RESEARCH REPORT

6

COMPETITION AND HEALTH CARE

A Comparative Analysis of UK Plans and US Experience

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KING'S FUND INSTITUTE

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Ray Robinson,
King's Fund Institute,
November, 1989.

SUMMARY

The government's plans for the NHS are designed to produce a new style health market. Hospitals will compete for service contracts from districts acting as purchasing agencies, GP budget holders and private patients and insurance plans. This arrangement is expected to increase efficiency, widen consumer choice and improve the quality of services while maintaining universal access to them.

For such a major programme of change, the publication of these plans was notable for their lack of detail. Little clear indication was given about how the new system is expected to work in practice. Subsequent debate has raised a number of issues which will need to be resolved if the plans are to have any chance of success.

Obtaining increases in efficiency will require managers and doctors to work together far more effectively than they have done in the past. New freedoms enjoyed by self-governing hospitals, over staff pay and conditions of service, may act to their advantage but could place district managed hospitals at a competitive disadvantage. The introduction of capital charges offers the scope for improving utilisation of NHS estate and buildings, but could lead to unforeseen shifts in the location of services. The theory and practice of price competition remains uncertain in view of the NHS's virtually non-existent experience of it. And the transactions costs of drawing up contracts between buyers and sellers loom large among the extra costs of the new health market.

Lack of responsiveness to consumer preferences has been a major criticism of public sector suppliers in recent years. Rectifying this defect is a major aim of the government's NHS reforms. Whether or not this aim will be realised depends crucially upon the success with which GPs' preferences on patient referrals are incorporated into district based contracts with hospitals.

Ensuring quality of service is maintained in the face of pressures to reduce unit costs will be a major responsibility of districts acting as purchasing agencies. Similarly, ensuring universal access to a comprehensive range of services for all their residents will be another major task facing districts.

At the moment there is little or no UK experience or data relating to these major changes. This makes it extremely difficult to assess the likely performance of the new style NHS. In the light of this deficiency, a good deal of attention has focussed on a country that has actual experience of health sector competition, namely the United States.

During the 1980s, US policy makers have sought to encourage a market-based, competitive environment within their health sector. To achieve this aim, a number of changes have been implemented. For example, cost sharing arrangements have been extended to make consumers more aware of the real costs of their health care. Anti-trust legislation has been employed to remove various restraints on trade, thereby permitting greater competition between health care providers. And, probably most important of all, various managed care systems have grown up in competition with traditional private insurance/fee-for-service providers.

The main impetus for these measures has been a desire to contain spiralling health care spending. At the macro level, however, these policy changes have not achieved one of their main goals. The proportion of GNP devoted to health spending has continued to rise throughout the 1980s and reached over 11 per cent in 1988. This compares with about 6 per cent in Britain.

At the micro-level, evidence on the impact of competition between hospitals is more ambiguous. For most of the period, competition seemed to take place in terms of quality rather than price with the result that unit costs were actually increased. Very recent evidence suggests, however, that competition between hospitals facing discriminating purchasers is starting to moderate the rate of cost increase. Equally, though, the strong form of price regulation operated through the Medicare prospective payments system has also played an important part in moderating cost increases.

The pursuit of cost containment has not, however, been the only US policy objective. Ensuring that consumers have freedom of choice, that care is of high quality and that there is widespread access to it have all been important policy aims. The strategy of injecting competition into the system has been more successful in pursuing some of these aims than others. Freedom of choice has always been accorded a high priority in the United States and the growth of competition between financers and suppliers seems to have stimulated it further. On the other hand, greater attention to cost control has meant that hospitals have been less willing to subsidise patients who are unable to meet their bills. As a result, the 30 million Americans without adequate insurance coverage have almost certainly found it harder to obtain a decent quality of care. Whether the quality of care in general has suffered because of efforts to contain costs is unclear. Some research evidence suggests that cost containment measures have led to lower utilisation of health facilities, and one study even suggests that higher mortality rates have resulted from tighter spending controls. But other studies dispute that health outcomes have been affected adversely by competition and related strategies.

Applying US experience to the UK is far from straightforward. For one thing, policy concerns often differ between the two countries. Most obviously, the UK does not have a problem with escalating expenditure on health. Quite the reverse: the public expenditure planning process keeps a tight rein on aggregate spending – rather too tight according to many people.

On the other hand, there are areas of common concern where US experience is more relevant. Encouraging the efficient use of resources *within* the health sector is a case in point. At present there are few incentives for encouraging greater efficiency in the NHS. The US experience of supply side competition between hospitals offers some prospect that discriminating purchasing behaviour on the part of district health authorities and GP budget holders will encourage competition and greater efficiency among NHS hospitals. But even here a number of important qualifying factors need to be taken into account. For example, competition is likely to be far more tightly

regulated in the NHS than in the US; indeed, present indications suggest that regulation could be so tight that it stifles the very incentive structure necessary to increase efficiency through competition. Also NHS levels of spare capacity are lower than those found in the US making it more difficult for hospitals to compete for additional patients. Furthermore, districts will not need to compete for subscribers in the way that US insurers have to do and will, therefore, have less incentive to be sensitive to consumer preferences. Moreover, US evidence makes it clear that, whatever markets may offer in the form of greater efficiency in the supply of clinical services, they inevitably impose a heavy burden in terms of transactions costs.

The US experience of measures to extend consumer choice and increase access to health care is of limited relevance to Britain. There is little prospect that NHS patients will be given the degree of choice enjoyed by the majority of US patients. On the other hand, the continuation of a tax-financed, free-at-the-point-of-use system in Britain means that everyone will be provided with access to a standard of health care that cannot be guaranteed to all in the US.

The US initiatives designed to improve the quality of care and health outcomes are currently attracting a good deal of attention in Britain. Hospital accreditation and the specification of clear guidelines on clinical appropriateness for the treatment of patients are two such examples. Much of the impetus for these initiatives in the US came from a desire to contain costs. However, they are desirable policy instruments in their own right and offer some clear pointers for NHS districts in their role as purchasers of hospital services.

Taken overall, it has to be conceded that although the US provides a fascinating laboratory for assessing experimentation in health finance and delivery systems, its lessons on competition cannot be easily exported to the UK. Nonetheless, in the total absence of UK experience of health competition policy, this report demonstrates that US evidence can alert us to potential pitfalls and focus attention on key issues that will need to be addressed when implementing the new style health market in Britain.

1 INTRODUCTION

A constant theme of government micro-economic policy since 1979 has been a belief in the superior efficiency of the private sector. A central component of this belief is that it is the competitive environment within which private sector firms operate that provides the necessary incentive structure for achieving greater efficiency. This has, of course, provided the stated rationale for successive privatisation programmes within numerous sectors of the economy, even though doubts have been expressed by some researchers about the degree of competition that has actually been established (Kay and Thompson, 1986; Kay, Mayer and Thompson, 1986).

For most of the last ten years, however, the National Health Service (NHS) has not been greatly affected by these policies. No doubt the government has been particularly wary about questioning the basic structure of an organisation which successive opinion polls show continues to command deep and widespread support (Jowell *et al.*, 1987). As a result, incursions of competition into the service have been largely confined to tendering for the ancillary services of laundry, catering and cleaning (Ascher, 1987; National Audit Office, 1987a).

But this situation now seems almost certain to change. Following the intense debate over the government's health spending record which took place towards the end of 1987, an internal review of the Service was set up under the chairmanship of the Prime Minister herself (Timmins, 1988). The fact that the review team met in secret created an uncertain but radical atmosphere. An apparent openness to new ideas led to a flurry of proposals for NHS reform from health professionals, independent researchers, political think tanks, politicians and others.

Among these proposals, there has been a persistent school of thought which has argued for the introduction of more competition into the NHS. Moreover, in developing this case, many of the suggestions for ways of doing this have been based on US models of health care (Enthoven, 1985; Green, 1986; Peet, 1987; Butler and Pirie, 1988; Goldsmith and Willetts, 1988; Havighurst *et al.*, 1988). The White Paper, *Working for Patients* (Department of Health, 1989a), published at the end of January 1989 bears the clear imprint of these ideas. It offers the prospect of a new-style health care market with 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.

These proposals have, of course, already attracted widespread comment and debate (see, for example, Barr, Glennerster and Le Grand, 1989; Bevan et al., 1989; British Medical Journal, 1989; Ham et al., 1989; Higgins and Ruddle, 1989; Maynard, 1989; Nuffield Institute for Health Service Studies, 1989; Propper, 1989; Royal College of Nursing, 1989; Social Services Committee, 1989; Willetts, 1989). All early commentary on the government's plans, however, suffered from a fundamental difficulty. Namely, for such a major programme of change, the proposals were seriously lacking in detail. Only now are these emerging as the Department of Health (DOH) and the NHS work out the practicalities of the broad guidelines the government has set them. Even so, uncertainty about both the form of the plans and their expected impact remains a serious problem, especially as the proposals represent a move towards a system about which there is very little existing UK experience or data. This makes it extremely difficult to predict the likely performance of the new style health care market. As the Social Services Committee commented:

> *By changing the incentive structure in the NHS, a very wide range of predictable and unpredictable consequences are likely to result.* (Social Services Committee, 1989, p.5)

Despite this uncertainty, however, some informed assessment of the consequences of introducing market based competition into the NHS is possible. It has been pointed out already that US experience provided a good deal of the impetus for these ideas. It would therefore seem natural to seek to learn from this experience. Interestingly, though, the current US system does not provide a long established model for a competitive health care system. The US has itself only been the subject of a 'competition revolution' during the 1980s. As a result, widespread changes have taken place. Research evidence on the impact of these changes is only now becoming available. And so while it would be premature to expect US experience to be definitive, as well as naive to expect it to be directly applicable to the very different UK environment, it can, with suitable interpretation, provide some insights into what can (and cannot) be expected in the UK.

This is the aim of this report. It seeks to bring together an account of UK plans and US experience in relation to competition in health care. However, to make such a potentially mammoth task more manageable, the focus of the report has been limited in two important respects. First, the analysis of markets and competition has been confined to the short stay or acute hospital sector. This mirrors the government's main emphasis as far as the introduction of markets is concerned. Issues affecting primary care are dealt with only insofar as they represent part of the market for hospital services. Long term and community care are not covered in this report. Second, the impact of competition is analysed primarily in terms of its effect upon the efficiency or cost effectiveness of service delivery. However, recognising that neglect of other important health sector objectives would be a serious ommission, the report also considers the relationship between competition and patient choice, service quality and access to services.

The structure of the report is as follows. Section Two describes how the government plans to introduce competition into the NHS. In view of the numerous commentaries on these plans that have appeared already, no attempt is made to provide an exhaustive account. Rather, emphasis is placed on those components of the proposals that are germane to the concept of market competition. In the second part of Section Two the government's expectations of the new health care market are examined. Section Three looks at the way competition and other cost containment policies have developed in the US in recent years. It examines the demand and supply side changes which

are usually described as having led to the new competitive environment. This is followed by an analysis of the available empirical evidence in an attempt to assess the impact of these changes upon costs, choice, quality and access. Finally, Section Four relates US experience to changes that are planned within the NHS, and uses this evidence as a basis for assessing the strengths and weaknesses of the government's proposals.

2 MARKETS AND COMPETITION IN BRITAIN

THE PROPOSALS

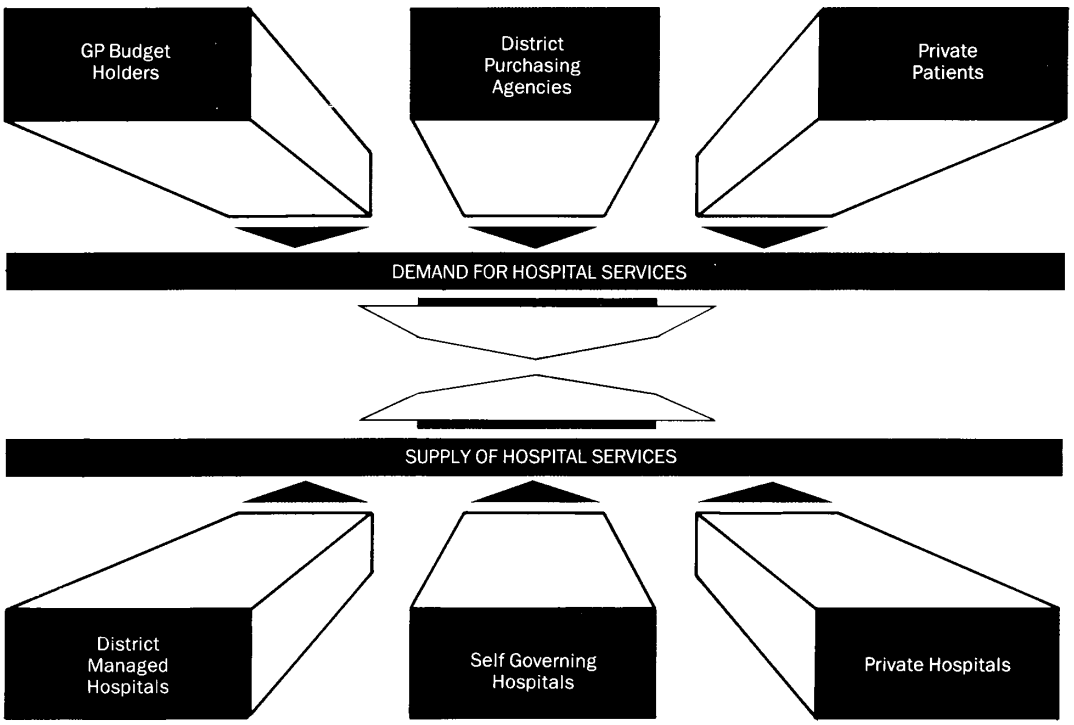
The White Paper, *Working for Patients*, offers the prospect of a new style health market in the United Kingdom (Robinson, 1989a). A system in which the allocation of expenditure is determined through a complex set of administrative formulae will be replaced by one that places far more emphasis on market-type transactions. On the demand side, budget holders acting as purchasing agents will be responsible for ensuring that the health care needs of their populations are met. On the supply side, devolution of decision-making power to individual hospitals is intended to offer them far greater autonomy than they enjoy at present. In short, important elements of the incentive structures facing consumers and providers in a market system are to be injected into the NHS.

Unlike a market, however, the new arrangements will not be used to determine the total amount of spending on health. The total DOH budget for the hospital and community health services will be determined as at present through the public expenditure planning process. Similarly, DOH cash allocations to regional health authorities will continue to be made on the basis of an administrative, needs-based formula, although a new weighted, population-based formula will replace the existing Resource Allocation Working Party (RAWP) formula. It is thereafter that the new market arrangements will come into play as the government's plans separate responsibility for the purchase of services from their delivery at the district level.

The purchasing arrangements will involve three main categories of budget holders. The major one, at least in the short run, will be existing district health authorities. They will receive annual cash allocations from their region – generally based upon their population size and its characteristics – and will be responsible for entering into contracts with providers for the delivery of services received by their residents. Ensuring an appropriate service mix is provided and monitoring its quality will be a part of a district's function. But they will not be directly responsible for providing services: increasingly this function will be devolved to individual hospitals.

The second category of budget holder will comprise selected general practitioners (GPs). Practices with at least 11,000 patients will be given the opportunity to apply for their own budgets with which they will be able to purchase selected hospital services. Over 1,000 practices will be eligible for budget holder status: this

FIGURE 1. THE NEW HEALTH CARE MARKET FOR HOSPITAL SERVICES
Budget Holders, Flows of Funds and Services



represents about 10 per cent of practices and about 25 per cent of the total patient population. Services they will be able to purchase directly on behalf of their patients include diagnostic tests, out-patient services and a defined group of in-patient and day cases, such as hip replacements and cataract removals. As in the case of districts, GPs who opt to become budget holders will be free to take out service contracts with hospitals of their choosing and, in some cases, to substitute their own services for existing hospital ones.

Finally, private patients and insurance plans can be expected to figure increasingly as purchasers of services. The government's only explicit incentive for greater private expenditure on health is the introduction of tax concessions on health insurance premiums paid by, or on behalf of, people over 60 years of age. This has been widely dismissed as a purely symbolic gesture which is largely irrelevant to the funding needs of the elderly. However, inclusion of this provision does signify continued support for the values underlying numerous ministerial criticisms of the low levels of private spending on health that have been made in recent years. How long these values will remain dormant is a matter for debate (Field, 1989).

On the supply side, there will be three main types of providers of hospital services. Initially, most hospitals will continue to be managed by districts, although it is intended that greater responsibility for operational functions should be delegated to individual hospitals.

Second, a new category of self-governing hospitals operating as independent trusts within the NHS will be created (DOH, 1989b). These play a key role in the government's plans. They will be given greater freedom over the employment of capital and labour than district managed hospitals. In particular, a major departure from current practice will be their power to employ consultants directly instead of having their contracts held at the regional level.

Third, there will be the independent sector comprising private, voluntary and charitable hospitals. The government has outlined various ways in which it wishes to see the expansion of the independent sector encouraged. These include: GP and district budget holders buying clinical services for NHS patients from the private sector, the extension of competitive tendering, and encouraging joint ventures between the NHS and private sector, especially in relation to the funding of capital projects.

THE EXPECTATIONS

Referring to its plan for the introduction of self-governing hospitals, *Working for Patients* stated that:

> *. . . a funding system in which successful hospitals can flourish . . . will encourage local initiative and greater competition. All this in turn will ensure a better deal for the public, improving the choice and quality of services offered and the efficiency with which these services are delivered* (DOH, 1989a, p.22).

This statement provides a convenient summary of the government's three main expectations of supply side competition: increased efficiency, more consumer choice and improved quality of service. To this list should be added a fourth objective; namely, ensuring equity or access to health care facilities, as this is an essential prerequisite of a service 'available to all, regardless of income' as defined in the Prime Minister's introduction to the White Paper. The remainder of this section will examine the reasons underlying the government's expectations of the new health care market in relation to each of these objectives, and look at some of the complications that may arise.

Efficiency

In the value-for-money context, the term efficiency is usually used to refer to cost-effectiveness; that is, the minimum achievable cost per unit of output. It is well known that firms pursuing financial objectives within competitive markets face an incentive structure which encourages the adoption of least cost methods of production. This is a major prerequisite for firms wishing to maximise profits, revenues or growth. Conversely, failure to achieve cost effectiveness will result in financial targets not being met and, in the limit, may result in a firm going out of business. This appears to be the model upon which the government has based its expectations concerning supply side competition.

Any examination of the way in which NHS services are provided at present will confirm that there is scope for increased cost effectiveness. Empirical evidence suggests that this may be achieved in at least two main ways.

First, there is often scope for using existing inputs more effectively to increase the volume of patient services, or to provide the same level of services with a smaller quantity of inputs. This involves the elimination of waste or what economists refer to as X-inefficiency. For example, a study of five district health authorities carried out by the National Audit Office (1987b) showed that only 50 to 60 per cent of daytime, weekday operating theatre sessions were actually used. Reporting on these findings – and the DHSS response to them – the House of Commons, Committee of Public Accounts commented:

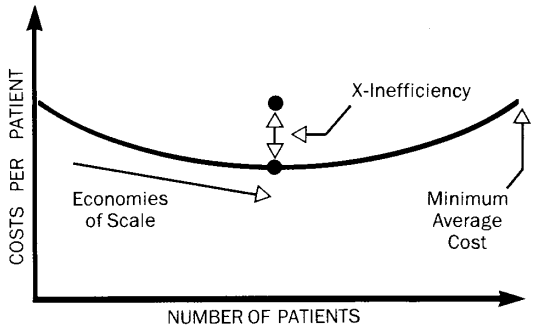
> *We acknowledge that the management of hospital resources is a complex task and that the use of operating theatres cannot be seen in isolation. However, we consider that the difficulty of achieving an exact balance between theatres, beds and staffing should not be used as a justification for failure to make best use of resources which are available and an excuse for low utilisation of theatres* (Committee of Public Accounts, 1988a, p.vii).

Failure to maximise the use of operating theatres, beds and staff time is also identified by Yates (1987) as one of the sources of excessive waiting times for hospital admission.

A second source of savings arises when there is potential for realising economies of scale; that is, more cost effective provision of services resulting from the concentration of delivery at a smaller number of centres. Although there have been surprisingly few econometric studies of health service, cost-output

relationships in the UK, those which have been carried out suggest a U-shaped hospital cost function with minimum costs reached at 430 beds or more (Wagstaff, 1989). At the moment only 23 per cent of hospitals in England have 250 or more beds (DOH, 1988). Practical experience also points to the scope for economies of scale. For example, experience gained through the provision of certain multi-district or regional specialties at a small number of designated sites suggests that there are likely to be further cost savings realisable elsewhere through greater rationalisation of service delivery.

FIGURE 2. COSTS AND HOSPITAL SERVICES



Both X-efficiency and economies of scale are essentially static concepts. They refer to the optimal use of resources in any given period of time. There is also, however, a need to ensure that resource use is optimised over time. This is usually referred to as dynamic efficiency. It concerns the responsiveness of suppliers to new production techniques and changing consumer tastes. The government believes that a market system encourages dynamic efficiency. This is thought to be particularly important in the health care sector with its rapidly advancing technologies and changing views of best practice in methods of care.

A final usage of the concept of efficiency arises in connection with the 'efficiency trap'. This term has been used to refer to situations in which hospitals that become more efficient, and reduce patient unit costs, are prevented from using the savings they have generated to the full because to do so would involve some extra expenditures and an overshooting of fixed budgets. The result is often unused capacity and widespread frustration among staff. Trade between districts is designed to overcome this problem. As the White Paper put it:

> *The Government is determined to change this* (i.e. the efficiency trap) *by making it possible for money available to treat patients to move freely to the hospitals which offer patients the best service and the best value for money* (DOH, 1989a, p.30)

All of these factors suggest that there is scope for greater efficiency within the NHS. Indeed in any organisation spending more than £20 billion per year and employing over a million people it would be surprising if this was not the case. The crucial question is however: will the new style health market provide the mechanisms necessary to achieve it? Any attempt to answer this question requires more detailed consideration of the way in which the market is likely to operate. Five areas require special scrutiny.

- Managers and Doctors.
- Employment policies.
- Capital spending.
- Price competition.
- Transactions costs

Managers and Doctors.

A major difficulty in using the conventional market model as a basis for predicting the behaviour of NHS hospitals in the new style health market arises because they are far more complex organisations than most commercial firms and pursue multiple objectives, many of them non-financial (Evans, 1984; McGuire *et al.*, 1988, Ch. 11).

In most firms, managers specify objectives in terms of profits, sales revenues, growth targets and other financial variables. Competition between rival firms pursuing similar objectives is the mechanism designed to encourage efficiency. However, the division of professional responsibilities within a hospital, especially the presence of doctors with clinical responsibilities, makes it far less easy to ensure that everyone works towards a common financial objective.

The government's answer to this problem is to delegate more authority to hospital managers. They will be responsible for winning service contracts from purchasers by offering cost effective packages of care. Funding will depend on their success in attracting business. But while managers will have overall responsibility for financial performance, doctors will continue to make clinical decisions that determine the way money is actually spent. They will also have the ultimate responsibility for meeting any changes in workloads, either upwards or downwards.

It has, of course, been a recognition of doctors' pivotal role in committing expenditure that has led to successive attempts to include them formally in management decisions about the use of resources. The resource management initiative (RMI) is the latest attempt to involve doctors and nurses in the management process (Ham and Hunter, 1988, Ch.3). However, despite the considerable enthusiasm displayed by some of the participants at the resource management sites, one study concluded that general experience of including clinicians in budgetary decisions was disappointing: neither managers nor doctors had shown much enthusiasm for it (Pollitt, *et al.*, 1988).

More recently, the interim report of the RMI evaluation team appointed by the DOH has appeared (Buxton *et al.*, 1989). The authors are at pains to point out that it is too early to form a definitive judgement about progress at the six acute hospital sites. Nonetheless they do note that:

> *. . . many of the service providers remain agnostic, going along with RM but waiting to be convinced, but they do so in the continued hope that RM will prove a means of improving the quality of care* (p.59).

They go on to argue, however, that these hopes may be endangered by the uncertainty generated by the government's NHS review.

On the specific subject of manager-doctor relationships within a trading environment, a study by Ranade *et al.*, (1989) offers some preliminary evidence. The study investigated those authorities which have already undertaken limited trade in clinical services and reported that obtaining consultants' co-operation in meeting additional workloads could be a major source of difficulty. Without a mechanism for ensuring that clinical activities within a hospital respond to the demands placed upon them by service contracts obtained by managers – whether this is achieved by tighter contractual control over doctors, through personal financial incentives, by budgetary incentives offered to clinical firms or by other means – it is difficult to see how competition can take place on an effective basis.

Employment policies

Self-governing status will offer hospitals more autonomy to manage their own affairs. Improved management performance and increased efficiency are expected to result from the greater freedom they will enjoy from centrally imposed restrictions and bureaucratic control. One area in which this freedom is likely to be particularly important is in employment policy.

Self-governing hospitals will be able to determine their own staffing levels, rates of pay and conditions of service. This contrasts with existing employment policy which, for the most part, is based upon national agreements. In determining the rates of pay of nurses, administrative and clerical staff, and ancillary workers hospitals will be able to take account of local labour market conditions. In areas of labour shortage they will be able to offer wages and salaries that are competitive with non-NHS employers. Similarly, hospitals that are successful in competition for service contracts will be able to offer higher rates of pay to attract good quality staff. Conversely, hospitals in areas of high unemployment may be able to reduce costs by setting rates of pay below the national average level. In short, the removal of national pay bargaining is intended to produce a more competitive labour market.

Doctors will also be affected by changes in their conditions of employment. The government believes that it is particularly important that self-governing trusts should be able directly to employ their own consultants. At the same time, a clearer specification of their contractual commitments is expected to contribute towards more effective management of clinical activity.

The consequences of hospitals' freedom over employment, pay and conditions of service can be expected to manifest themselves at both the micro and macro levels. At the micro level, the government believes that there will be more scope for using wage and salary payments as incentives to encourage increased productivity. Pay differentials will emerge reflecting differences in individual and hospital levels of productivity.

However, while these differentials may be consistent with increased efficiency, they may give rise to equity problems. For example, some nursing staff may be attracted towards self-governing hospitals by their better wages and salaries, especially if salaries in other NHS hospitals continue to be restricted by national pay agreements. A number of NHS hospitals are already suffering from the loss of key nursing staff to the private sector in specialties such as intensive care and theatre nursing. Competition from self governing hospitals may well exacerbate this problem and make it difficult to provide the desired level of care at all hospitals.

At the macro level, the freedom for individual hospitals to determine their own rates of pay has been identified as a potential source of overall cost escalation (Barr *et al.*, 1989). One of the financial advantages possessed by the NHS, in comparison with the health finance systems found in most other countries, is that as a close-to-monopoly employer of health service workers it has been able to use its monopsony power to control wage and salary increases. As a result doctors' earnings, for example, are approximately two and a half times average earnings in the UK compared with over five times average earnings in the US (OECD, 1987). However, with the emergence of self-governing hospitals and their greater pay flexibility, this monopsony power will be eroded. Hospitals can be expected to compete with each other, and in the face of the profession's control over the supply of doctors, pressures for increases in overall spending may arise.

Of course, the government will still have the ability to control total spending through cash limits. However, some districts may find themselves facing higher prices at their local self-governing hospitals – as a result of higher salary levels – and that without adequate allowance for this price inflation in their cash allocations, there would be a reduction in the volume of services they would be able to purchase. If so, another source of calls for extra funding may be anticipated (Robinson, 1989b).

Set against fears of cost escalation, however, it can be argued that NHS monopsony control of wage and salary levels has been a mixed blessing. After all, doctors' salaries comprise less than 9 per cent of total hospital and community health services expenditure (House of Commons, 1988), and so even quite large increases in their earnings would result in only modest changes in overall spending. More significantly, to the extent that hospital consultants are motivated by personal financial incentives, these are far more likely to be pursued through private earnings, alongside which any extra NHS salary is likely to pale into insignificance. Appointments at prestigious self-governing hospitals will be more important for the professional kudos they bestow (and possibly associated private practice earnings) than for any NHS salary differentials they offer.

On the other hand, the freedom to offer higher wages and salaries to nurses, administrative and ancillary staff may have a sizeable positive impact. At the moment, low pay is a perennial source of low morale and staffing problems. This is the obverse of

successful cost containment. Relaxation of pay restraints may well result in increases in productivity that offset increases in total costs. This is not to argue that productivity gains would necessarily materialise, but that they are a consideration that should at least be taken into account (Ham *et al.*, 1989a).

Capital spending

The government's proposals in relation to capital spending embody three main components: greater freedom for NHS hospitals to manage their capital stocks; the desire to promote competition between hospitals on equal terms; and the encouragement of public/private sector collaboration.

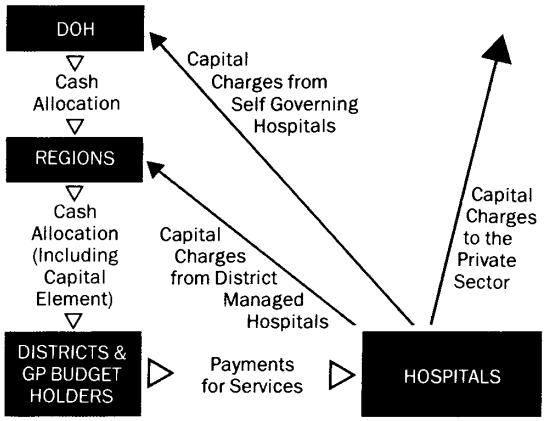
Self-governing hospitals will be given the power to acquire and dispose of assets. They will be able to borrow for investment purposes – within overall national limits – either through the government or from private institutions. And they will be able to make operating surpluses which may be used to finance new investment projects. At the same time a system of capital charges will be introduced throughout the NHS. All hospitals will be responsible for meeting the interest and depreciation costs of their existing assets and new investments.

For hospitals that remain under district management, the flow of funds resulting from capital charges will be as follows. On receipt of its annual cash allocation from the DOH, a regional health authority will make weighted capitation payments to its districts and GP budget holders. These payments will include an element to meet the capital charges that hospitals will include in the prices they charge for their services. Thus funds will flow from the region via districts and GP budget holders to hospitals. Hospitals, in turn, will make capital payments incurred on their assets to the regional health authority (see Figure 3). Because the flow of funds would be circular, regions will keep inter-authority accounts so that actual cash transactions can be minimised. In the case of self-governing hospitals, interest and capital payments on their debt will be made directly to the DOH.

Taken together, the introduction of capital charges and greater freedom over borrowing are expected to increase efficiency in the management of the NHS capital stock. Capital assets will no longer be 'free goods'. More attention will need to be given to the use made of the substantial NHS holdings of estate and capital equipment (Committee of Public Accounts, 1988b). Maintenance and repair policies should receive a higher priority as the costs of replacement capital become more apparent. The changes should also encourage a clearer assessment of the relative costs of capital and labour, and a more thorough consideration of their appropriate mix in service provision. Furthermore NHS hospitals will be placed on a more equal footing with private hospitals. They will have more freedom to borrow money, but will have to be able to service their debt – albeit at subsidised rates. In this respect, the proposals represent a move towards competition on an 'even playing field' basis.

But the proposals are not without their problems. Probably the most notable one is the impact that a system of full capital charging would have on the cost

FIGURE 3. CAPITAL CHARGES AND THE FLOW OF FUNDS



NOTES
(1) Regions 'own' the existing capital stock of district managed hospitals and therefore receive capital payments.
(2) Self-governing hospitals make payments on debt arising from their capital stocks directly to the DOH.

of providing services at inner city locations, especially in London. If hospitals such as Guy's, St Thomas's and Bart's were expected to meet the full market rental values of their sites, their costs would be significantly above those of hospitals in suburban or provincial locations. Purchasers seeking to maximise the volume of services obtainable from a given budget would face a powerful incentive to buy services from less expensive hospitals. As a result there might well be a rundown of central city hospitals as services were relocated at less expensive sites.

However, the government has made it clear that it expects core services to be made available locally. As such it will not allow capital charges and other market based costs totally to determine location decisions.

To meet this aim three measures have been designed to assist high-cost hospitals (DOH, 1989c,d). First, districts dependent on the services of hospitals with higher costs resulting from factors beyond the management's control will receive higher levels of *per capita* funding. Geographical differences in land values and building costs are cited as examples of these factors. Second, transitional arrangements will be employed to prevent any abrupt changes resulting from the introduction of capital charges. For example, these may be needed to take account of higher capital costs resulting from poor investment decisions made sometime in the past. As the Working Paper on capital charges puts it:

> *The Department . . . will phase the movement towards weighted capitation funding to coincide with the pace at which authorities can act to bring capital charges back to the average level expected for*

the facilities concerned. This will not be an easy process and will result in some Districts and GP practice budget holders being funded at a higher level than others in order to allow them to purchase from these transitionally higher cost providers (DOH, 1989c, p.8).

However, the Working Paper goes on to make it clear that if districts are funded for the higher costs of their local providers, they will not be able to use the additional funding to place contracts with less costly providers elsewhere.

Third, high cost hospitals will be cushioned from the full impact of capital charges by the land and building valuation process. Land held for operational use will be valued at the open market value in its *existing use*. This will usually tend to be below its *alternative use* value. Only land and buildings that are surplus to requirements will be valued at alternative use value.

The reasons why the government has chosen to subsidise certain high cost sites are clear. It wishes to ensure that local access to services is maintained and to avoid sudden disruptive change. However, in pursuing these perfectly legitimate aims, it has revealed an unavoidable conflict of policy objectives: namely, it wishes to use market forces to encourage efficiency and yet the need to meet wider social objectives means that it must place limits on the market process. Where precisely the balance is struck in the trade-off between efficiency and equity will, of course, be a political judgement. In many ways this is the nub of the strategy of 'managed' competition which the government has chosen to follow.

The final component of the government's approach to capital spending is the encouragement of partnerships between the public and private sectors. In recent years partnerships involving joint public-private funding have been used by a number of health authorities, often as a means of circumventing tight public sector capital constraints (Robinson *et al.*, 1988). At first sight it might seem that the additional freedoms offered to self-governing hospitals would obviate the need for this type of funding. However, this may not be entirely so. Total capital spending by self-governing hospitals will still be subject to annual financing limits, in much the same way that nationalised industries are subject to borrowing limits. As such it is not difficult to envisage some future situation in which the macro economic needs of the economy dictate a tight public expenditure policy with a resultant squeeze on NHS capital spending. Faced with the threat of disruption to their capital programmes, self-governing hospitals would doubtless be attracted by private sector development finance, especially if accounting arrangements could be devised to keep it outside their formal capital allocations.

From an efficiency point of view, the main concern arising from joint funding is that it might distort capital planning priorities. In effect a hospital contemplating joint development in order to raise additional capital funds faces a limitation on its freedom of action which it would not face if all the funds were available to it directly through the public sector. Such a limitation might govern the form of facility that it is encouraged to build, its size or location. Managers who have a clear idea of their own service priorities are unlikely to have them seriously thrown out of kilter by these pressures. However these limitations, together with the increased dependence on finance from service contracts, constitute potential sources of financial bias that will need to be watched carefully.

Price Competition

Within a market system, prices play a crucial role in bringing about an efficient allocation of resources. They act as signals reflecting the relative costs and benefits of the goods and services provided. It is well known however that health care markets display certain failings. Imperfect information and supplier induced demand, monopoly power, and external costs and benefits are all sources of market failure that inhibit the ability of the price mechanism to achieve an efficient allocation of resources. Furthermore the NHS has certain practical limitations that are likely to compound this problem when trade in clinical services gets under way.

Taking the specific NHS problem first, it has to be recognised that few hospitals possess cost data at the level of disaggregation necessary to specify costs per case with any precision. A number of commentators have argued that this should not prevent trade as broad brush estimates will be sufficient for setting prices (Perrin, 1989). Moreover others point out that participation in trading activities itself should provide a stimulus for generating the necessary cost information. While these pragmatic arguments clearly have some force, it is nonetheless important to stress that unless prices actually reflect costs, there is absolutely no reason to suppose that efficiency will result. Decisions based on imperfect price signals will result in the misallocation of resources: too much provision of some services, too little provision of others. Trade in itself is not a sufficient condition for achieving an efficient allocation.

Even when accurate cost data are available, the more general problems associated with markets will still need to be addressed. Probably the most important of these is the quasi-monopoly position of many NHS hospitals. Outside the major cities, patients' inability or unwillingness to travel beyond their local hospital often serves to produce a local monopoly. At the same time, financial and other barriers to entry deter new hospitals from setting up in competition with established ones. As in any monopoly market, the absence of competitors means that prices may be set substantially above costs – thereby yielding monopoly profits – in the knowledge that purchasers are unable to turn to rival hospitals. To ensure that this does not happen, some form of monitoring and/or price regulation will be necessary. This will need to be undertaken by regional health authorities or some other supra-district body, such as the Audit Commission.

NHS monopoly power also poses a problem as far as competition between the public and private sectors is concerned. Few independent hospitals offer the full range of services found in a typical district general

hospital. Abortions and minor elective surgery still form the overwhelming bulk of private sector work (Nicholl *et al.*, 1989) This specialisation means that many NHS hospitals do not face competition in the supply of the majority of core services. As such they have scope for adopting monopoly pricing on these services with the resultant surpluses being used to subsidise cut-throat pricing on services facing competition from other hospitals.

The government was clearly aware of this threat to level playing field competition when it stated that:

> *hospitals will have the scope to charge marginal costs in order to utilise spare capacity. It would not however be acceptable for hospitals to cross-subsidise in order to enable keener pricing of those services subject to competition* (DOH, 1989c, p.13).

To this end, the NHS Management Executive intends to develop a standard approach to cost allocation and will seek to ensure that this is applied by undertaking external statutory audit. But as Williams has pointed out, this will be no easy task and should 'keep the accountants, or perhaps even lawyers, wrangling for some time' (Social Services Committee, 1989, p.9)

In an effort to resolve some of these problems, DOH economists have put forward a pricing policy which endeavours to balance the allocative function of pricing with the regulation necessary to take account of special health market imperfections (DOH, 1989e). This balance, they argue, would be achieved by local price negotiation together with some mixture of central guidance and 'openness'. Thus districts would be able to set their own prices, subject to Treasury guidance on full cost pricing and the need to earn a real rate of return of 6 per cent. In addition, openness in pricing and costing – through the publication of tariffs – would be expected to reveal abuse of monopoly or monopsony power.

Transactions Costs

To enable the new health care market to function, service contracts will have to be drawn up between buyers and sellers. This will be a complex process. The basic format will be a block contract between a district and a hospital specifying an annual fee for the provision of an agreed range and volume of core services. The contract will also need to specify performance targets in terms of the maximum length of waiting times, the proportion of patients to be treated as day cases, their lengths of stay in hospital and so on. Other contracts will be on a cost per case basis and will be used to cover services which fall outside of the block arrangements. These will cover services in excess of agreed volumes and one-off referrals where a purchaser does not have a block contract with a hospital.

Whatever their merits in terms of encouraging cost effectiveness in the actual delivery of services, these arrangements will inevitably lead to a massive growth in expenditure on recording, costing and billing. Districts will need staff with the management, financial and legal skills necessary to draw up contracts, to supervise their implementation and to monitor hospital performance. Information technology will play an increasingly important part in this process, handling large data sets on costs, prices and quality of services.

Self-governing hospitals will need to develop similar management expertise and information systems for costing and pricing their services. In addition, they will need to establish effective billing procedures, especially for cost-per-case work. Their reliance on success in attracting service contracts may well mean that marketing managers will become an important part of the management team. Many hospitals have already appointed income generation managers, but at the moment their work is mainly confined to support services. Competition for contracts for clinical services will shift marketing to a more central area of hospital activity.

GPs who choose to hold their own budgets will need to develop managerial and financial expertise. This can be expected to lead to growth in the numbers of full-time practice administrators. Another development could be the emergence of purchasing cartels. Groups of GPs could appoint a contract manager who – with the enhanced bargaining strength represented by control over a number of GP budgets – would be able to negotiate more favourable service contracts with hospitals than any single practice could obtain on its own.

Clearly the introduction of a health care market will involve substantial transactions costs. From an efficiency point of view, it is necessary to establish whether or not the benefits – in the form of more cost effective provision of clinical services – outweigh the additional costs. Unfortunately it is totally impossible to carry out this calculation at the moment. The publication of *Working for Patients*, as far as is known, was not preceded by any attempt to estimate the likely costs and benefits of its proposals. This does not appear to be the form of policy making favoured by the Government. Instead a broad agenda has been set, the costs and benefits of which, will only become clear as the implementation process proceeds.

Consumer choice

Lack of responsiveness to consumers' preferences on the part of public-sector, monopoly suppliers has been one of the major criticisms levelled at public organisations in recent years. According to Enthoven (1989), in the health sector:

> *They are unresponsive to consumer preferences regarding times and places and modalities of treatment. They are guided much more by provider preferences and convenience than consumer preferences. They ration by queues. They lack accountability.*

Often public monopolies have been contrasted with private firms, operating in competitive markets, where responsiveness to consumer demands is taken to be a necessary prerequisite for financial success and/or survival. Ultimately this provider responsiveness derives from consumers' possession of purchasing power which can be used to back up their demands. This is the essence of consumer sovereignty.

In an effort to replicate the conditions of consumer sovereignty within the NHS – while at the same time guaranteeing everyone access to services – some commentators have argued for the introduction of health vouchers (Green, 1988a; Whitney, 1988; Letwin and Redwood, 1988). Vouchers would be distributed to everyone. They would have a nominal cash value and could be used to buy health services from the provider of the patient's choosing. Services could be purchased directly but, given the uncertainty of demand associated with health care, vouchers would probably need to be used to purchase health insurance. Many different forms of voucher scheme are possible. Their value could be adjusted in the light of the likely needs of different age groups. Similarly their value could be income related with lower income groups receiving a higher value voucher. In this case it would be necessary to allow individuals to supplement their vouchers with their own money. They could also include a transport cost element to assist patients and/or relatives with their travelling expenses. Whatever variant is favoured, advocates of a voucher scheme claim that it would offer patients greater choice and encourage suppliers to be more responsive to consumers' preferences.

The main problem facing such a scheme is the large variation in demand for health services among the population. In any one year 90 per cent of the population make no use of hospital in-patient services (OPCS, 1989); of the remainder who do use them, treatment can vary from minor diagnostic procedures to high-cost, intensive care. This variability would make it difficult to develop a standard voucher allocation procedure, even after allowing for the risk pooling of insurance arrangements. Population rating – which adjusts for differential use between population sub-groups – would reduce the problem, but is unlikely to be able to cope fully with the substantial variations in service use within subgroups. In this connection it is significant that major variations in demand do not occur in the education and housing sectors where voucher schemes have been widely advocated and, in some cases, applied.

Possibly for these reasons, the government has not responded to calls for the introduction of health vouchers from new-right advocates, even though they might otherwise have been expected to receive a sympathetic hearing. Nonetheless, increased consumer choice occupies a central position among its aims for the NHS. How exactly is this to be achieved?

Having rejected proposals for devolving purchasing power to individual patients, the government needed to designate some alternative budget holder. In fact two distinct categories of budget holder are proposed. For the majority of hospital services, district health authorities will act as purchasing agents on behalf of their residents. For some services though, GPs opting for budget holder status will be able to purchase selected services directly for their patients.

In the case of GP budget holders, it is possible to envisage discussions between doctors and patients about appropriate forms of hospital treatment and the location of possible referrals. This facility, together with the greater freedom for patients to change GPs, appears to offer the scope for enhanced consumer choice. But these arrangements will cover only a minority of GPs and hospital services. Most patients will have decisions about where they are treated determined by the contracts taken out by their district health authorities. As such, districts as purchasers will have new responsibilities for making sure that their decisions reflect the needs and preferences of their resident population. In discharging this task, the DOH has made it clear that it expects districts to take account of GPs' preferences regarding referrals when placing service contracts. Moreover, GPs will retain a residual right to refer patients to non-contract hospitals in the case of emergency and some non-emergency referrrals (DOH, 1989f).

It may be that these safeguards are sufficient and that the preferences of patients, GPs and districts will knit together neatly. But equally there may be tensions. It is the district that will be accountable for expenditure. For this reason, it must retain ultimate control over the placing of contracts and thereby the pattern of referrals. In some cases this will involve shifting decision making power away from individual GPs with the result that the line of accountability to the patient is stretched and possibly weakened.

Quality of Services

By making hospital funding dependent upon service contracts obtained from the purchasers of health care, the government believes that suppliers will face an incentive to provide good quality services that are responsive to patient needs.

To ensure that acceptable standards of care are met, purchasing agencies will need to include quality specifications within service contracts taken out with hospitals. These will include details of the facilities to be made available, criteria for admission and discharge of patients, maximum waiting times and measures of the quality of clinical care (DOH, 1989f). Among these different dimensions of quality, the assessment of standards of clinical care will pose the major problem. At the moment little information about this aspect of quality is available on a systematic basis. The government intends that this information should be generated through the extension of medical audit: that is, the process whereby clinicians regularly review their activities and performance with the aim of improving standards. The government envisages that every district will establish a medical audit advisory committee which will be chaired by a senior clinician and include representatives from the major specialties and general management. It will be responsible for producing an annual report which, *inter alia*, records clinical performance over the previous year and points to areas where action is needed to improve quality.

With access to annual reports, purchasers will have some of the basic information necessary for assessing the quality of services provided at different hospitals. Moreover contracts will be expected to contain provisions for monitoring service quality, including the guarantee of access to premises and relevant data for inspection purposes. But will these provisions be sufficient to ensure that a district's patients actually

Medical Audit in Practice

The *Lothian Surgical Audit* involves voluntary participation by general surgeons and urologists in monitoring and improving the quality of care. The data collected enable each surgical unit to compare its performance with that of the group as a whole. Weekly meetings are devoted to discussion of specific problems. Changes in clinical practice have resulted from the audit including the decision to concentrate arterial surgery in the hands of surgeons who specialise in vascular surgery because they obtained better results. The Lothian system has been developed by the surgeons themselves with limited financial and staff support from the health authority.

The *Stoke-on-Trent Medical Audit* goes under the name of Clinical Review. Participation includes both consultant medical staff and juniors. The audit centres on monthly meetings at which cases selected by an independent chairman are presented by the doctors best acquainted with the case concerned. The cases are chosen from patients who have died in the hospital during the previous month. Discussion then follows on the management of the cases and on how care might be improved.

Source: Ham and Hunter (1988) p.11.

receive an adequate quality of care? Barr *et al* (1989) raise the possibility that cost-conscious purchasing agencies, faced with cash-limited budgets, will be under heavy pressure to pursue least-cost service contracts. In the event of a cost:quality trade-off this could lead to a reduction in service quality.

To guard against this possibility both the Institute of Health Services Management and the National Association of Health Authorities have suggested that there should be an independent body responsible for monitoring the quality of care (Social Services Committee, 1989). This could take the form of an NHS inspectorate or an accreditation agency (Brooks, 1989).

Apart from the danger that the quality of services may fall below acceptable minimum standards, some fears have been expressed that the proposals will mean variations in service quality above the minimum standard according to the patient's ability to pay. After all variations in the amounts that consumers are willing to pay are typically the source of differences in service quality in a market system, and the government intends to give patients limited opportunities to supplement NHS provision if they choose to pay for it. However, the freedom to buy higher quality services is not envisaged to extend to standards of clinical care; rather, it is the quality of hotel services that can be expected to show somewhat greater variation as patients are offered the choice of purchasing 'extras' in the form of private rooms and other facilities. This is unlikely to lead to a two-tier system within the NHS as far as the most important aspects of care are concerned.

Access to Services

Considerations of equity or fairness are usually taken to mean that everyone should have equal, or at least adequate, access to health services. Although this might seem a fairly straightforward concept, on close scrutiny it becomes clear that it is not. For example, Mooney (1982) identifies seven possible definitions of equity (which he defines in terms of equality). These are equality of:

- expenditure per capita
- real resources per capita
- input for equal need
- access for equal need
- utilisation for equal need
- marginal net need
- health

That few of these objectives have been met has, of course, been the source of an intense debate about inequalities in health over the last 10 years (Black, 1980; Whitehead 1987; Wilkinson, 1988; Green 1988b). However, it is not the purpose of this paper to enter this already overcrowded area. Instead attention is confined to some of the practical impacts upon access that may arise following the introduction of the government's plans. In this connection, access is measured in terms of the money, time and inconvenience costs facing individual patients, and is expressed in relation to their geographical location, their socio-economic group and their health care needs. Although they are rarely stated in precise terms, it is possible to discern three sets of arguments which have been advanced to suggest that the proposed changes will mean greater inequality of access.

The first argument maintains that the adoption of a market type system will inevitably increase inequality between socio-economic groups. This view derives from the fact that within a market system income and ability to pay are major determinants of access to goods and services. And because incomes are distributed unequally, so access to services is also unequal. However, while this may be true of market systems in general, it will not necessarily be a feature of the new style health market. This is because the purchasing power assigned to each individual will be determined by the DOH's weighted capitation formula. This formula will be able to be adjusted to produce whatever cash distribution is deemed appropriate. Hence a market type system will be used to allocate spending between hospitals, but not for determining the initial cash allocation to purchasers. To this extent fears about market inequalities are misplaced.

There is, though, one area in which more unequal access to services may occur as a result of the new purchasing arrangements. This centres on possible GP bias in the selection of patients. In any GP practice a small proportion of patients account for a large percentage of time and expenditure, whereas the majority of patients make few demands on the service. Because of these variations in use, GP budget holders will face a financial incentive to attract healthier, low-risk patients and to deter high users. Variations in capitation payments based on up-to-date health status measures can go some way towards reducing the

problem by reflecting differential use rates. But they are unlikely to be finely tuned enough to eliminate it completely. Stop-loss provisions which absolve budget holders from meeting annual expenditure on any one patient in excess of £5,000 will also reduce the problem. Paradoxically, however, they also remove some of the incentive for efficient management of the care of such patients (Scheffler, 1989).

The second argument on inequality relates to differential access between geographical areas. This could arise if trade in clinical activities results in some specialties becoming concentrated at a smaller number of hospitals. This is, of course, how economies of scale could be realised. But a corollary of lower hospital costs could be higher user costs as patients have to travel longer distances for treatment. This may be expected to disadvantage low income and less mobile individuals and their families – particularly women and children, people with disabilities, frail elderly people and those without access to cars.

Ensuring continuity of care after hospital discharge for those patients treated outside their districts of residence will also pose problems. Liaison between hospital consultants and GPs, community services and social services departments is already a source of concern in many areas and treatment at a distance will do nothing to reduce the problem. In drawing up service contracts, responsibility for care after hospital discharge will need to be specified in some detail. Moreover, if patients are required to travel longer distances for treatment, careful thought should be given to the finance and provision of transport and other support services. One possible approach would be to require travel costs to be paid either by the hospital providing treatment, or by the referring district or GP. In this way, transport costs could be included as part of the contract between buyers and sellers.

The final reservation over access relates to the comprehensiveness of local service provision. To be specific, the spectre has been raised of glamorous teaching hospitals offering high technology medicine to a national or international clientele while the needs of the local population suffering from chronic sickness are neglected. In fact, the government has made it clear that core services will have to be provided locally to guarantee local access. Community based services, including those for elderly or mentally ill patients, are mentioned as examples of these services. It is most unlikely that the Secretary of State would permit a self-governing hospital to refuse to enter into a service contract for the provision of such services if there was no adequate alternative in the locality. Claims that hospital trusts will mean a reversion to the pre-1948 two-tier system of voluntary and local authority hospitals are surely exaggerated.

Nonetheless, there may well be threats to comprehensive local provision at the margins. When managers make decisions about the most cost effective or profitable use of hospital beds, financial considerations may well provide incentives that act against the interests of some non-remunerative local services. Easily specified services covering minor elective surgery – involving short stays and minimal complications after discharge – may appear more attractive than some forms of longer stay, less predictable, geriatric care. While, in principle, it should be possible to avoid this form of patient selection bias – if the prices specified in contracts reflect accurately the degree of risk involved – in practice, this is likely to be less easily achieved. Therefore, in order to avoid this danger, monitoring of services should be extended beyond individual clinical outcomes and incorporate more general surveillance of the comprehensiveness of services and access to them.

Conclusion

The governments plans for the NHS do not constitute an easily defined model of health care finance and delivery. Rather they are a hybrid deriving from ideological motives tempered by the recognition of political constraints and practical considerations (Maxwell, 1989). Moreover they lack precision and appear to be scheduled for more detailed specification, and modification, during the implementation process. But through the mists of uncertainty certain signposts are clearly discernable. A belief in the merits of competition and a determination to subject public sector providers to its cathartic properties appears to be one of them. Clearly this is a high risk strategy. As the preceding account of the plans and expectations surrounding them shows, there is at the moment precious little hard UK evidence on which forecasts about the performance of the new style health market can be based. For this reason, those who believe that predictions and policy based upon empiricism are preferable to those resting on faith need to look elsewhere. Given the government's predisposition towards US models of economic and social policy – and the contemporary experience of competitive strategies in that country – the next section presents a review of US experience of markets and competition in health care.

3 MARKETS AND COMPETITION IN THE USA

The finance and delivery of health care in the United States is organised in a very different way from that found in the British system. Nearly 60 per cent of US national health expenditure is financed privately – compared to less than 15 per cent in Britain – and nearly three quarters of short-term general hospitals are in private ownership. During the 1980s the main policy concern has been to control escalating expenditure on health care which, by 1987, had reached over 11 per cent of GNP, compared with around 6 per cent in Britain. Policies that have endeavoured to cope with this problem at first relied on different forms of regulation, but in recent years far more emphasis has been placed on competition. It is these policies which may contain some lessons for Britain in the light of the government's proposals for the NHS. So how have these policies evolved in the US and what has been their impact on the health care system? This section aims to answer these questions by describing the shifting policy emphasis in the US, and assembling empirical evidence about the impact of competition and related policies on health sector performance.

FROM REGULATION TO COMPETITION

In the traditional US health care system, services are supplied by self employed doctors – operating on a fee-for-service basis – and by, predominantly, privately owned hospitals which levy patient charges. Faced with the need to meet their own medical expenses – and the often high cost and intrinsic uncertainty surrounding the the demand for health care – consumers increasingly turned towards insurance as a means of protecting themselves from the impact of unexpected bills. The non-profit Blue Cross hospital insurance plans which grew up during the 1930s were the first programmes to offer wide scale protection. Blue Shield insurance plans covering the cost of doctors' services followed during the 1940s. The Blues were established under special state laws and supervised by state insurance departments. Subsequently, a number of for-profit commercial insurance companies entered the market.

After World War II insurance coverage grew rapidly. In the 15 years from 1945-1960, the number of people with hospital insurance increased nearly four-fold, from 32 million to 122 million. Growth in insurance coverage for doctors' services over the same period was even more dramatic – from less than five million to over 83 million people (Fuchs, 1988). By the beginning of the 1960s, however, the spread of insurance had slowed down. Extension of coverage to the remaining uninsured sections of the population was hampered by their inability to meet the necessary premium payments. In the light of this constraint, concern to improve access to care for those with inadequate insurance cover – through the development and funding of more comprehensive programmes – became a primary objective of public policy makers (McNerny, 1982). These efforts culminated in major legislation in 1965 designed to provide publicly financed benefits to the elderly and low-income groups through the Medicare and Medicaid programmes.

The Medicare Programme

Medicare is a federally funded health insurance programme for people of 65 years and over. It also covers certain disabled groups, especially those requiring dialysis treatment for kidney disease. The programme was introduced in 1965 in an effort to ensure access to health services for the elderly population at a stage in their lives when the combined effects of higher risk of illness and reduced income made it difficult for them to meet private insurance premiums.

The programme has two parts. Hospital insurance (known as "Part A") helps to pay for in-patient hospital care, some nursing home care, home health care and hospice care. Medical insurance (known as "Part B") contributes towards the costs of doctors' fees and other non in-patient services. Both parts of the programme, however, require patients to bear a portion of their costs. As a result nearly three-quarters of Medicare beneficiaries subscribe to supplementary private insurance schemes known as "Medigap" policies. Others qualify for Medicaid as low income households.

At present, Medicare accounts for about 20 per cent of total US health expenditure.

While more comprehensive insurance arrangements succeeded in increasing access to health care, the growth of third-party payments – both private and public – gave rise to another problem: namely, spiralling expenditures. Between 1965 and 1980 national health expenditure grew from just under $42 billion to nearly $250 billion dollars. This represented an increase in the proportion of GNP devoted to health spending of over 50 per cent, *viz*, from 5.9 per cent to 9.1 per cent (US Health Care Financing Administration, 1988, Table 1). As a consequence of this rising burden on the economy, the attention of policy makers shifted towards methods of cost containment. (To clarify subsequent discussion, it is worth pointing out that in the US the term cost containment is usually used to refer to strategies designed to restrict the growth of *aggregate spending*, either through moderating increases in *unit costs* or by reducing growth in the *volume of services*).

For most of the 1970s strategies for cost containment were based primarily on *regulation* by state and/or federal government. Regulatory policies sought to control, *inter alia*, capital investment in health facilities, hospital utilisation, prices and the spread of new technology. For example, certificate of need (CON) legislation – which was mandated on a federal basis in 1974 – aimed to control costs by regulating the expansion of hospital and nursing home capacity. Hospitals were required to obtain a certificate for major capital expenditures in order to be eligible for Medicare and Medicaid payments. Subsequently many private insurance companies also required hospitals to meet the same certificate criteria

The Medicaid Programme

The Medicaid programme is an insurance scheme for low income families that is funded jointly by individual states and the federal government.

The programme is administered independently by individual states within broad federal guidelines. Receipt of Medicaid benefits is usually linked to the welfare system and covers the health care costs of low income people who are elderly, blind, disabled or members of families with dependent children. It does not, however, offer protection to all low income groups. Those who are not eligible for assistance include non-elderly single people, most two-parent families, and families with a low-paid job. Individual states have a degree of flexibility in setting income eligibility levels, and in determining the range of services covered and the duration of coverage. As a result, there are considerable variations between the way individuals in identical circumstances are treated in different states. California, for example, has one of the most generous schemes whereas Mississippi applies far more stringent rules.

At present, Medicaid spending accounts for just over 10 per cent of total US health expenditure.

as a condition of payment. However, avoidance of these controls was widespread and they seemed to have done little to restrict hospital expenditure (Merrill and McLaughlin, 1986). At best they appear to have diverted spending from investment in new beds to more capital intensity per bed (Luft, 1985).

Professional standards review organisations (PSROs) represent another regulatory mechanism. These were established in 1972 with the aim of ensuring that services paid for through Medicare and Medicaid were medically necessary, of high quality, and delivered at the lowest possible cost. More than 185 PSROs were developed throughout the country. Their work included pre-admission reviews and a variety of retrospective studies on quality of care and utilisation. In 1978, however, the President's Office of Management and Budget claimed that PSROs had not succeeded in reducing costs and did not contribute significantly to increased quality of care. In 1981, amid widespread doubts about their usefulness – and calls for their abolition – PSROs were replaced by a smaller number of peer review organisations (PROs). These were charged with a renewed responsibility for quality control and cost containment (Raffel and Raffel, 1989). Whether or not new style PROs have been successful at cost control is a matter of debate. Overall, wide variations in the performance of monitoring procedures makes a definitive judgement difficult (Luft, 1985).

While specific regulatory instruments have been the subject of particular criticisms, some analysts have raised a general query about whether regulation can ever be an effective means of cost control. For example, Enthoven (1978) argued that price regulation, instead of containing costs, was actually likely to raise them. He based this view on the assumption that price regulation involves cost-plus pricing and, therefore, amounts to a system of cost reimbursement: precisely the system that had given rise to the problem of cost inflation in the first place. Moreover, according to Enthoven, attempts to control expenditure by controlling the price per unit of services had also failed because providers – both doctors and hospitals – had responded by redefining and increasing the volume of services they supplied.

In the face of the apparently limited success of regulation, and – possibly more importantly – the changed political climate represented by the Reagan administration, policies for cost-containment during the 1980s have relied on a different mechanism. Emphasis has been placed on market forces in the belief that they will result in cost minimising behaviour.

According to this view, a market-based competitive environment within the health economy constitutes a more effective source of financial discipline than one of bureaucratic regulation. A number of strategies have been based on this belief. Among them, demand-side policies have used the price mechanism in order to make consumers more sensitive to the costs of health care through the increased use of *cost-sharing* arrangements; while, on the supply-side, *anti-trust legislation* has been employed to remove various restraints on trade, thereby permitting greater competition between health care providers. But probably most important of all, straddling both the demand and supply sides of the market, various *managed care systems* have grown up in competition with traditional private insurance/fee-for-service providers.

Cost Sharing

Approximately 85 per cent of the US population have some form of health insurance. Around 65 per cent of the population have private insurance with Blue Cross/Blue Shield, commercial companies and health maintenance organisations, while 20 per cent are covered by state and federally funded Medicare and Medicaid programmes (Stoline and Weiner, 1988). All of these plans insulate consumers from the full costs of their health care. Medicare or Medicaid beneficiaries incur no insurance premiums. Nor do those employees for whom employers meet all of their premium payments. Moreover, by definition, most policies ensure that a substantial proportion of the patients costs incurred at the time of use are met through third party payments. In 1987, over 72 per cent of total personal health care spending was met in this way. Furthermore this proportion is rising: in 1965 less than 50 per cent of health expenditure was acounted for by third party payments.

The growth of third-party payments has, of course, been a corollary of the extension of health insurance. But according to some critics, it has also contributed towards cost escalation through the increased incidence of moral hazard: that is, excessive use of health care facilities because the patient faces a near to zero price at the time of use. In an effort to restrict overuse, there have been a number of moves to shift a

greater burden of payment onto consumers. This is known as cost-sharing.

Cost-sharing can take two main forms. It can be applied to insurance premiums whereby individuals are required to bear a proportion of the cost alongside government or employer contributions. In this instance, it is designed to encourage consumers to be more discriminating about the range of benefits they select when choosing between competing plans. Alternatively, cost sharing can be applied at the time of use through co-payments, deductibles or payments for services not covered by insurance plans.

McNerny (1982) summarises the potential advantages of cost-sharing as stimulating rational, cost-effective purchasing decisions by consumers so that they will be more resistant to price increases than government or carriers seem to be. Among the disadvantages he notes: that supplementary insurance programmes will probably grow up thereby offsetting the discipline of consumer charges; that co-payments may be regressive because they constitute a larger proportion of low-income group expenditure than of middle or high income groups; that cost-sharing increases administrative costs; that many individuals lack the information necessary to make rational decisions; and that the varying application of cost-sharing can lead to a shift of expenditure to those services with less restrictive co-payment conditions.

Removal of Restraints on Trade

According to some writers (Green, 1986; Havighurst *et al.*, 1988) anti-Trust action on the part of the Federal Trade Commission has played a major part in creating a more competitive environment within the health care market. Prior to 1975, the federal government was largely content to view the medical profession as a self-regulating body of professionals. As such, normal business competition between providers was deemed inappropriate. In 1975, however, a judgement by the Supreme Court in the case of *Goldfarb v Virginia State Bar* rejected the assumption that the 'learned professions' were immune from general anti-trust law. The ramifications of this decision were far reaching. According to Havighurst, prior to the Goldfarb judgement:

> *nearly everyone . . . tended to discount any role for competition in health care and to overlook the profession's collective infringements on the operation of market forces . . . (then) one stroke of the Supreme Court's pen – in a case not involving doctors or health care providers at all – suddenly made competition clearly mandatory in the health care field in the sense that infringements of it could be prosecuted* (Havighurst *et al.*, 1988, p.57).

The removal of restraints on trade has influenced the development of competition in a number of ways. Strategies in two related – but distinct – sectors of the market are particularly worth noting.

First, there has been substantial growth in the number and variety of health insurance plans on offer. These use intensive advertising and marketing techniques in their efforts to enrol individual subscribers either directly or through their employers. Competition between plans takes place in terms of both price and qualitative features including, *inter alia*, the extent of service coverage offered, the range of choice between alternative providers, premium rates and the extent of cost-sharing.

Second, there has been growth in the extent of supply side competition between hospitals – and between other forms of health care providers – for the business of health insurance plans. Marketing executives now play a more prominent role within hospital management structures. In 1987 hospitals spent almost $1.4 billion on advertising and marketing activities (Goldsmith, 1988). Competition takes place not only in terms of price (Kenkel, 1988) but also in terms of the range and quality of services on offer (Luft *et al.*, 1986). Teaching hospitals, in particular, with their higher levels of overhead costs frequently seek to attract patients by emphasising the superior quality of their care (Taft, 1988).

Managed Health Care

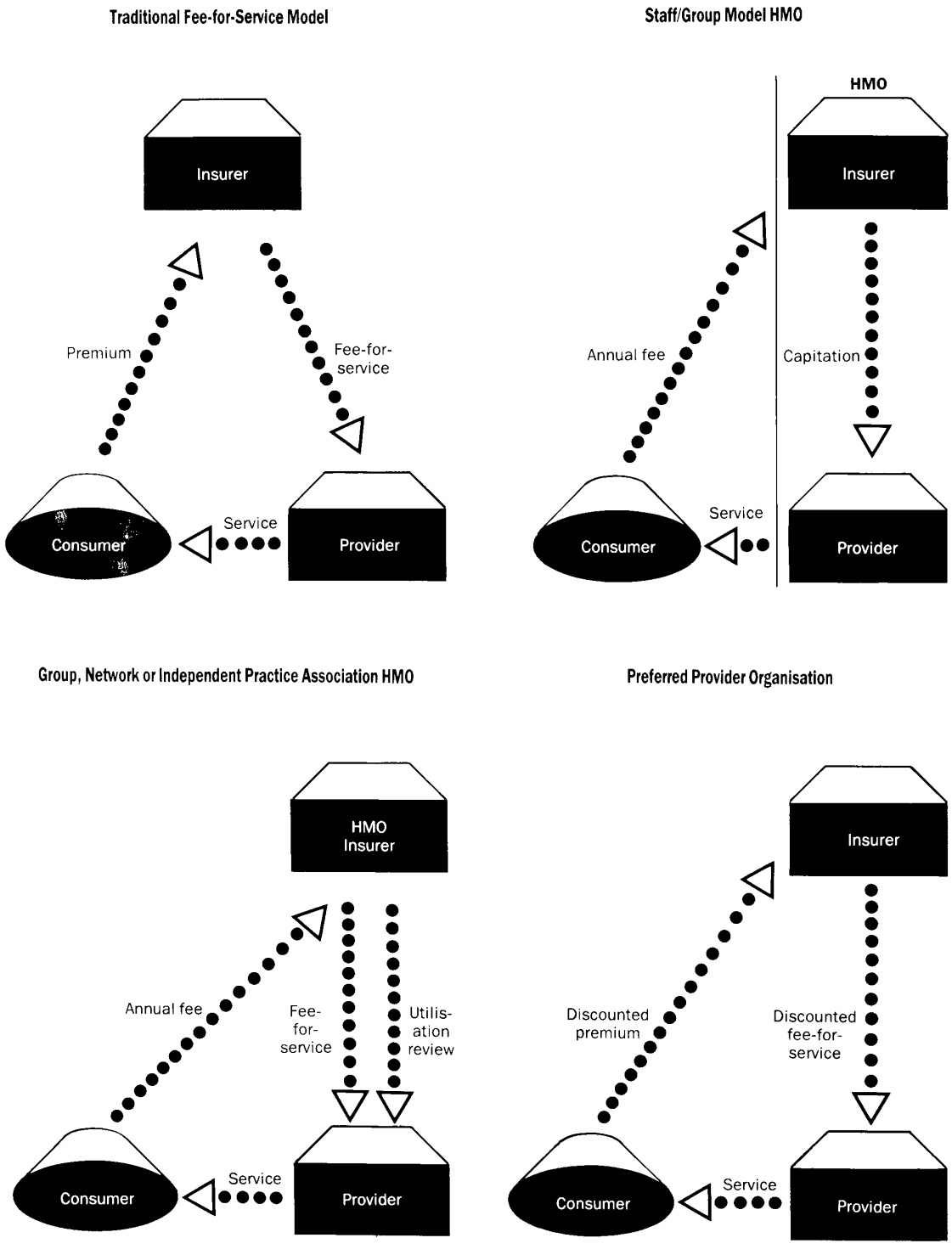
The growth of organisations offering alternative forms of finance and delivery has been an important element within the new, competitive environment. Collectively these alternatives have become known as managed care systems. Typically they aim to offer high quality care while controlling costs more effectively than traditional fee-for-service providers.

In the traditional US insurance based system, most of the financial risk is borne by an insurance company which pays doctors' bills and/or hospital costs on a fee-for-service basis. This gives providers no incentive to minimise costs. Quite the reverse, there is a financial incentive to provide as much treatment as possible. As a result, it is generally considered to have resulted in the provision of many unnecessary services. Managed care systems seek to avoid this pitfall.

Health maintenance organisations (HMOs) were the first of these systems to develop. A typical HMO operates on a pre-paid or prospective payments basis. Patients enrol through the payment of a set, annual fee usually through their employer. In return the HMO contracts to provide all the health care that is deemed necessary. This may be organised in a number of different ways. A staff model HMO involves the full integration of the finance and delivery functions. The organisation will have its own health centres and will either contract for hospital services or, in the case of larger HMOs, may own them itself (Rayner, 1988). In a staff model, doctors are usually employed full-time on a salaried basis. This removes the incentive for them to overutilise hospital and other services.

Other forms of HMO maintain a larger degree of separation between the role of insurer and that of service deliverer. Thus an HMO – acting primarily as an insurer – may contract with a large group practice to provide care (a group model), or with a number of group practices (a network model) or with a number of solo practitioners or small groups (an independent practice association (IPA)). In contrast to the staff model – with its directly employed, salaried doctors – providers in this second category of HMOs have rather more autonomy. Primary care doctors may be paid a

FIGURE 4. A TAXONOMY OF US MODELS OF HEALTH CARE



fixed fee per enrolee (i.e. capitation), but they may also be paid on a modified fee-for-service basis. And practically all hospital care will be provided on a fee-for-service basis. In these settings the payments system cannot be relied upon to encourage cost-saving to the same extent as in a staff model and so considerable emphasis is placed upon utilisation controls, such as pre-hospital admissions certification, as a means of containing costs.

The growth of HMOs over the last 20 years has been dramatic. In 1970 there were fewer than 30 serving just under 3 million people. By 1980 their number had grown to 230 serving 9 million people, and by 1988 there were over 700 catering for over 29 million people (Stoline and Weiner, 1988). In fact, growth during the 1980s was probably too rapid. Between 1984 and 1986, the number of plans increased by 86 per cent and the number of enrolees rose by 54 per cent. During 1986, however, nearly three quarters of plans made losses. The increase in price competition which they did much to precipitate, tighter federal government limits on payments through the Medicare system (see below) and poor financial management have all contributed towards these losses. As a result, the industry has experienced a degree of shake-out and growth is now proceeding more slowly (Moore, 1989).

But it would be a mistake to judge the impact of HMOs simply in terms of their numbers and rates of growth. Their influence has also been exerted through responses to them on the part of other health care providers. This process has been described by Ellwood (1984) in the following terms:

> *they (i.e. HMOs) are becoming mainstream medicine in many places and are forcing, albeit, grudgingly, fee-for-service doctors to rethink their willingness to assume economic risk, to practice in groups and alter their practice patterns and their use of the hospital, to become more price sensitive in order to protect their patients from new alternatives, and to be financially attractive enough to compete for new patients"* (p. 309).

One of the main responses on the part of mainstream medicine has been the emergence of preferred provider organisations (PPOs). In essence, PPOs are insurance plans which are able to offer lower premiums to enrolees because they negotiate fee-for-service discounts with specified doctors and hospitals in return for guaranteeing them a given volume of work. Part of the popularity of PPOs stems from the fact that patients have more choice between doctors. Many people view HMO patients as being locked in and having limited scope for changing doctors in the event of unsatisfactory service. The attraction of PPOs has led to a growth in their numbers of nearly five fold since 1983, so that by 1987 there were over 600 with an estimated 31 million enrolees. This means that PPOs now cater for rather more enrolees than all forms of HMO taken together.

But just as PPOs represent a modified form of insurance-based, fee-for-service response to HMOs, so HMOs are themselves responding to the growth of PPOs. Many HMOs are responding to criticisms of limited choice by offering enrolees the option of going outside the HMO for specified services. In overall terms, it seems that competition between alternative forms of managed health care systems has resulted in an extremely fluid market structure. Numerous new initiatives and adaptive responses are producing a heterogeneous set of arrangements that appear to be constantly changing through time.

BACK TO REGULATION

Despite the emphasis placed on competition during the 1980s, regulatory policies have far from disappeared. In 1987, 42 states still had a certificate of need programme or some similar mechanism for controlling investments in new hospital facilities. Similarly, utilisation reviews carried out by peer review organisations continue to play an important part in managed care systems by determining whether a patient should be admitted to hospital, for how long and whether major therapeutic and diagnostic procedures should be undertaken (Stoline and Weiner, 1988).

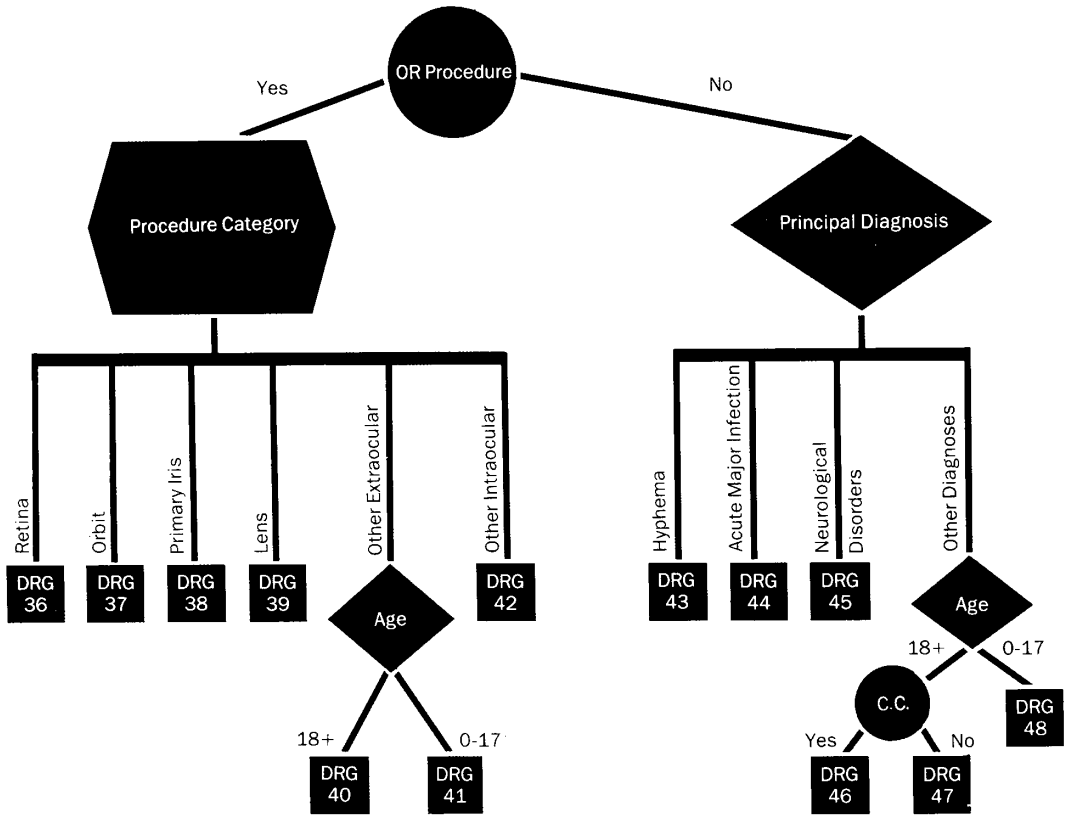
But probably the most important example of regulation is the new form of price control introduced in 1983 via the Medicare prospective payments system (PPS). Prior to 1983 Medicare reimbursed hospitals on a retrospective cost basis. This gave hospitals an implicit incentive to spend more. More expenditure generated more revenue (Sloan *et al.*, 1988). Under PPS, however, hospitals are paid a fixed amount per patient admission. The precise payment is determined by allocating a patient to one of approximately 470 diagnostic related groups (DRGs). These DRGs seek to separate patients into clinically homogeneous categories which can be used as a basis for measuring different levels of resource use. Payments can then reflect differential resource use.

To ease the transition from retrospective reimbursement to PPS, the programme was phased in over a 3 year period. In the first year it was designed to be budget neutral: that is, total expenditure was planned to be the same as under the previous system. By 1987, however, the programme was implemented in full and was being used as part of a conscious effort of cost containment. This objective is pursued via the Prospective Payments Assessment Commission which updates the level of payments made each year. In the updating process the Commission takes account of hospital input price inflation as well as other factors such as changes in productivity and the take-up of new technologies. But it does not see its role as adjusting payments passively to increased hospital costs. Rather it seeks to set a payments structure which actively offers incentives for greater efficiency (Young, 1988).

From the individual hospitals point of view, because they are able to retain any surplus over costs arising from DRG payments, and also because they bear the risk of losses through overspending, PPS provides an incentive for containing costs. On the other hand, the fact that this method of payment only covers in-patient charges and does not include doctors' fees means that there is an incentive to shift costs onto unregulated sectors of the market (see next section).

FIGURE 5. MEDICARE DRGs 36 TO 48, DISEASES AND DISORDERS OF THE EYE

(a) Surgical and Medical Partitioning



(b) Relative Cost Weights

			Procedures	Weights
DRG	36	S	Retinal procedures	·7019
	37	S	Orbital procedures	·5571
	38	S	Primary Iris procedures	·4280
	39	S	Lens procedures	·4958
	40	S	Extraocular procedures except orbit age >17	·3936
	41	S	Extraocular procedures except orbit age 0-17	·3657
	42	S	Intraocular procedures except retina, iris — lens	·5845
	43	M	Hyphema	·3788
	44	M	Acute major eye infections	.6233
	45	M	Neurological eye disorders	·5582
	46	M	Other disorders of the eye, age >17 with C.C.	·5902
	47	M	Other disorders of the eye, age >17 w/o C.C.	.5011
	48	M	Other disorders of the eye, aged 0-17	·4018

Note: S Surgical
M Medical

Source: M Bardsley et al *(1987)*

To summarise, it is clear that the US health care market has undergone some fundamental changes during the 1980s. Many commentators have referred to these changes as a competition 'revolution' (Fuchs, 1988). And certainly competition has increased. But it would be quite wrong to imply that this is the whole story. Numerous forms of regulation have been retained and new ones – such as Medicare PPS – have been introduced. Similarly, new institutional forms represented by managed health care systems have, sometimes, through greater vertical integration in service provision, actually reduced the level of pure competition. As such it is more accurate to say that particular forms of regulated or managed competition have been developed. The next section analyses the impact of these changes in market structure upon the performance of the US health care system.

EVIDENCE ON PERFORMANCE

The control of escalating expenditure has probably been the major health policy objective in the US during the 1980s. This is therefore an obvious yardstick against which the performance of the sector should be judged. But cost containment is by no means the only policy aim. Extending the degree of patient choice, improving the quality of service and ensuring access to it are all important objectives. The remainder of this section considers the empirical evidence on performance in relation to each of these objectives.

Expenditure and Costs

From the point of view of the US economy as a whole, it is the opportunity cost of the health sector that is of primary interest. This can be measured in terms of the percentage of GNP devoted to health spending. As figure 6 shows, this percentage has followed a long-term upward trend since 1965. During the 1980s there was a slight fall in 1984 – from 10.5 to 10.3 per cent – but thereafter the series continued its upward trend, as it did following similar falls in 1974 and 1978. At this level of aggregation, there is little indication that the long-term growth in health expenditure has been contained.

While the ratio of health expenditure-to-GNP is an appropriate measure for examining the overall burden of health spending on the economy, the impact of competition and other cost containment strategies on the health sector itself is best examined in terms of changes in health care prices and the quantity of services provided. These changes can be investigated by using the expenditure identity specified by Fuchs (1988):

$$\text{Total Expenditure} \equiv \left[\begin{matrix}\text{input}\\ \text{prices}\end{matrix}\right] \times \left[\begin{matrix}\text{inputs per unit}\\ \text{of service}\end{matrix}\right] \times \left[\begin{matrix}\text{quantity of}\\ \text{services}\end{matrix}\right]$$

The first term on the right hand side of the identity – input prices – measures changes in health specific input prices; these generally increase at a faster rate than those in the economy at large as a result of the relative price effect (Robinson and Judge, 1987). The term 'inputs per unit of service' is designed to take account of changes in productivity. An increase in input prices accompanied by an offsetting increase in productivity would, of course, leave costs per unit output unchanged. However, without a clear measure of what constitutes the service output of health care, the concept of productivity becomes problematic. In practice, this term is often indistinguishable from the third term, the 'quantity of services', as it is often possible to argue that more inputs mean more outputs, at least in qualitative terms.

Measuring changes in input prices is complicated by the diversity of providers within the US health system. Unlike the NHS, there is no single index comparable to the NHS pay and price index. Rather there are a number of separate indices. Figure 7 shows annual percentage changes over the period 1980-88 for two of these: hospital input prices and charges for physicians services. Taken together these inputs account for just under 70 per cent of personal health expenditure (ie national health expenditure minus certain central administrative, research and public health programme costs). The figure also shows annual changes in the general price level – as measured by the GDP deflator – so that changes in health prices can be compared with overall price changes.

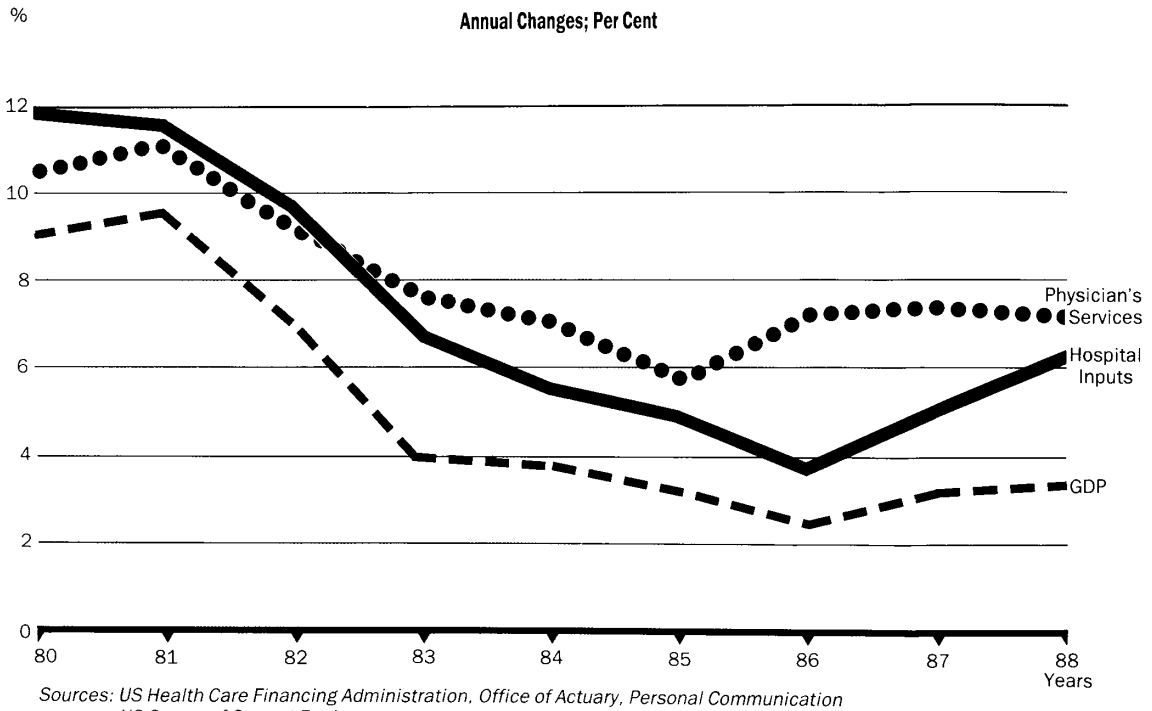
As the figure indicates, the rate of hospital price inflation fell sharply throughout the period 1980 to

FIGURE 6. US NATIONAL HEALTH EXPENDITURES, 1965-87
Per cent of GNP

Source: US Health Care Financing Administration (1988)

FIGURE 7. US HEALTH CARE PRICES, 1980-88

Annual Changes; Per Cent



Sources: US Health Care Financing Administration, Office of Actuary, Personal Communication
US Survey of Current Business

1986, although most of this fall appears to have been the result of reductions in general inflation rather than attributable to health sector specific causes. However, even after allowing for general price changes, there was a discernable fall in hospital price inflation between 1982 and 1986. Over this period hospital relative price inflation (ie hospital price changes minus general price changes) fell by nearly one third – from 3 per cent to just over one per cent. Since then, however, relative prices have started to rise again and by 1988 were increasing by nearly 3 per cent per year. The rate of increase in charges for physicians services also fell between 1981 and 1985, but subsequently it too started to rise again. However, the pattern of relative price changes was more erratic. This rose between 1981 and 1983, fell until 1985, rose in 1986 and fell thereafter.

Taken overall, the only conclusion that can be drawn from these data is that there seemed to be some moderating influences exerted on hospital input price inflation over the period 1982 to 1986, but that this effect is now losing its impact.

An estimate of the way in which the quantity of services supplied each year has changed over the 1980s can be obtained by adjusting changes in national health expenditure for changes in input prices. In the UK context this is usually referred to as volume or purchasing power expenditure. If, in addition, adjustments are made for changes in the size of the population, volume expenditure may be expressed in *per capita* terms. This is done in Table 1.

The table shows that the rate of growth of cash expenditure fell steadily between 1981 and 1985, but started to rise again in 1986 and 1987. When cash spending is deflated by input prices, the falling trend over the period 1981-1985 is less distinct, but it is still noticeable. Similarly the rise in the rate of growth of spending in 1986 and 1987 is clearly discernable. With population changes accounting for an approximately one per cent increase in spending each year, growth in volume expenditure *per capita* displays a similar pattern to total volume expenditure.

As most cost containment policy has been directed at hospital spending, changes in the volume of hospital services are of particular interest. These are shown in Table 2. Between 1980 and 1983 the rate of growth in volume expenditure showed no clear pattern. However, in 1984, there was a striking reduction in the growth rate. In fact, after adjustments for population size, the change in expenditure *per capita* was actually negative. It was this occurrence which attracted the attention of Evans (1986) and led him to describe the shift in hospital spending patterns as 'both unprecedented and massive'. More recent data, however, suggests that this was a temporary phenomenon, as the rate of growth in volume expenditure has risen in each of the three subsequent years.

TABLE 1 · US NATIONAL HEALTH EXPENDITURES, 1980-87

Annual Change, per cent

YEAR	CASH	VOLUME	POPULATION	VOLUME PER CAPITA
1980	15.6	3.8	1.0	2.8
1981	15.9	4.2	1.0	3.2
1982	12.8	3.1	1.0	2.1
1983	10.4	3.3	1.0	2.3
1984	8.8	2.7	1.0	1.7
1985	7.9	2.7	1.0	1.7
1986	8.7	3.8	0.9	2.9
1987	9.8	4.1	0.9	3.2

Note: Volume expenditure obtained from cash expenditure deflated by a composite, weighted price index comprising hospital inputs, nursing home inputs, and physicians' services.

Source: US Health Care Financing Administration (1987, 1988) and personal communications.

At first sight, the fact that volume expenditure has started to rise again might seem surprising. After all trends in hospital activity rates suggest falling workloads. As table 3 shows the number of in-patient admissions has fallen in every year since 1983, while the average length of stay has shown no appreciable increase following a marked fall between 1982 and 1984.

However, the explanation for rising volume expenditure is to be found elsewhere. In part, it is the result of hospitals' and doctors' attempts to avoid Medicare price regulations. Thus much in-patient, pre-admission diagnostic work has shifted from hopitals to doctors' offices where it is not subject to PPS. At the same time, there has been a tendency for many of the in-patient services that are covered by PPS to be replaced by non regulated out-patient and day surgery cases. Disaggregation of hospital revenue data into in-patient and out-patient categories over the period 1983-87 demonstrates this trend. In-patient revenues grew at 5.7 per cent per year whereas out-patient revenues grew at an annual rate of 16.7 per cent (Levit and Freeland, 1988). Over the same period spending on physicians' services grew twice as fast as hospital in-patient revenues.

Additional evidence of this substitution process is provided in Figure 8 which shows large falls in Medicare in-patient utilisation for those procedures for which ambulatory care is an appropriate alternative. Moreover, the availability of these procedures at less expensive ambulatory settings may also have generated additional net demand and thereby contributed towards greater volume expenditure (Prospective Payments Assessment Commission, 1988, p.18).

Even within PPS, there is evidence of increased volume expenditure arising from DRG 'creep': that is,

TABLE 2 · US HOSPITAL EXPENDITURES, 1980-87

Annual Change, per cent

YEAR	CASH	VOLUME	VOLUME PER CAPITA
1980	14.2	2.0	1.0
1981	17.2	5.1	4.1
1982	13.5	3.5	2.5
1983	13.0	6.0	5.0
1984	6.3	0.7	−0.3
1985	6.8	1.8	0.8
1986	7.0	3.3	2.4
1987	9.1	3.9	3.0

Note: Volume expenditure obtained from cash expenditure deflated by the hospital input price index, including capital and medical fees.

Source: US Health Care Financing Administration (1987, 1988) and personal communications.

TABLE 3 · US HOSPITAL IN-PATIENT ADMISSIONS AND LENGTHS OF STAY, 1980-87

YEAR	ADMISSIONS	LENGTHS OF STAY (ALL ADULTS)	LENGTHS OF STAY (ADULTS OVER 65)
	Per cent change	Days	Days
1980	2.9	7.2	10.4
1981	0.9	7.2	10.4
1982	0	7.2	10.1
1983	−0.5	7.0	9.7
1984	−3.7	6.7	8.9
1985	−4.9	6.5	8.8
1986	−2.1	6.6	8.8
1987	−0.6	6.6	8.9

Source: US Prospective Payments Assessment Commission (1988)

the classification of patients into more costly DRG categories than is strictly necessary on clinical grounds in order to increase hospital revenues (Birch,1988). Certainly case mix data reveal a rapid increase in case complexity since the introduction of PPS (Newhouse *et al.*, 1988)

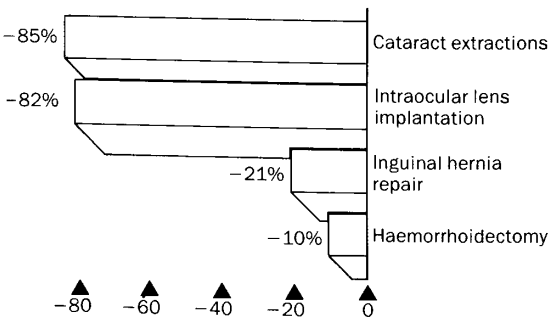
Finally, expenditure in those areas not covered by PPS has been subject to increases in the 'intensity' of treatment. In particular, the availability of expensive new medical technologies – such as magnetic resonance imagers – has meant that the quantity of inputs per case has tended to increase quite markedly, with a resultant increase in total spending. In recent years it has been estimated that about one-third of the annual increase in national health spending has resulted from 'changes in consumption *per capita* and intensity' (Health Care Financing Administration, 1987, p.11). In the absence of research evidence on the efficacy of these expenditures – in terms of their impact on health outcomes – it is impossible to establish whether they represent a gain or a loss in productivity.

To summarise the evidence so far, it seems likely that both competition and regulation policy contributed towards a fall in the rate of hospital price inflation over the period 1982-86. Separating their individual contributions is difficult, although the dramatic fall in hospital volume expenditure in 1984 is extremely likely to have been associated with the introduction of Medicare PPS in the previous year. But neither of these policy packages appear to represent durable stategies for overall cost containment. More widespread use of non-price regulated, ambulatory care and increased intensity of service suggest that health spending is rather like a balloon: when squeezed in one place, it simply bulges out in another (Long and Welch, 1988). This tendency, together with a resumption in the upward trends of hospital prices and volumes over the last two years, has meant that the share of GNP devoted to health care has continued to rise.

On the basis of the above evidence, it seems difficult to argue that cost containment policies have had a clear and lasting effect. But perhaps it is too early to be sure about this. Fuchs (1988) argues that it is unreasonable to expect cost containment policies to show any marked effect on spending within just a few years. He points out that major effects on costs are determined by supply side factors, viz. the number of hospitals and physicians, and the rate of growth and adoption of new technology. These are all factors which can only be expected to change over the longer term.

A rather different interpretation of the apparent failure of cost containment is offered by Pauly (1988a). He argues that competition should never have been expected to result in aggregate cost containment. Instead of promising cost minimisation, competition is designed to produce the right level of expenditure on health care through enhancing consumer choice. Pauly puts his case as follows:

FIGURE 8. CHANGES IN HOSPITAL IN-PATIENT UTILISATION, 1984-86



Source: US Prospective Payments Assessment Commission (1988) Table 1.8. p.18.

It (ie competition) *will not minimise the share of GNP going to medical care, nor will it necessarily slow the rate of growth in that fraction compared to some regulatory alternative. It will result in costs being minimised given the level of quality, intensity, or amenity selected. But since consumers may not prefer the minimum medically acceptable quality, but instead may choose some higher level of quality, some more expensive level of quality or some more rapidly growing level of quality, competition may not in fact produce 'cost containment'; it may fail to restrain expenditures* (p. 25).

This argument distinguishes between micro efficiency or cost effectiveness (which competition should promote) and aggregate cost containment (which, it is argued, is not the purpose of market competition). Pauly goes on to link rising quality to greater service intensity, especially that arising from new technology. In his view, rising volume expenditures, at a time when in-patient activity is falling, are an expression of consumer preferences and therefore consistent with economic efficiency.

Mitchell (1988) supports the Pauly interpretation when he locates part of the explanation for high levels of US spending in a value system that, quite legitimately, demands medical attention, no matter what the cost, if there is any chance of extending or improving the quality of life. The 'fix the problem at any cost' approach may only produce a slight incremental improvement in health status at a high cost, but it is what people want.

To probe the Pauly hypothesis further it is necessary to consider the micro-economics of health care markets. How does competition take place? Are unit costs minimised for given levels of quality? And is the level of quality a legitimate reflection of consumer preferences?

Numerous studies of hospitals' behaviour in local markets certainly suggest that competition has often taken place in terms of quality and amenity rather than price. Robinson and Luft (1985) examined the impact of market structure on in-patient costs. Using data for 1972 they found that hospitals operating in more competitive markets – defined as having 11 or more neighbouring hospitals within a 15 mile radius – had higher costs than those in less competitive markets. In a later study the same authors (Robinson and Luft, 1987) updated their work with more recent data for 1982. Once again they found a positive correlation between the degree of market competition and price. Another study by Luft and his associates (Luft *et al.*, 1986) investigated the source of these higher costs. They analysed the impact of competition on the availability of a range of specialised clinical services, *viz.* mammography, emergency services, cobalt therapy, heart surgery and cardiac catheterization. Their findings suggested that the presence of a nearby competitor increased the probability of finding the expensive clinical facilities necessary to be able to offer these services within any given hospital. In another study Merrill and McLaughlin (1986) examined the impact of competition, measured – in terms of the extent of HMO penetration – in 25 of the largest US metropolitan areas over the period 1971-81. They found no evidence that competition reduced costs. Rather costs were driven by supply side factors such as the number of hospital beds or medical specialists in an area.

Zwanziger and Melnick (1988) summarised all of this evidence in the following terms:

The unanimity of the studies of hospital competition is striking; they have consistently found that hospitals operating in areas with greater competition tend to use more resources and to have higher costs. Despite the presence of methodological problems in all of these studies, they provide convincing evidence that competition will tend to increase costs in a market environment competing on non-price bases (p. 305).

However, while the evidence tends to confirm that competition has taken place in terms of quality rather than price, whether or not this is consistent with an efficient use of resources (i.e. the *right* level of expenditure) remains a matter of debate. Whereas Pauly interprets these increased costs as a response to consumers' preferences for higher quality services, McLaughlin (1988) takes a rather different view. She points to the importance of initial market structure as a determinant of the way in which providers behave following attempts to increase competition. While price competition, leading to greater efficiency, may be expected in a perfectly competitive market, health care markets more usually resemble monopolistic competition or differentiated monopoly. Within these markets, firms concentrate on non-price rivalry, usually through product differentiation. The outcome is prices above minimum long run costs and excess capacity.

Whether additional resources represent wasteful excess capacity, or are a legitimate response to consumer demands, will depend ultimately on the confidence that can be placed in the ability of the purchasers of health care to assess price and quality. In this connection, some recent research findings throw a rather different light on the impact of competition in the post-1982/83 period: a later period than dealt with in the studies referred to above.

Noether (1988) points out that, until recently, the only major constraint facing hospitals – in terms of their pricing policy – was that imposed by insurance companies needing to raise premiums to cover increased costs. As this constraint was weak, hospitals concentrated their competitive efforts on quality dimensions. Subsequently, however, the growth of cost-sharing, the extension of HMO and PPO membership, and Medicare PPS have meant that purchasers are more sensitive to price. Zwanziger and Melnick (1988) and Robinson and Luft (1988) provide empirical evidence to support this hypothesis. Their work suggests that since 1982 competition has indeed started to moderate the rate of increase in costs.

Zwanziger and Melnick concentrate on evidence from the state of California over the period 1980 to 1985. During that period two major pieces of legislation changed the environment within which hospitals operate. First, in June 1982, a law was passed permitting purchasers to engage in 'selective

contracting'. This enabled third-party payers to exclude providers from their participating lists without the threat of anti-trust legislation. A central objective of the law was to promote price competition among health care providers. Second, in 1983, Medicare PPS was introduced.

By comparing hospital costs in the period prior to the introduction of this legislation with those found afterwards, the authors sought to assess the impact of competition. Their results suggest that all hospitals displayed a change in behaviour between the first and second period, but that hospitals located in highly competitive markets experienced a rate of decline in cost inflation that was significantly greater than those in less competitive markets. The rate of increase in cost per discharge in highly competitive markets, for example, was 3.5 per cent lower than the rate in low competition markets during the period 1983-1985.

Robinson and Luft report similar findings on the basis of a nationwide study of 5490 hospitals for the years 1982 and 1986. They found that, in both years, hospitals in more competitive local markets experienced higher levels of cost than those in less competitive markets, but that the competition-cost gradient was less steep in 1986. This contrasted with stability in the gradient between 1972 and 1982 which they found in their earlier study (Robinson and Luft, 1987), and suggested to them that the cost increasing effects of non-price competition were diminishing. In fact, in California the positive competition-cost gradient had completely disappeared by 1986: hospitals with 11 or more neighbours had costs 1.3 per cent lower than did hospitals with no neighbours, although this difference was not statistically significant.

Emerging research evidence does seem to suggest, therefore, that supply-side competition between hospitals, when faced with a more discriminating approach to the price component of service contracts on the part of large group purchasers, both private and public, is starting to lead to a moderation in the rate of cost inflation. The impact seems to have been particularly marked in California, a state with considerable spare capacity in terms of both empty hospital beds and a high doctor-to-population ratio.

Interestingly, however, the same research also indicates that regulation, especially Medicare PPS, is having an impact on cost inflation. In their study Zwanziger and Melnick used multivariate analysis to separate the effects of competition from PPS, and found that the cost reducing impact of both variables were of roughly the same magnitude. Robinson and Luft report that a slightly different form of price regulation (ie all payer rate regulation), operating in the states of Maryland and Massachusetts, was even more successful at cost containment than the California selective contracting approach. On the other hand, similar rate regulation schemes in New York and New Jersey were less effective.

Other studies at the national level confirm the moderating influence of Medicare PPS on overall expenditure growth. Thus Feder *et al.*, (1987), using data from 1982-1984, found that hospitals paid through PPS had significantly lower increases in costs and greater declines in use than did other hospitals. The cost containing impact of PPS was confirmed by Russell and Manning (1989). Through the use of aggregate Medicare expenditure projections for the years 1979-1988, they estimated that PPS will result in Medicare expenditure in 1990 being approximately 20 per cent below the level it would otherwise have reached.

It is, however, not entirely clear whether it is PPS price regulation which is restraining expenditure growth or the associated PRO scrutinies of in-patient admissions. Sloan *et al.*, (1988) found that the Medicare programme had resulted in significant cost reducing effects but that these were almost entirely generated by reduced admissions resulting from PROs. Moreover, reduced admissions may reflect cost shifting. Newhouse and Byrne (1988) argue that reduced lengths of stay in short-stay, acute hospitals among the Medicare patients covered by PPS have been associated with an increase in the numbers of patients staying more than 60 days who are not covered by PPS. This has resulted in an increase in the mean length of stay among the total elderly population.

Clearly there are still many uncertainties about the precise impacts of competition and regulation on health care costs and spending. But what recent US evidence does seem to suggest is that a combination of supply-side competition, discriminating purchasers, price regulation and utilisation controls have exerted a moderating influence on health costs. But equally clearly there is evidence that income or revenue maximising providers will seek, and often find, ways of circumventing these constraints. The inexorable growth of aggregate spending supports the metaphor of the health service as a balloon. Moreover, it is important not to lose sight of the fact that cost containment is only one policy objective. Ensuring that consumers have freedom of choice, that care is of high quality, and there is ready access to it are all important policy aims.

Choice, Quality and Access

The need to offer consumers *choice* over finance and provision has always been an important part of the US health care system. Developments over the 1980s have almost certainly extended the range of choice for the majority of the population. On the demand side, there has been a growth in the diversity of insurance plans enabling consumers to select packages which reflect their individual needs and ability to pay. On the supply side, competition between hospitals has meant that patients can now choose from a range of providers offering services which reflect different levels of quality, intensity, amenity and price.

The development of managed care systems has played a major part in increasing consumer choice. Health maintenance organisations now offer an alternative to traditional fee-for-service health care in many parts of the country; an alternative that has already been chosen by 30 million Americans. For their part, traditional providers have responded to this

competition through the development of preferred provider organisations. These now cater for rather more people than all forms of HMO taken together.

As in any rapidly evolving market, the dissemination of information is seen as an important activity. Predictably, much advertising is more persuasive than informative. But both state and federal government departments are actively seeking to improve the quality of information available to consumers. As well as the publication of numerous pamphlets and handbooks offering advice to patients on such matters as the desirability of second opinions before surgery, there have been federal government initiatives publicising mortality rates at individual hospitals (Roper, 1988) and legislation in some states which makes it mandatory for hospitals to publish their charges, mortality rates and degrees of seriousness of illness of patients on admission (Pauly, 1988b). Despite these initiatives, however, the consumer's limited ability to assess quality of care, especially the appropriateness of treatment, remains a severe problem.

To some extent this is because the concept of *quality* is an elusive one. It inevitably involves a degree of subjectivity. From the consumer's point of view, Roberts and Prevost (1987) identify the following components:

- responsiveness to perceived care needs
- level of communication, concern and courtesy
- degree of symptom relief
- level of functional improvement.

According to this definition, the consumer's perception of quality derives from a complex mix involving both the process of care and its outcome in terms of health status. This complexity poses considerable measurement problems. This is no doubt one reason why most of the hundreds of papers written about quality of care contain little or no quantitative data (Brook and Kosecoff, 1988). Nonetheless there have been some studies which have sought to identify the impact of various changes in the US health system upon the quality of care through the careful collection and analysis of empirical data.

In this connection, it is worth returning to the earlier research evidence which suggested that quality – when measured in terms of resource inputs – may well have been enhanced by non-price competition between hospitals. If this is the case, is it possible that cost containment policies have led to a deterioration in quality and worsened outcomes? A series of studies carried out by the RAND Corporation throw some light on this question.

Newhouse *et al.*, (1981), in a study of cost sharing, found that utilisation of health services fell as the degree of cost sharing increased. Adults who had to share the cost of care made a third fewer ambulatory visits and were hospitalised about a third less often than individuals who received free care. With some experts claiming that the fee-for-service system results in as many as 40 per cent of all hospitalisations being unnecessary (Brook and Kosecoff, 1988), these findings might be expected to reflect a welcome reduction in inappropriate treatments. However, a study by Siu *et al.*, (1986) indicated that cost sharing did not selectively reduce inappropriate hospital admissions. In insurance plans with cost sharing arrangements, they classified 22 per cent of admissions inappropriate compared with 24 per cent in plans where care was free to the patient. As the difference was not statistically significant, these results imply that cost sharing reduces appropriate use to the same extent as inappropriate use.

Research evidence does not suggest, however, that reductions in use necessarily result in worse outcomes. For example, Brook *et al.*, (1983) found that individuals who received free care did not seem to be healthier because of their greater use of it. Across a wide set of health status measures, there was no significant difference between health outcomes for those in cost sharing plans and those receiving free care. The one exception was in relation to special conditions which doctors had been trained to diagnose and treat, such as hypertension. At the end of the research experiment, persons receiving free health care tended to have lower blood pressure and therefore, it was inferred, a lower risk of early death.

Yet another RAND study developed the focus on health outcomes, this time in relation to HMOs (Ware *et al.*, 1987). It set out to investigate whether cost reductions in HMOs, which were achieved largely through reductions in hospital admissions, had an adverse effect upon health status. To do this, it compared health outcomes between a sample of individuals assigned to an HMO with those of individuals registered under two forms of fee-for-service (FFS) system, one offering free care at the point of use and the other including a degree of cost sharing. The results suggested that non-poor individuals assigned to the HMO experienced no adverse health effect on any of the 13 measures of health status adopted in the study. In fact, for high-income individuals who were initially sick, the HMO produced more favourable general health ratings than the free FFS system. Low income, initially sick individuals assigned to the HMO fared less well however. They reported more bed days per year due to ill health and more serious symptoms than those assigned to the free FFS system. They also had a greater estimated risk of death in comparison with those in the cost sharing FFS system. On the face of it, these findings tend to suggest that cost reductions in HMOs have been achieved at the expense of low income groups. Indeed, the authors offer a possible explanation for this finding in terms of the lower ability of poorer, less articulate individuals to 'work the system' when there is non-price rationing. This is much the same case as made by Goodin and Le Grand (1988) in their claim about middle class capture of the welfare state in Britain.

In another study Shortell and Hughes (1988) examined the impact of regulation and competition on hospital mortality rates. Regulation was defined in terms of hospital rate regulation and state certificate of need (CON) programmes. Competition was measured in terms of the degree of HMO penetration and the number of hospitals operating within a defined area. Using records for over 200,000 patients treated between July 1983 to June 1984, covering nearly 1,000

hospitals in 45 states, they found a significant positive correlation between the tightness of rate regulation, the stringency of CON legislation, the level of HMO enrollment and higher mortality rates. However, competition among hospitals in the same market area, as measured by the presence of competing hospitals, did not have a statistically significant association with higher mortality rates.

Mortality rates are, of course, an important index of hospital performance. Several studies indicate that these rates fall as the volume of work in a particular surgical procedure increases (Luft *et al.*, 1979; Flood *et al.*, 1984; Roos *et al.*, 1986). The extent to which competition and other cost containment policies result in these qualitative economies of scale depends upon whether or not they promote greater concentration of activity and specialisation. In many cases competition, by increasing the number of providers, has worked against this tendency.

More generally, the maintenance of an acceptable quality of care, in the face of pressures for cost containment, seems to depend upon the successful regulation of standards. In the United States, this function is carried out, in large part, through professional self regulation by the Joint Commission on Accreditation of Health Care Organisations. The Commission, which was established in 1951 by the American Colleges of Surgeons and Physicians, the American Hospital Association and the American Medical Association, undertakes a range of activities designed to promote high quality health care (US Joint Commission, 1988). Whether its efforts will succeed in strengthening mechanisms for quality assurance or whether, as Brook and Kosecoff (1988) fear, advertising will replace quality assurance as competition intensifies, remains to be seen.

Within the US health care system, *access* to care is determined to a large extent by the individual's ability to pay for it, either from his own resources or with the aid of price and income subsidies. It is therefore the financing arrangements that are a major determinant of access.

The various policy initiatives designed to tighten cost control have been described already. These include the introduction of Medicare PPS which controls hospital payments on behalf of the elderly more tightly. At the same time, in many states, Medicaid payments on behalf of the poor have been subjected to far more restrictive eligibility rules: fewer than 40 per cent of poor Americans are currently covered compared with 65 per cent 10 years ago (Ansberry, 1988). Private health insurance plans – in their efforts to attract enrolees through lower premiums – have become far more discriminating about the fees they will pay for hospital services. And, on the supply side, competition between hospitals has been encouraged as a means of meeting these demands for reduced costs.

The combined effect of all these measures has been to place increasing pressure on hospital finances. In some cases they are actually leading to bankruptcy and hospital closures. Since the early 1980s the number of hospitals closing each year has increased by about 50 per cent, with 81 closures in 1988 alone (Mechen and Whitaker, 1989). Many of these closures are taking place in rural areas, often resulting in the communities affected having no access to nearby facilities. More generally, reduced profit margins (or surpluses over costs in the case of not-for-profit hospitals) have meant that private hospitals have been less able to engage in their traditional cross-subsidisation of patients who cannot meet their bills from those who can. This has made them less willing to treat the uninsured, with resultant reduced access to care on the part of these groups.

Probably the most striking manifestation of this trend has been an increase in patient dumping: the practice of private hospitals sending patients home or to public hospitals when it becomes clear that they cannot meet their bills. In one study of patient dumping, Kellerman and Hackman (1988) monitored telephone requests and actual transfers of patients to a publicly subsidised hospital in Memphis, Tennessee, over a 92 day period, 1st June-31st August, 1986. During this period, the hospital received over 260 transferred patients (and refused telephone requests for 70 more), of which 91 per cent were sent for primarily economic reasons. One quarter of patients were found to be unstable in terms of explicit clinical criteria on arrival. Over a third of patients transferred for economic reasons required emergency hospitalisation. Three patients died prior to discharge.

Most states have anti-dumping legislation. Moreover, in 1986 legislation was introduced requiring all hospitals receiving Medicare payments to screen patients adequately if they are seeking emergency care and to refrain from inappropriately transferring an emergency patient or a woman in active labour. A hospital is only supposed to transfer a patient if this is requested by the patient or their guardian, or when it is considered to be in the best medical interests of the patient. Hospitals violating these conditions are liable to fines and potential exclusion from Medicare. Nonetheless, a recent Congressional hearing was told that an estimated 250 thousand patients are still transferred from the emergency rooms of private hospitals to public hospitals each year solely for economic reasons (Berliner, 1988).

With pressures for cost-containment leaving hospitals less scope for absorbing the costs of uncompensated care, it is not really surprising that there has been a reduction in access to health services for many under and uninsured people. Extending insurance coverage – through government regulation and subsidisation – is the means of overcoming this problem favoured by a number of legislators and health experts.

In the state of Massachussetts, for example, a law was enacted in 1988 designed to make health security available to all citizens of the Commonwealth and to improve hospital financing. The Act has two main features. First, it has created a Department of Medical Security which will contract with private health insurance plans to make affordable coverage available to small businesses, most of whom presently do not offer health insurance to their employees. Second, the Act will impose a payroll tax on all firms with six or more workers. The revenues from this tax will be used

to subsidise insurance for individuals not covered by these schemes.

Employment based insurance also plays a central role in a proposal for national health insurance recently put forward by Alain Enthoven (Enthoven and Kronick, 1989). In this plan, all employers will be required to offer their employees insurance coverage and would be required to meet 80 per cent of the cost. They would also be required to contribute towards a payroll tax. The revenues from this tax would be used to meet 80 per cent of the cost of insurance of families not covered through employment. Families on low incomes would receive additional assistance towards the remaining 20 per cent of insurance costs, with those below the poverty line having their costs met in full.

CONCLUSION

The US health care system is large, complex and heterogeneous. Indeed to refer to it as *a system* at all is, in some respects, misleading. To anyone whose perception of a health service is based on the NHS it represents a potentially bewildering patchwork of institutions – private and public; local, state and federal. This pluralism is also a source of frequent change. The 1980s have been a particularly active period in this respect. From among the many policies that have figured in this process, this section of the report has highlighted the growth of cost sharing, anti-trust legislation, the emergence of a diverse set of managed care systems and government policies for price regulation, especially Medicare PPS. The main impetus behind each of these initiatives has been a desire to contain escalating health expenditures. Empirical evidence suggests that they have not been particularly successful at the macro level, although some doubt has been expressed about whether overall cost containment is an appropriate objective in a market based system driven by consumer preferences. Similarly, at the micro level, most of the evidence seems to indicate that competitive strategies have led to increased costs as hospitals have competed in terms of quality rather than price. Again views differ as to whether this is an efficient use of resources reflecting consumer preferences or whether it represents the over supply of inappropriate treatments within a monopolistic market. Some very recent evidence, however, does suggest that supply side competition – when faced with discriminating, cost conscious purchasers – may be starting to moderate the rate of cost increase. However, as cost containment policies have begun to bite, attention has focused upon their impact on the quality of care and access to it. Preliminary evidence indicates that without appropriate safeguards, cost containment may lead to a deterioration in both of these dimensions of care.

4 LEARNING FROM EXPERIENCE

Section Two describes the government's plans for introducing greater competition into the NHS and some of the expectations surrounding these plans. It argues that the performance of the proposed new style health market should be judged in terms of its impact on:

- efficiency
- consumer choice
- quality
- access to services.

Section Three offers an account of competition policy in the United States during the 1980s and brings together evidence in terms of these criteria. This section relates this experience to the government's plans for the NHS in an effort to gain a firmer understanding of what is (and is not) likely to happen to it during the 1990s.

EFFICIENCY

Debates about the efficient use of health sector resources in the US have been dominated by the issue of cost containment. Competition policy became the focus of attention because it appeared to offer the prospect of containing growth in total spending. This aim assumed particular importance following the 1979 oil price shock and the resultant deep recession in 1981-82. In fact, judged in terms of its impact on overall spending, competition policy cannot be deemed a success. As Section Three shows, the proportion of GNP devoted to health spending has continued to rise throughout the 1980s. In any case, unlike the US, the UK does not have a problem of aggregate cost containment. Health expenditure accounts for only about 6 per cent of GDP in Britain, compared with over 11 per cent in the US, and has remained around this level for the last ten years. With nearly 90 per cent of health spending channelled through the Department of Health, the public expenditure planning process is able to maintain tight control on spending levels. This arrangement will be unaffected by the government's proposals. On the contrary, where change is proposed – as in the case of indicative drugs budgets for GPs and the establishment of GP budget holders – the principle of cash limiting expenditure is likely to be extended, offering even greater control over aggregate spending.

Only two minor aspects of the government's plans give any cause for anticipating increases in public spending. First, the decision to offer tax relief on health insurance premiums paid by, or on behalf of, the elderly represents an additional form of tax-expenditure. Interestingly, this is an area where US experts have urged others to learn from their mistakes. For example, Enthoven (1989) argues that open-ended tax relief on health insurance in the US has decreased cost consciousness on the part of those taking out insurance; that it is extremely expensive, costing the federal government over $40 billion per year – an amount which is growing rapidly; that it is regressive because 80 per cent of the tax-expenditures go to families with above average incomes; and that much of the subsidy constitutes a 'deadweight' loss because it is received by families who would have taken out the same level of insurance anyway.

Present indications suggest that UK policy is unlikely to have such major effects. Certainly it is doubtful whether the announced levels of tax relief for the elderly will encourage many additional subscribers (Propper, 1989). Nonetheless, numerous Ministerial statements in the run-up to the publication of the White Paper did maintain that Britain's low spending on health – in international terms – is the result of low levels of private spending, and that increased private expenditure was the answer to the problem. If these sentiments persist, further encouragement of private spending should not be ruled out entirely (Field, 1989).

The second possible source of increased public spending arises because self-governing hospitals will be able to set their own rates of pay. Some commentators have argued that this constitutes an erosion of the NHS's monopsony power as an employer and that competitive bidding between hospitals will force up doctors' salaries (Barr, *et al.*, 1989). Certainly US evidence confirms that doctors incomes rose consistently throughout the 1980s at a time when competition was increasing. Once again, however, overall NHS spending controls and doctors' opportunities for private earnings make cost-push pressures for increased public spending far less likely in the UK.

On balance, therefore, it does not seem that US experience on aggregate expenditure control is particularly relevant to the UK. On the contrary the British system of cash limits offers the US some valuable lessons. Interestingly, Evans (1986, 1988) shows how Canadian experience holds a similar lesson for the US. As a close neighbour, with a similar cultural outlook, Canadian spending on health care closely mirrored that of the US until the early 1970s. Thereafter, the introduction of social insurance and bi-lateral bargaining between provincial governments and health care providers – involving, *inter alia*, prospective global budgets for hospitals – has led to a far slower rate of growth of spending in Canada.

However, even though US experience appears to hold few lessons for the UK at the macro level, it might nonetheless provide some relevant guidance at the micro level. As Williams has pointed out, the UK is macro-efficient in spending terms but offers few incentives for efficiency at the micro level (Williams, 1988). This was also the judgement of Enthoven (1985), whose suggested remedy in terms of an internal market, has done so much to shape Ministers' thinking about the future of the NHS. Thus, the key question is how to improve cost effectiveness in the use of resources within the NHS at the local level. To what extent does US evidence suggest that greater competition between providers will achieve this aim?

Somewhat paradoxically much of the US evidence suggests that competition has actually increased costs. Hospitals have typically competed on a non-price basis, emphasising quality and the range of services on offer rather than price. This has meant that hospitals in more competitive areas have sought to offer more facilities, resulting in higher costs than those facing less competition. Retrospective cost-plus reimbursement by insurers placed few limits on this process. But some evidence is emerging to suggest that

this situation is changing. Two recent studies (Zwanziger and Melnick, 1988; Robinson and Luft, 1988) indicate that competition is starting to moderate rates of cost increase. However, these results appear to hinge on important demand-side developments: namely, the emergence of cost sensitive purchasers in both the public and private sectors. Managed health care plans, self-insured employers and Medicare are no longer acting as passive cost-plus reimbursers of hospital services. Increasingly they shop around for cost-effective providers.

This experience may give reason to expect similar cost reductions within the NHS as discriminating purchasing behaviour on the part of district health authorities and GP budget holders encourages competition and greater efficiency among hospitals. However, a number of important caveats apply. These relate to the form of competition that is likely to emerge in Britain; the levels of spare capacity in the NHS; the incentives facing health care purchasing agencies within the NHS; and the transactions costs of trade.

First, it has to be recognised that the competitive process is likely to be more tightly regulated in Britain than in the United States. Numerous centrally imposed restrictions governing, *inter alia*, capital charges and pricing policies, will constrain the freedom of individual hospitals in their choices of competitive strategies. Moreover, the pattern of ownership, and hence behaviour, of hospitals in the US is very different to that found in Britain. Nearly three-quarters of US hospitals are privately owned, and even though 80 per cent of them are not-for-profit institutions (American Hospital Association, 1988), financial considerations play a far more important part in their strategies than they do in NHS hospitals. It is unlikely that even self-governing hospitals will be thrust into an environment in which their fortunes are so dependent on market success as hospitals in the US. As such their responsiveness to demand side pressures is bound to be more muted. This judgement is likely to be even stronger in the case of district managed hopitals. They will occupy a curious role in a system with nominal separation of finance and delivery functions: they will be supply side organisations under the control of purchasing agencies. Without clear separation of demand and supply functions, it is difficult to see how purchasers will be able genuinely to shop around outside their districts and thereby encourage supply side competition.

The second reservation concerning the scope for hospital cost savings centres on the relative levels of spare capacity in the US and the UK. Evidence that competition is starting to reduce costs in the US is particularly marked in California, a state with high doctor-to-population and hospital bed-to-population ratios. More generally, long periods of open ended cost reimbursement have resulted in a level of service capacity throughout the US that is far higher than that found in the UK. Starting from a higher benchmark, it is obviously far easier to envisage competition reducing costs. Put simply, there is likely to be far less fat to cut in the NHS.

Against this argument, however, it is possible to point to longer lengths of hospital stay and lower rates of day surgery in the UK as examples of areas where the introduction of financial incentives may lead to a more efficient use of resources.

A third caveat concerning the relevance of US experience to the NHS centres on the behaviour of purchasers. A more discriminating attitude towards costs on their part has been a major aspect of recent US experience. As far as private purchasers of hospital services are concerned, this has been prompted by a need to attract subscribers in the face of keen price competition on insurance premiums. Although the same pressures may exist – albeit in a less extreme form – in relation to GPs, as they become more dependent on capitation payments for their incomes, the need to attract patients will not be a feature of district purchasing arrangements. Districts will have monopoly purchasing rights for all of their resident population. As such the incentive to pursue cost effective suppliers will be less pressing than in the US.

Fourth, whether or not cost-reducing efficiency gains are realised within the NHS will depend upon the level of transactions costs generated by trade in clinical services. In the US this source of cost escalation is well-known. It has been dubbed the B (Bureaucratic) Factor. According to Reinhardt (1988), the US has the highest B ratio of bureaucrats to direct health care providers in the industrialised world. On average, each doctor employs one extra person just to handle his payments system. Computer requirements are similarly vast: to handle its billing, it would not be unusual for a US hospital to have a system comparable in size to that presently necessary to handle finance in an entire NHS region. Not surprisingly, US administrative costs are in excess of 20 per cent of total health expenditure – compared to less than 10 per cent in the UK – and are rising fast (Lee and Etheredge, 1989).

Fortunately the government's decision to reject proposals for a widespread expansion of private health insurance means that the worst excesses of the US system will be avoided. At present American consumers spend countless hours sifting through alternative health insurance policies and claiming reimbursement after receiving treatment. For most people this need will not arise in Britain. But other aspects of the B-factor might become more familiar.

In the US numerous large accounting firms are engaged in keeping health care books, structuring and re-structuring hospital organisations, and helping them to finance and re-finance themselves. In this country, management consultants are already gearing up their health divisions to offer comparable assistance to the NHS. With the service about to be pitched into an unfamiliar world of trade and marketing, there is clearly going to be plenty of demand for these services. The extremely rapid timetable of change laid down by the government makes it difficult to see how sufficient numbers of staff with the requisite skills can be found and trained internally. The NHS Training Authority has already highlighted the dangers of shortages of staff able to work with modern information technology, while Duncan Nichol, the Chief Executive of the NHS Management Executive, has voiced worries about staff

shortages slowing down the introduction of resource management systems in hospitals. These shortages should ensure that generous fees are paid to those whose skills are bought-in, adding yet more to the costs of implementation.

Of course, it should not be supposed that increased transactions costs within a more market-based NHS would necessarily be inconsistent with greater overall cost-effectiveness. Many of these costs will be only transitional. Moreover, markets offer financial incentives for efficiency. The lack of incentives has undoubtedly been a source of inefficiency during the past. But the US experience with the B factor does indicate the need to focus attention on the cost-benefit balance of the government's proposals.

Finally, on the subject of cost savings, it was pointed out in Section Three that US policy makers have not relied exclusively on market competition in their quest for cost containment. In fact, the development of managed health care systems – involving greater vertical integration in service provision – has sometimes reduced the level of competition. And yet these systems appear to have been particularly successful in containing costs through control of hospital utilisation. As in the case of aggregate cost containment, however, this experience suggests that the US has more to learn from Britain than *vice versa*. This judgement is based on the British, GP-based hospital referral system which performs an effective gatekeeping role preventing unnecessary, and costly, direct access by patients to hospital specialists. This service is far less developed in the US where only 12 per cent of doctors are family practitioners compared with 46 per cent in the UK (Weiner, 1987).

CHOICE

The role assigned to consumer choice in any health care system depends upon an underlying set of values. These vary substantially between countries. The US stands at one end of the spectrum with a strong belief in consumer sovereignty. In the US, it is axiomatic that consumers should be free to choose what they want, how much they want and from whom they should purchase it. These values are applied to health care just as they apply to most other areas of economic activity. The result is an extremely diverse system with a large amount of consumer choice. Moreover, there seems little doubt that the abolition of restraints on trade and increased competition between providers has played a major part in increasing diversity and choice. Individuals are now able to subscribe (either directly or through their employers) to a vast range of insurance plans and/or managed health care systems. In choosing between them, variations in the range of services on offer, the hospitals and doctors that may be used, and the extent of cost coverage all need to be taken into account. But, consistent with the underlying values, major responsibility for making these decisions rests with individual patients. This places considerable reliance on their ability to do so. As Pauly (1988a) notes:

> *the critical assumption needed to offer a market orientated alternative to heavily regulated or publicly-run systems is the assumption that consumers can, somehow, make or can be expected to make reasonably well-informed choices in medical markets* (p. 24).

In practice, though, consumers of health care rarely possess adequate information. Indeed it was recognition of the unequal information and bargaining strength possessed by lone consumers facing large scale providers that led Enthoven to modify his earlier views about consumer sovereignty and to argue for sponsoring agencies that will act on the consumer's behalf. Writing in 1986, he conceded:

> *I now see much more clearly than in 1977 the need for an active and extensive role for sponsors as an essential part of a successful competition strategy* (p. 107).

According to Enthoven, sponsors could be employers, unions, health and welfare trusts and government agencies. The essential point is that these agencies would have more information and bargaining power than any single consumer. He describes a system within which they would operate as one of managed competition.

> *Managed competition must involve intelligent, active agents on the demand-side, contracting with health care plans and continuously structuring and adjusting the market to overcome attempts to avoid price competition. I call these agents 'sponsors'; they play a central role in managed competition* (p. 106).

The UK has started from a very different position as far as consumer choice in health care is concerned. Collective values have figured far more prominently in the NHS. One consequence of this approach has been the development of the 'agency' relationship between doctors and patients (McGuire *et al.*, 1988). Instead of viewing the relationship as one between buyer and seller, the agency role views the doctor as an agent acting on the patient's behalf. This role becomes important if Pauly's 'critical assumption' fails to be met. For as Evans (1984) points out, informational asymmetry is an important determinant of the need for agency behaviour. As long as it is doctors who effectively determine patients' demands, there will be a breakdown in the normal provider-consumer relationship. Put simply, supplier induced demand undermines the concept of consumer sovereignty.

It appears, therefore, that the US and the UK have approached the doctor/patient relationship from polar extremes. The US has traditionally emphasised the roles of buyer and seller whereas, in the UK, reliance has been placed on the common interests of the doctor and patient through development of the agency relationship. However, just as Enthoven and others have been arguing for demand-side management as a means of boosting consumer power in the US, so there has been a growing body of opinion which believes that the rights of patients *qua* consumers should be strengthened within the NHS. This is, of course, consistent with the rise of consumerism across a wide range of social policy and reflects dissatisfaction with the role of passive recipients of services often assigned to users of large scale public services. The

government's rhetoric is clearly attuned to the consumerist movement. But will its proposals actually increase responsiveness to patients needs?

On the positive side, measures offering patients greater freedom to change between GPs, and those providing financial incentives for GPs to attract patients, should both contribute towards greater responsiveness to patients' needs. It is also possible that the introduction of practice budgets will encourage GPs to be more imaginative about the range of services they offer, possibly substituting some of their own services for routine tests and procedures presently carried out in hospitals. Minor surgery carried out on GPs' premises may prove more attractive to some patients than a visit to a hospital day surgery or out-patients department. Many family doctors in the US already routinely carry out minor 'lumps and bumps' surgery. Those patients who are not attracted by this prospect will, of course, still have the option of registering with GPs who continue to refer their patients to hospitals. Thus a range of practice styles offering more choice may well develop.

The main reservation concerning GP budget holder arrangements, however, centres on the possibility of patient selection bias. As mentioned in Section Two, increased dependence on capitation payments offers GPs a financial incentive to avoid registering patients who are likely to make heavy use of their services and budgets. Scheffler (1989) describes an American HMO's response to higher capitation payments for the elderly: in an effort to attract old people in good health, applications were invited at a dance held on the second floor of a building without a lift!

In principle, the way to avoid this problem is to devise a system of capitation payments that approximates individual levels of use. Unfortunately, the NHS simply does not have data at the necessary level of disaggregation for this to be introduced at the moment. To date the only experience with capitation payments reflecting hospital use has been through the far more aggregate RAWP formula. However, with GP budget holder populations of only 11,000 patients there would be far less scope for averaging out the expenditure consequences of high and low users. Significantly, US evidence of HMOs suggests that for acceptable risk pooling to take place a minimum of 25,000 subscribers is necessary. HMOs below this number tend to be growing or going out of business (Weiner, 1989).

A rather different reservation about the plans for general practice queries whether they go far enough in offering more patient choice. Holders of this viewpoint note that barriers to entry imposed by the Medical Practices Committee will continue to limit the establishment of new practices in many areas. As at present, the Committee will be able to place restrictions on GPs setting up practices in restricted or intermediate areas (Barnard and Wood, 1986). These cover areas where there are 2,100 or fewer patients per GP; in 1986 nearly 92 per cent of GPs were located in such areas. The aim of these restrictions is to achieve a more even distribution of GP list sizes throughout the country. However, they also serve as a powerful barrier to new entrants, protecting established practices from competition and limiting patient choice. As GP payments move over to a capitation basis there should be less need for them. The total patient population in any area can be expected to act as a check on its attractiveness to prospective entrants. Moreover, the increased popularity of general practice among newly qualified doctors suggests that an increase in aggregate supply can be expected to contribute towards an easing of supply shortages in areas with large patient list sizes. If necessary, special payments can always be used more vigorously to attract GPs to areas of particular local need.

In contrast with the plans for GPs, the government's claim that its proposals will increase patient choice in relation to acute hospital services is more questionable. Admittedly, in the case of patients registered with GP budget holders, decisions about whether and where a patient is referred may be taken by the GP in direct consultation with the patient. Only rarely, however, will GPs shop around and make individual choices for particular patients. In most cases they will have annual service contracts with particular hospitals and will refer their patients accordingly. For most GPs this is unlikely to represent any great change from their current referral practices. But budget holding GPs will be in a minority and will cover only a small proportion of hospital services. The majority of patients will find that the hospital from which they receive treatment will be determined by the district acting as a purchasing agency. Despite the DOH's assurance that districts will be expected to work closely with GPs in arranging the placement of contracts, it is made clear that if a conflict arises it will be the district's view that dominates:

> *The DHA as budget holder is accountable for its expenditure and it cannot therefore be put in a position of being a mere cypher and reflecting individual GP's wishes regardless of their effect on other patients services* (DOH, 1989f, p.13).

While balancing the interests of individuals with those of the totality of patients is obviously a legitimate task for the district, this arrangement will inevitably restrict GPs' freedom of referral in some cases. How large a restriction on choice this will represent is not yet known.

QUALITY

Ensuring that an adequate quality of care is maintained in the face of pressures to reduce unit costs is going to be a major task facing the NHS. Although there is only patchy evidence of lower standards resulting from cost containment strategies in the US, there is nonetheless a sufficiently widespread concern about this threat to alert British policy makers (Quam, 1989). In the light of this danger, it is instructive to note some of the positive strides the US is taking to counteract these tendencies. Three initiatives are of particular interest. These involve efforts to eliminate clinically inappropriate treatments, the regulation of quality through hospital accreditation, and the dissemination of information about quality to consumers.

Interest in clinical appropriateness arises because

the practice of medicine involves a good deal of uncertainty. Diagnosis and treatment is often an imprecise science. One consequence of this uncertainty is the existence of marked variations in clinical practice (Ham, 1988). For example, there are threefold variations in rates of prostatectomy and twofold variations in hysterectomy and hernia repair between NHS districts in the same region. Success rates after renal transplant are known to vary widely between different surgical centres as do those of cardiac surgery. And there are significant variations between hospitals in their rates of avoidable death after anaesthesia and surgery (Buck *et al.*, 1988).

In the US, the RAND corporation has carried out a number of studies with the aim of reducing variations resulting from unnecessary or inappropriate treatment. In these studies, expert panels of doctors examine batches of patients' medical records in order to establish clinically appropriate treatments for patients on the basis of their presenting symptoms (Merrick *et al.*, 1986). This work suggests that levels of inappropriate use of up to 30 per cent apply in some areas of surgery (Chassin *et al.*, 1987).

Preliminary application of this methodology to UK surgeons, in the case of coronary artery by-pass grafts, suggests that they are more conservative than their US counterparts and undertake fewer surgical procedures. Other things remaining equal, this might be taken to imply a lower incidence of inappropriate surgery in the UK. However, the work of Siu *et al.*, (1986), referred to previously, suggests that, in the US, areas with low rates of surgery do not necessarily have a lower proportion of inappropriate admissions. Moreover, focusing greater attention on appropriateness could no doubt contribute towards improvements in related areas of care — involving, for example, lengths of stay — where there are also large, unexplained variations.

The second area in which US experience may prove instructive is in relation to hospital accreditation. At the moment, the government's plans for the NHS make it clear that service contracts between purchasers and hospitals will need to specify quality standards. These will cover the facilities that will be employed, the speed with which patients will gain access to services, measures of clinical quality, including appropriateness, and, where possible, measures of clinical outcomes (DOH, 1989f). By far the most difficult task will be the measurement and regulation of quality in relation to clinical care. In this connection, the government's plans rely largely on an extended and enhanced role for medical audit. However, this is essentially a quality control process which is internal to provider organisations. Individual hospitals will be charged with self regulation. As was pointed out in Section Two, both the Institute of Health Services Management and the National Association of Health Authorities have argued for an independent body to be responsible for this task. The US (along with Canada, Australia and New Zealand) provides a model for such a body in the form of a Joint Commission on the Accreditation of Health Care Organisations.

The Commission is a voluntary, non-governmental body owned by the American Medical Association, the American Hospital Association, and the American Colleges of Surgeons and Physicians. In order to qualify for accreditation, hospitals must meet certain standards. These are established by Commission staff during intensive two-to-four day visits to hospitals. Without accreditation it is more difficult for hospitals to receive Medicare and Medicaid payments. Moreover many private insurers are influenced by accreditation status in meeting claims for payments. These conditions provide a powerful incentive for hospitals to obtain accreditation. As a result the Joint Commission deals with 84 per cent of US general hospitals (Sketris, 1988).

Brooks (1989) – along with a strong body of other expert, professional opinion – is under no doubt about the value of a similar initiative in Britain.

> *Unless we develop a national standards framework operating as an integrated whole with local quality assurance initiatives, the issue of quality will remain half way down the management agenda . . . We need to grasp the present opportunity for action, and experiment carefully, learning lessons from existing British and international quality initiatives* (p.264-5).

Thus far, the government has shown little enthusiasm for such a body, although local initiatives involving external assessors and individual hospitals are underway (King's Fund Centre, 1989).

The third area in which US experience of efforts to maintain or raise standards of care may provide some lessons concerns the dissemination of information. Enthoven (1989) refers to American initiatives in this connection as examples of 'glasnost' or openness. Increasingly measures of hospital standards (including differential mortality rates) are published and made available to purchasers of services. In some cases, newspapers carry regular in-depth reports about variations in hospital performance based upon official publications and research reports. Clearly the production of information on quality is vital if consumers are to be given any chance of making wise decisions.

To date, most of the emphasis on performance in the NHS has concentrated on inputs or activity statistics. These are recorded in terms of performance indicators (Smith, 1987). However, these indicators are not the primary concern of potential patients who wish to assess the quality of care. To them, measures of the outcome of activities are far more important.

Kind (1988) conducted a preliminary investigation of outcomes by calculating mortality rates for English health authorities for 9 age groups across 24 diagnostic categories. His work revealed threefold variations in standardised mortality rates between the best and worst districts. However, commenting on Kind's findings, Charny (1988) points out that variations in case complexity, inaccuracies in diagnostic coding, co-morbidity and many other factors make a straightforward comparison of mortality rates extremely hazardous. He is also critical of the US practice of publishing mortality rates, arguing that:

> *There have been anxieties that the publication of inadequately adjusted mortality rates may not only*

unjustly mar a hospital's reputation but may also contribute to a hospital's decision to change its admissions criteria to exclude patients with a high risk of a poor outcome (p.1451).

Clearly, the publication of mortality rates or other quality of care data needs to be handled carefully if it is not to be misleading or counterproductive. But to argue, as some have done, that information should be witheld or supressed on these grounds is, of course, the common cry of experts who feel that they are the only ones competent to judge other people's fate. Work to improve data reliability, and the patient's ability to interpret them, represents a potentially more worthwhile response to criticism. And in this connection US practice may contain some useful pointers.

ACCESS

Unequal access to health care in the US is primarily the result of variations in insurance coverage. For those people with adequate insurance, timely access to a good quality service is usually guaranteed. But nearly 20 per cent of Americans under 65 years of age have no protection against medical expenses, either public or private (Short, 1989).

Problems of access stemming from inadequate insurance should not arise in Britain. In the foreword to Working for Patients , the Prime Minister reaffirmed that:

The National Health Service will continue to be available to all, regardless of income, and to be financed mainly out of general taxation. (DOH, 1989a).

Hence there is no reason to believe that the principle of universal coverage is likely to come under threat. In this sense, the British system has already achieved what various proposals for extending insurance coverage in the US are seeking to establish.

Understandable fears have, however, been expressed about the introduction of markets and competition, arguing that they will disadvantage certain vulnerable groups. Section Two has discussed the danger of this coming about if financial incentives change the behaviour of GPs and hospitals in undesirable ways. But this is by no means inevitable. By ensuring that purchasing power is distributed in an equitable way that reflects health care needs, the new health care market has the potential for ensuring universal access in a way that is not possible in the present US system.

CONCLUSION

Throughout this report the uncertainty surrounding the government's plans for the NHS has been emphasised. In large part, this uncertainty has resulted from the unusual form of public policy making the government has chosen to adopt. Detailed consideration of how the proposals will work in practice has followed the announcement of the reforms, rather than – as has usually been the case in the past – preceding them. As such there has been a shifting policy agenda. A succession of Working Papers have appeared since the publication of Working for Patients. Often these contain hints that certain proposals have been modified as the theoretical and practical difficulties associated with them have become beyond dispute. The role assigned to competition is a case in point.

Early support for competition policy drew heavily on the properties of market systems with their incentives for efficiency and the extension of consumer choice. A procession of US experts visited Britain – usually at the invitation of right-wing think tanks – and offered lessons based on their experience with competition policy in the United States. The concept of an internal market was one imported idea that held particular appeal for Ministers searching for a model of health care that was consistent with their market-based philosophy. In recent months, however, there has been a noticeable softening of approach. No doubt in response to the widespread professional and popular opposition to their plans, Ministers have been at pains to point out that their proposals are essentially common sense, pragmatic measures designed to improve NHS performance. Efforts have been made to distance the plans from market models as recognised by economists and other experts. As part of this process, the term managed competition has been adopted to describe the form of regulated market the government now favours. In fact, in some cases, it now appears likely that the degree of regulation will be so strong as to cast doubt upon the appropriateness of the term market at all. It may be more accurate to speak of partial deregulation of the existing system. At the same time, some of the more acceptable consequences expected of competition have been given greater prominence. Far more emphasis has been placed on competition between doctors and hospitals as a means of enhancing the quality of health care, with considerations of efficiency and cost-effectiveness receiving rather less exposure.

But these changes should not be dismissed as merely cosmetic devices based upon political opportunism. In many ways they are the fruits of a dialogue which has taken place since the initial publication of the government's plans. Constructive criticism and commentary seems to have influenced the direction of policy. This judgement applies with special force to the relevance of US experience. This report has shown that the US evidence on competition and efficiency is ambiguous. Moreover, there are many features of the NHS – and the model of managed competition that now seems likely to be applied – that make it hazardous to generalise from US experience. On the other hand, the US is making headway in devising new methods of quality assurance. In the longer term, ideas on clinical appropriateness and accreditation may be more influential imports than the concept of market competition.

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