs performing below par would have their budgets frozen.

At the same time, the Department of Health should specify the rights and responsibilities of CHCs in relation to the new health authorities, FPCs and Hospital Trusts. In so doing, the Department should ensure that CHCs have adequate access to information and meetings, and have the staff and resources needed to monitor the new health care market in operation. As we suggested above, health authorities may choose to commission CHCs to provide an independent assessment of service quality but it is vital that in addition CHCs have core funding to allow them to carry out their duties effectively.

In the case of general practice, the main proposal for making services more responsive to patients is to place greater reliance on capitation payments in determining the income of GPs. A potential danger in this proposal is that GPs will have bigger list sizes and therefore less time to spend with individual patients. As a consequence, the quality of care may suffer. A recent study in Scotland indicated that shorter consultations are, *ceteris paribus*, likely to result in a failure to make a proper diagnosis and inappropriate prescribing (Howie, Porter and Forbes, 1989).

Against this, GPs who attract extra patients may choose to appoint additional support staff to assist them in their work. In this way, greater responsibility could be taken on by practice nurses, health visitors, counsellors and other members of the primary care team. This could result in the more effective use of expensive staff time, although *it will be important to establish whether patients are satisfied with a service where they see less of their GP and make greater use of support staff.*

On two issues the white paper makes claims which do not seem to be justified by the detailed proposals. First, it is suggested that hospitals should offer:

> *Clearer, easier and more sensitive procedures for making suggestions for improvements and, if necessary, complaints* (White Paper, p. 7).

As we have argued elsewhere (Ham, Dingwall, Fenn and Harris, 1988), reform of health service complaints procedures is long overdue. At present, these procedures are complex, fragmented and slow, and lack

the independence needed if patients are to be confident that their grievances will be properly investigated. Unfortunately, there is no indication of how hospital complaints procedures, particularly those involving complaints about clinical matters, will become clearer, easier and more sensitive, and clarification of this point is needed. *We would urge the government to come forward as a matter of urgency with proposals for reform.*

Second, one of the two principal objectives set out at the beginning of the white paper is to give patients greater choice of services. The provision of more information about the services on offer may help patients to exercise choice in future, but in many areas this choice will be between a more limited range of services than at present. In particular, the ability of GPs to refer patients to any hospital in the NHS – an ability which has admittedly been reduced as a consequence of financial constraints in recent years – will be more limited than in the past.

In future, GPs' referrals will have to be broadly consistent with the contracts negotiated by health authorities. These contracts are likely to be restricted to a small number of hospitals. The white paper envisages that referrals to other hospitals will be possible and health authorities will be expected to keep funds in reserve to meet the cost of these referrals. Whether these proposals are tenable in the long term remains to be seen.

Those GPs who hold budgets will have the freedom to refer patients to hospitals with which they negotiate contracts, but again this involves purchasers of care exercising choice on behalf of patients. And even with GP practice budget holders, referrals for services not covered by practice budgets will have to fit in with health authority contracts.

As we noted above, an impediment to patient choice in primary care is likely to be the incentive facing GPs to be more careful in their selection of patients. As Fleming (1988) has shown, young children, women and elderly people are relatively more expensive to treat than other groups. Faced with budgetary constraints, GPs may discriminate against high risk patients, thereby reducing choice. *The precise weightings applied to capitation payments will need to be finely tuned if GPs are not to favour younger, healthier patients at the expense of those who are older, sicker and more expensive to treat.*

Thus, on the issue of patient choice, the reality of the white paper falls short of the rhetoric. This reinforces the emphasis we placed above on the need for health authorities, and we would add GP practice budget holders, to test public opinion on expenditure priorities. *Specifically, when service contracts are negotiated or come up for renewal, the assessment of patients and of the public should form a key consideration in the decisions that are made.*

Also, as we argued in the case of primary care, patients should be given more information about the hospital and community health services available. This should include standardised data on peri-operative deaths and other outcome rates for surgical procedures, hospital cross-infection rates and similar indicators. Greater transparency about information of this kind will become possible as data collection within the health service becomes more sophisticated. If promoting consumer choice is genuinely a priority, the Management Executive must encourage local managers to provide information to enable patients to exercise this choice on an informed basis.

Promoting Provider Pluralism

At first sight, the white paper offers major new business opportunities for private providers. The expectation that purchasers of care will seek the best deal for their patients regardless of whether providers are in the public, private, or voluntary sector, opens up the possibility of the much greater use of public finance to support private and voluntary sector provision. In the case of acute hospital services, there is considerable surplus capacity among non-NHS providers, although there appears to be wide variation between different parts of the country. It can be anticipated that these providers will grasp the opportunities that have been created and will actively market their services to health authorities and GP practice budget holders.

The creation of a more enterprising and innovation-oriented mixed economy of health care could bring benefits, but there are a number of attendant dangers in the details outlined in *Working for Patients*.

- What are the implications of a level playing field in which there can be fair competition between public and private providers?
- Will joint ventures between the public and private sectors be of real benefit to the NHS?
- Is tax relief on private insurance relevant to the real needs of the elderly?

Whether private providers succeed in winning a bigger share of the market is an open question. The 1988 Health and Medicines Act gives health authorities power to generate income through the development of their services for private patients. This is likely to lead to stronger competition for private patients between NHS hospitals and the independent sector.

As we discussed earlier, NHS hospitals will be allowed to charge marginal cost only under certain circumstances, but the private sector which has excess capacity will not be so restricted. It seems possible that, on the basis of price, the private sector may squeeze out the NHS in relation to elective day surgery for example. Although the reduced price represents a gain in efficiency in the supply of health care overall, assuming the price does not subsequently rise, it will be achieved as a result of the greater freedom under which private hospitals operate. *There is a strong case for allowing NHS hospitals the same commercial freedom over pricing policies as private hospitals, subject to effective regulation in both sectors.*

The white paper makes it clear that in encouraging the development of the mixed economy of health the government wants to support cooperation as well as competition between different sectors. More specifically, various forms of joint venture are suggested, including the sale of NHS land to private

developers in return for the construction of new NHS facilities. *The use of unconventional finance of this kind is to be welcomed, provided that patients' access to core services is not reduced, for example, because of higher transport costs. These schemes should also be monitored to ensure that NHS assets are not traded at below market values.*

The other main proposal designed to promote pluralism is the extension of tax relief on private health insurance premiums to the over-60s. The stated rationale for this is to help retired people who were previously covered by their employers to continue to make use of private services. *In our view this proposal should be resisted.* The cost to the Exchequer is

Tax relief for private health insurance is a mistake.

significant (£40 million) and giving tax relief for particular people flies in the face of the fiscal policy pursued by the Chancellor of the Exchequer during the 1980s. Furthermore, by encouraging individuals to pay for private health care directly, the government is undermining the principle that services should be available on the basis of need and not ability to pay. This only serves to cast doubt on the veracity of its claim that it is committed to the NHS and has no plans to privatise the service.

Better Management

It is difficult to find fault with an intention to improve the management of the NHS, but it remains important to subject what is proposed to critical appraisal. There are three principal questions.

- Will the new arrangements for management of the NHS in Whitehall create a stable strategic framework free from trivial political interference?
- Is the implied level of investment in training and skills development sufficient to ensure that the human resources available are adequate to the task?
- Is the board of directors model proposed for health authorities suitable for its purpose?

Many of the white paper's proposals continue and extend developments initiated by the Griffiths report on general management. At the centre, the revised arrangements for a Policy Board and Management Executive should help to clarify responsibilities, although the experience of the Health Services Supervisory Board suggests that *a strong commitment on the part of both ministers and the non-executive directors will be required if the Policy Board is to provide national leadership to the Service.*

A more problematic issue concerns the willingness of ministers to stand back and allow the Management Executive and health authorities to implement national strategies in an intelligent, developmental way. The accountability of ministers to Parliament creates an incentive for them to intervene in matters that are properly the responsibility of others. As long as MPs ask detailed questions about the functioning of the NHS, ministers will feel obliged to make frequent requests to health authorities for information. There is little way around this given the current constitutional position of the NHS. On the other hand, it ought to be

Ministers must . . . focus on the broad direction of policy.

possible for there to be clearer strategic guidance. A key test here is whether ministers will agree to limit the NHS policy agenda to a small number of major items. Also important will be the style set from the centre where the focus should be on the substance of policy, giving health authorities space in which to innovate and experiment in the implementation of policies. *Above all, for the new arrangements to work effectively, ministers must avoid the temptation to issue prescriptive and detailed blueprints and instead focus on the broad direction of policy.*

A major responsibility will fall on RHAs to lead the implementation of the white paper at the local level. This includes guiding hospitals to self-governing status, overseeing the implementation of GP practice budgets, holding FPCs to account, and divesting themselves of responsibility for the direct provision of services. This amounts to a formidable set of responsibilities, many of which are new to RHAs. Furthermore, in the longer term, the role of RHAs is likely to focus on regulating relationships between purchasers and providers; ensuring that core services are available in each locality; guaranteeing the continued provision of education and research; and acting as guardians of the values of the service in the face of competitive pressures which may threaten these values.

The new role of RHAs calls for management skills and abilities of a quite different order to those that have been required in the past. A major programme of training and management development will be needed, as well as a recruitment strategy to bring in skills that are currently absent. Much the same applies to DHAs and FPCs in relation to their new responsibilities. *A commitment of funds for training and development on a significant scale by the government would signal recognition that the size of the challenge is acknowledged by ministers.*

The other major change to the management of the service is the introduction of the board of directors model. This change stems from the government's view that the existing composition of health authorities is inappropriate for providing the local leadership needed to implement the white paper. It is difficult to argue with this view. Despite the best efforts of the individuals concerned, health authorities have fitted uncomfortably with the introduction of general management, it has been difficult in many places to weld members into a corporate whole, and the influence of members over policy making has been intermittent and uneven.

The new role set out in the white paper makes it clear that it is the management responsibility of authorities which will be emphasised in future as the service becomes more business-like. This should fit

more easily with general management and with the contract culture that will emerge. The price to be paid, though, is a reduction in local accountability and less public participation. On the other hand, as we argued above, by separating responsibility for funding and provision, it may be possible for health authorities to take on a more active role as community advocates, provided that the new authorities include members who can speak for the consumer interest, are open and accessible to the public, and make efforts to test public opinion.

The evidence from commercial and industrial organisations suggests that the board of directors model is not a panacea. The performance of boards is extremely variable; many are dominated by their top executives; and non-executives often lack independence. To overcome these problems, *careful consideration needs to be given to recruiting the right people, providing training and development, organising the work of authorities to enhance the contribution of non-executive directors, and selecting chairmen of high calibre. A strong case can also be made for paying realistic fees to both chairmen and non-executive members.*

New Financial Allocation Mechanisms

The chief financial change in the white paper is the shift from funding providers of care to funding purchasers of care which we have addressed above. In this section, we view the financial allocation mechanisms as the basis on which purchasers of health care are allocated their budgets. The main changes envisaged are the adoption of indicative drug budgets for GPs and the replacement of RAWP. The questions raised by the government's approach are:

- Will the approach to drug budgets be able to transcend crude economising and take account of the impact of changes on the health of patients?
- Will the new approach to post-RAWP resource allocation ensure that variations in need are properly taken into account?
- Will the related proposals for teaching and research recognise their vital contribution to establishing and maintaining a more cost-effective NHS?

Drug Budgets

Encouraging GPs to think more carefully about prescribing within broad budgetary allocations makes sense. Drug expenditure, therefore, should be subjected to the kinds of resource constraints which apply elsewhere in the NHS. Nevertheless, there are a number of aspects of the proposals for drug budgets which need more careful attention. These include:

- Careful thought about the formula for allocating funds to RHAs/FPCs;
- The need to maintain the flexibility of indicative budgets at the practice level;
- Monitoring the impact of changes in prescribing behaviour on the general quality of care in general practice;
- Switching the emphasis in any evaluation of drug budgets from economy to cost-effectiveness.

It is proposed that a weighted capitation formula should be used for allocating budgets to health authorities. This is presumably based on the assumption that drug needs are a function of population characteristics. *But sole reliance on age and sex rates would be insufficient, and it is unlikely that standardised mortality ratios would be a good proxy indicator for morbidity in respect of primary care prescribing. Careful analysis, and almost certainly further research, will be essential.*

Given the uncertainties associated with the likely lack of sensitivity in any weighted capitation formula, it is of paramount importance that a crude approach is not adopted to allocations at the practice level, not least because, as O'Brien points out:

> *Population characteristics may explain only part of the variation in prescribing; several studies have shown that a range of characteristics of doctors are correlated with prescribing behaviour in addition to external influences such as promotion by the pharmaceutical industry* (1989, p. 945).

The government clearly recognises these complexities and it is essential that they be encouraged not to be tempted to move from indicative to binding budgets. Some degree of local flexibility is going to be required for many years.

Another point, mentioned above but worth reiterating, is that prescribing behaviour cannot easily be divorced from other aspects of the quality of general practice. Reduced rates of prescribing may increase pressure in other areas either at the practice level or elsewhere in the NHS. *Detailed audit of any single aspect of general practice such as prescribing, therefore, must be located in the wider context of the overall quality of primary health care.*

Finally, it is critical to improving the long-term cost-effectiveness of the NHS that the government does not fall into the trap of evaluating drug budgets solely by reference to how much money is saved. *As many other commentators have observed, what are required are properly conducted trials to assess the impact of the new policies on the quality of care and the health outcomes for patients.*

Post-RAWP

Issues on the replacement of RAWP are:

- What will be the exact basis of the new formula and what impact will this have on regional allocations?
- Is the timetable for implementation feasible?
- How will costs not reflected in the capitation formula such as teaching, research and training be covered?
- What are the implications of the aim of eventually funding GP practice budgets on the same weighted capitation basis?

The NHS Management Board's report on the review of RAWP recommended a revised formula which continued the methodology of weighting for health need on the basis of standardised mortality ratios (SMRs) but added a weighting for deprivation. The government has announced that it will take account of the review of RAWP in determining regional revenue allocations. In the absence of further information, it is

difficult to offer a detailed commentary on the new formula. At this stage, the principal concerns are the extent to which adequate allowance will be made for the relative costs of providing services in different parts of the country, the way in which morbidity and social deprivation are handled, and whether provision will be made for private health insurance coverage.

The timetable for implementing the new formula is ambitious: it envisages direct cross charging between regions by 1991 – 92 and the removal of cross-boundary flows for regions from 1992 – 93. Although this may be possible much will depend on the co-operation of the health authorities concerned and some flexibility may be needed especially if the revised formula as finally adopted proves controversial.

On the additional costs not reflected in the capitation formula, the direct costs of undergraduate medical and dental education will be met by the government. To set such costs outside the pricing mechanisms of service contracts is correct in principle, although the complexities in disentangling teaching and service costs are considerable. Similarly, allocations from central government for the fixed costs of supraregional health services seems the right approach. An early statement on the treatment of research costs is important to reduce uncertainty. But these additional non-capitation costs will not wholly be met by the centre: for example, variable costs of supraregional services and the costs arising from more complex case mixes in teaching hospitals will need to be met from pricing of hospital contracts.

The government acknowledges that moving to the capitation basis for DHAs will take some time. This is because there will be a significant difference in some cases between allocations based on existing utilisation rates and those based on weighted capitation. As in the case of allocations to RHAs, it will require considerable effort to ensure that the new budgets of DHAs are realistic.

4 CONCLUSIONS

Working for Patients outlines an ambitious and high-risk strategy. Its success depends on implementing managed competition in a way which is consistent with the underlying values of the NHS. A balance must be struck between the stimulus of competition and the regulations which are needed to safeguard the accessibility and equitable provision of services. Given the magnitude of the changes involved, we believe it is unwise not to test out the central proposals in a limited number of trials.

In fact, even though ministers have said there will be no experiments, that is in practice what the first batch of self-governing hospitals and GP practice budget holders will be. If significant problems emerge in the first phase it will be very difficult indeed to implement the strategy without modification in the rest of the NHS. Ministers have indicated as much in recent speeches, and we believe that a firm commitment to independent monitoring of the white paper's proposals in action would help to allay many of the fears that have been expressed.

The government should also reconsider the pace of change. The timetable set out for implementing resource management, establishing self-governing hospitals, setting up the new authorities, and creating a system of capital charges – to list just four of the white paper's proposals – is over-ambitious. We can understand the government's wish to make progress on its agenda for reform, but too hasty an approach will be counter-productive.

Further encouragement to the management of change would be greatly facilitated by a more honest appraisal of the resources needed for a modern health care system. These should cover the immediate costs of implementation, including the roll-out of resource management, implementing medical audit and installing information systems for trading purposes. In addition, a strong case can be made for extra resources to maintain existing standards in direct patient care.

Finally, an early announcement of the government's response to the Griffiths report on community care (Griffiths, 1988) is needed to fill the gap that exists in this area. A planning blight is currently hanging over community services and action is required as a matter of urgency.

There is one other issue of importance, namely the long term vision which lies behind the government's proposals. From one standpoint, *Working for Patients* can be seen as the first step along the road to a health care system in which public funds are used to purchase a basic health care plan but where increasingly citizens purchase additional services. This might take the form of mini-HMOs in which GPs would eventually hold budgets for all hospital services. Patients would be able to supplement the services available from GPs by paying directly for additional care in the form of physiotherapy for sports injuries, superior hotel services in hospital or regular health checks. Such a move may or may not reflect what a majority of people want. But it would look much more like a two-tier NHS than the one we have at the moment. We do not wish to be alarmist, but given the frequently expressed concerns about a 'hidden agenda', *the government ought to be much more explicit about the real scope for consumer choice in health care and its long term plans.*

As we noted in the Introduction, the white paper addresses one of the three key questions facing the NHS as it approaches the 1990s. It does not confront the future financing of health services – except indirectly in endorsing the current method of tax funding – nor does it tackle the issue of public health and healthy public policy. Our own view is that alternative methods of financing health care are likely to emerge again as an issue of debate. The pressures on the NHS budget will not go away, and this is likely to stimulate a renewed interest in the role of private health insurance, social insurance and supplementary sources of funding. As we have argued elsewhere (Robinson *et al.*, 1988), *there is a strong case for retaining tax funding of health services, although this may increasingly be supplemented by private financing, whether through insurance or direct payment.*

The future of public health and healthy public policy is more obscure. Given the limited interest in government, and the diffuse constituency for public health issues, it is difficult to see where the pressure for change will emerge. At the local level there is some prospect that the new Directors of Public Health will provide a focus for action, but on a national level the situation is less promising.

This suggests that the agenda of issues concerning the delivery of health care raised by the white paper will dominate debate for the foreseeable future. Our view on the white paper, in summary, is that it contains a programme which could help tackle the weaknesses of the NHS provided that there is proper monitoring, a more realistic timetable, adequate funding and appropriate safeguards for quality.

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