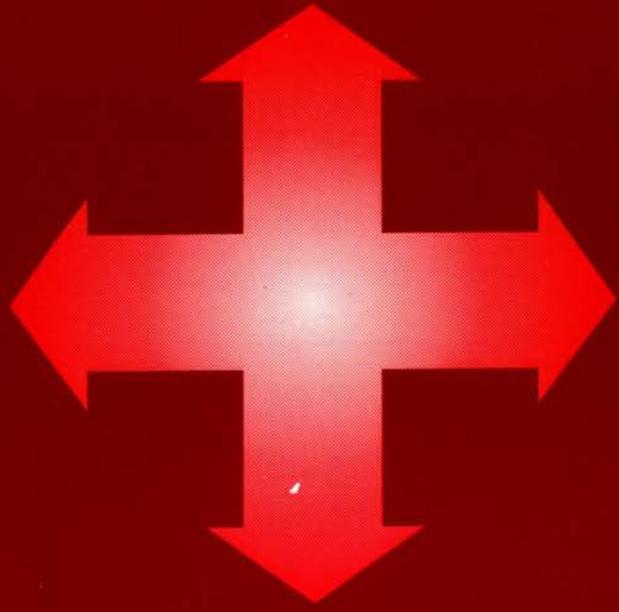


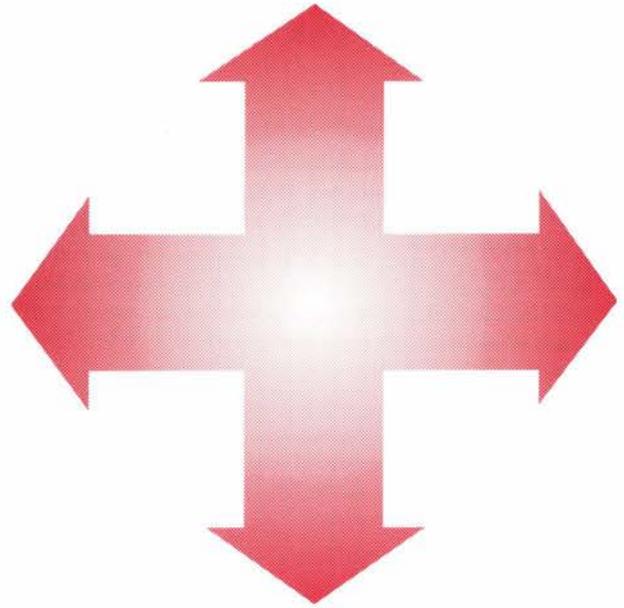
# MANAGING THE NHS



**past, present and  
agenda for the future**



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agenda for the future**

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## **Office of Health Economics**

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To collect data from other countries.

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# Preface

The recent pace of administrative change in the NHS has been rapid, culminating in the October 1993 decision to abolish the Regional tier of management and merge DHAs and FHSAs. This paper by William Laing is a timely and successful attempt to put these changes in context. It sets out the history of administrative change in the NHS since its inception in 1948, and the concerns that successive reform measures have been designed to address. As the paper shows, the internal market reforms cannot be seen simply as an aberration in the administrative development of the NHS. In many respects they can be seen as the logical consequence of a long series of government initiatives to give strategic direction to the service.

The paper discusses the challenges of the technology induced reconfiguration of services, demographics, patient expectations and rationing. It identifies those issues that remain unresolved by the October 1993 decisions, outlining the future options available for managing the internal market in a way that is accountable, ultimately, to the public.

The paper is intended to be analytical and descriptive. It does not seek to judge the effectiveness of the 1948 administrative structure or of subsequent changes, including the management structures put in place for the internal market. Rather it sets out objectively where we have got to, how we got there, and where we might be heading.

ADRIAN TOWSE,  
*Director of the Office of Health Economics*

# List of abbreviations used

ABPI	Association of the British Pharmaceutical Industry
AHA	Area Health Authority (abolished in 1982)
BMA	British Medical Association
CHC	Community Health Council
DGH	District General Hospital
DHA	District Health Authority
DMU	Directly Managed Unit
ECR	Extra Contractual Referral
FPC	Family Practitioner Committee
FHSA	Family Health Services Authority
GP	General Practitioner
HMO	Health Maintenance Organisation
IHSM	Institute of Health Services Management
IPA	Indicative Prescribing Amount
IT	Information Technology
NAHAT	National Association of Health Authorities and Trusts
NHS	National Health Service
NHSME	National Health Service Management Executive
RAWP	Resource Allocation Working Party
RHA	Regional Health Authority
RMI	Resource Management Initiative
SMR	Standardised Mortality Ratio

# Contents

<b>1. Introduction</b>	<b>7</b>
<b>2. Evolution of NHS administration since 1948</b>	<b>8</b>
2.1 Initial structure of the NHS	8
2.2 The 1974 reorganisation – integration and strategic direction	8
2.3 Introduction of general management in 1984	11
2.4 Limiting the autonomy of professional groups	12
<b>3. The 1990 NHS and Community Care Act – the internal market</b>	<b>14</b>
3.1 NHS providers	17
3.2 NHS purchasers	20
3.3 The consumer voice – Community Health Councils	22
3.4 Existing upper tiers of administration and the October 1993 functions and manpower review reforms	23
3.5 Consensus on key recommendations from the functions and manpower review	25
3.6 Issues unresolved by the functions and manpower review	25
<b>4. Forces for change in healthcare – impact on NHS administration</b>	<b>27</b>
4.1 Medical technology and reconfiguration of healthcare services	27
4.2 Consumerism and rationing	29
4.3 Demography – the ageing population	32
<b>5. Agenda for the future</b>	<b>35</b>
5.1 The degree of regulation	35
5.2 Scope for decentralisation in the NHS	37
<b>References</b>	<b>41</b>

# 1 Introduction

This paper is about NHS management in its broadest sense. It is not just about describing administrative structures. It is concerned with the whole range of issues relating to the strategic direction of the health services, the framework of accountability and the setting of financial and other incentives under which managers, healthcare professionals and consumers of health services operate. The paper looks at the underlying relationships and dynamics of the healthcare system following the introduction of the NHS internal market in 1991. It also looks at the administrative implications for the NHS of being a central element of the welfare state and a major spending department of government.

At the time of writing, new proposals for streamlining NHS administration – *Managing the New NHS*, based on the work of the Functions and Manpower Review Group – had just been published (Department of Health, 1993a). These proposals, which are intended to tie up the administrative ‘unfinished business’ of the internal market reforms, include the abolition of the fourteen Regional Health Authorities (RHAs) in England, their replacement with eight newly constituted regional offices of the NHS Management Executive (NHSME) and legislation to permit the merger of District Health Authorities (DHAs) and Family Health Services Authorities (FHSAs). This paper does not seek to pass judgement on the merits of these streamlining proposals, or indeed on the merits of the internal market reform process as a whole. Rather, it aims to set out as objectively as possible how the administration of the NHS has evolved since 1948, what the key unresolved issues are and how management of the NHS internal market may continue to evolve in the 1990s.

The paper is divided into four sections. The first section covers the major landmarks in the evolution of the NHS since 1948 and the thinking behind the changes that took place. The second section describes the main features of the internal market created in 1991, including the administrative streamlining proposals set out in *Managing the New NHS*. The third section identifies and analyses three of the principal forces for further evolution of the NHS – changing medical technology, demographic change and consumerism.

Finally, the fourth section considers the broad directions that NHS administration may take as the internal market evolves. It asks to what extent the

aim of decentralising decision making to local managers can be achieved. It concludes that whereas ‘light touch’ regulation of the provider side of the NHS can be achieved, there is a fundamental problem in seeking to delegate the rationing decisions which lie at the heart of the purchasing function. Such rationing decisions as are presently taken centrally derive legitimacy from the periodic election of governments. But DHAs are not elected bodies and devolution of the rationing element of purchasing to DHA managers would weaken that legitimacy. The problem can be resolved either by Ministers setting DHAs more detailed guidelines on priorities than they do at present – *ie* by centralising the rationing process – or by seeking some other source of legitimacy. One alternative source of legitimacy in rationing healthcare resources is through an expanded GP fundholding scheme, with GP accountability to patients replacing Ministerial accountability to parliament. Another option, though one that is unlikely to find favour with the present government, is to transfer DHAs’ purchasing functions to locally elected bodies. Each of these options has its strengths and weaknesses. Ultimately, the choice is a political one, involving differing perceptions of the merits of ‘exit’ (changing GP) and ‘voice’ (political pressure) as mechanisms for expressing choice in the development of health services.

Which ever route is chosen, further management changes will follow. The thread running through this paper, however, is that successive reforms to the management structure of the NHS since 1948 have tackled the same basic concerns of governments of both political parties, namely the need to secure control of overall expenditure and to create an organisation that responds to strategic direction and delivers healthcare efficiently.

# 2 Evolution of NHS administration since 1948

## 2.1 Initial structure of the NHS

The creation of Britain's National Health Service in Britain emerged from the wartime political consensus. Following the Beveridge Report of 1942, all political parties subscribed to the view that universal access to a comprehensive healthcare service should form part of the post war settlement.

It is interesting to note, in view of the current internal market reforms, that the original Beveridge concept was for public funding of a plurality of decentralised healthcare providers. In the event, the centralised shape that the NHS took in 1948 was a product of the then Labour Party's approach to social reform. The aim of Clement Atlee's Labour administration, elected in 1945, was to create a centralised, unitary system as a means of securing equality of healthcare throughout the country. In some ways Aneurin Bevan, Labour's health minister, succeeded in creating a unitary system, for example through the nationalisation of voluntary hospitals and their fusion with hospitals previously run by local authorities. In other ways he was forced to compromise, mainly in order to gain the co-operation of the British Medical Association (BMA) and other doctors' representative bodies for the new system. A crucial feature of the agreement reached with hospital doctors, which appeared unexceptionable at the time, was that they were to retain their clinical autonomy. The 'tripartite' structure of the NHS was also a consequence of political pressures from the medical profession. The BMA insisted on independent contractor rather than salaried status for General Practitioners (GPs) in the NHS. Doctors' representatives were also instrumental in securing the separation of hospital from community health services, because of hospital doctors' fear of the NHS being subsumed within local government and becoming subject to local electoral pressures. As a result, when the NHS was established in 1948, it consisted of three separate administrative structures, one for hospitals run by Hospital Management Committees and Boards of Governors of teaching hospitals, one for community health services operated by Local Authorities and the third for general practitioners, pharmacists, dentists and opticians, all of whom worked as independent contractors to Executive Councils.

The immediate popularity of the NHS put paid to any Conservative Party thoughts of reverting to a more pluralist approach. Indeed, for the next

twenty-five years the agenda for reform of the NHS was dominated by the perceived need to achieve more effective unification of the three parts. Creating a more integrated healthcare system was seen as a precondition for improving treatment, particularly for patients with chronic conditions whose needs required a co-ordinated response. It was argued that planning and development of services was inhibited by the split between the hospital and community health services. There was also concern about the professional isolation of general practitioners from what was then seen as the mainstream activity of hospital medicine.

The case for reorganising the NHS and unifying its three components was greatly strengthened by the apparent inability of government to control its cost. The first of many NHS cash crises took place in 1951 when the Labour government introduced charges for spectacles and dentures. Faced with mounting costs, the succeeding Conservative administration set up the Guillebaud Committee of Enquiry which, in its 1956 report, found no evidence of inefficiency – concluding rather that increased real healthcare spending was an inevitable consequence of demographic change. This uncomfortable conclusion simply focused attention on the absence of existing mechanisms by which government could control the direction of a massive undertaking which threatened to absorb an increasing share of national resources. On the few occasions when central government did seek to embark on strategic initiatives, such as Enoch Powell's Hospital Plan of 1962 – changes proved difficult to implement against the massive inertia of the NHS. How to create the capacity for strategic direction came to occupy an increasingly important place on the policy agendas of each of the main political parties.

## 2.2 The 1974 reorganisation – integration and strategic direction

By the late 1960s both main political parties had accepted the case for a reorganisation of the NHS which would involve both unification of the tripartite structure and the creation of a strategic tier. In 1968 the Labour government indicated its intention to legislate with the publication of the first of its two Green Papers on the NHS. Following the 1970 election, the new Conservative government continued to pursue the aim of NHS unification with the publication of a Consultative

Document in 1971 and the White Paper of 1972. The NHS Reorganisation Act passed through parliament in 1973, though by the appointed day for implementation, 1 April 1974, a Labour administration was back in power. The steady progress of NHS reorganisation despite two changes of government was indicative of the degree of consensus regarding NHS policy at that time. There was debate over whether the strategic tier should be at regional or area level, but the main thrust of the reorganisation was not contentious.

In the event, the regional tier of administration was given the role of strategic planning (Box 1). The 14 Regional Health Authorities (RHAs) created in England were also given finance and hospital building functions together with powers to direct the lower tier of 90 Area Health Authorities (AHAs). AHAs in turn were responsible for administering the NHS at the operational level and overseeing the work of the Family Practitioner Committees (FPCs) – which replaced Executive Councils as the agencies charged with administering the contracts of general practitioners, pharmacists, dentists and opticians. AHAs were also given responsibility for providing community health services, including district nursing, health visiting, school health services and chiropody, which had hitherto been in the hands of local authorities.

Though AHAs were the lowest tier of statutory authority, the 1974 reorganisation also put in place a lower, district level, management structure with District Management Teams. The concept of the ‘natural health district’ was a product of the 1974 reorganisation. Districts were intended to be the smallest units for which substantially the full range of general health and social services could be provided and also the largest ones within which all types of staff could actively participate in management through effective representative systems. The 1972 ‘Grey Book’ (DHSS, 1972) indicated they would have populations of around 250,000, typically enough to support a single district general hospital. Districts were to provide the basis for a new lower tier of administration when AHAs were abolished in the 1982 reorganisation.

Finally, Community Health Councils (CHCs) were a lasting creation of the 1974 reorganisation, intended to introduce an element of consumer representation into the NHS. However, though the work of many CHCs is highly regarded, they were and still are consultative bodies with no executive powers and no right to veto health authority decisions.

Unification of the NHS was to a large extent achieved by the 1974 reorganisation, but at a price of splitting community health services from personal social services. Local authorities remained

responsible for residential homes and a range of community care services for elderly, mentally ill and mentally handicapped people including home helps and day centres. To deal with the planning and operational issues raised by the split of community health and personal social services, Joint Consultative Committees were set up, with membership from AHAs and local authorities. However, problems caused by different geographical boundaries and different professional and political agendas continued to bedevil effective co-ordination of community health and social services.

The capacity for strategic direction created by the 1974 reorganisation was reinforced in 1976 by the introduction of a new formula, RAWP, for distributing finance to constituent parts of the NHS. Previously, money had been allocated to regions on the basis of historical spending. It was widely recognised that as a consequence the four Thames regions, and inner London in particular, were over-resourced in relation to the rest of the country. RAWP, named after the Resource Allocation Working Party which proposed it, represented the first concerted effort to introduce ‘need’ as the criterion for NHS financial allocations. The RAWP formula calculated a target revenue allocation for RHAs on the basis of population, weighted by age, sex and standardised mortality ratio (SMR – being the ratio of actual mortality to expected mortality in a given area), the latter as a proxy for relative morbidity. The government then took a decision in each succeeding year on how far actual allocations to RHAs should move towards target RAWP allocations. To a varying extent, RHAs in turn applied a sub-regional RAWP. The system enabled a gradual shift of resources to take place towards regions with a higher than average ratio of ‘need’ to resources. RAWP also enabled health authorities to be financially compensated for services provided to other authorities’ populations, through cross-boundary flow payments. Such payments, however, did not accrue to the hospital or unit providing the service, but gave rise to an adjustment in the authority’s overall budget in the subsequent financial year. Cross boundary flow payments, therefore, did not involve direct transfers or ‘money following patients’. Though few managers understood the more arcane intricacies of RAWP, during the period of its use from 1976 to 1991 it did allow resource distribution to become more responsive to healthcare service needs than hitherto. One fundamental problem that was not, however, resolved by RAWP – and which remains unsolved in the post 1991 internal market system – is the absence of any convincing formula for calculating the relative need of populations for healthcare resources. Utilisation rates (eg by age, sex) provide one means of calculating relative resource need, but a utilisation based formula may

**Box 1 THE 1974 NHS REORGANISATION**

The services brought together under the unified NHS administration were:

- a) The hospital and specialist services formerly administered by the Regional Hospital Boards, Hospital Management Committees and Boards of Governors.
- b) The dental, ophthalmic, pharmaceutical and family doctor services, transferred from the administration of the Executive Councils to Family Practitioner Committees under Area Health Authorities.
- c) The personal health services previously run by the local authorities through their health committees. These included:

- |                         |                                      |
|-------------------------|--------------------------------------|
| Ambulance services      | Home nursing and midwifery           |
| Epidemiological surveys | Maternity and child care             |
| Family planning         | Vaccination and immunisation         |
| Health centres          | Other preventive and caring services |
| Health visiting         |                                      |

- d) The school health services.

**Notes**

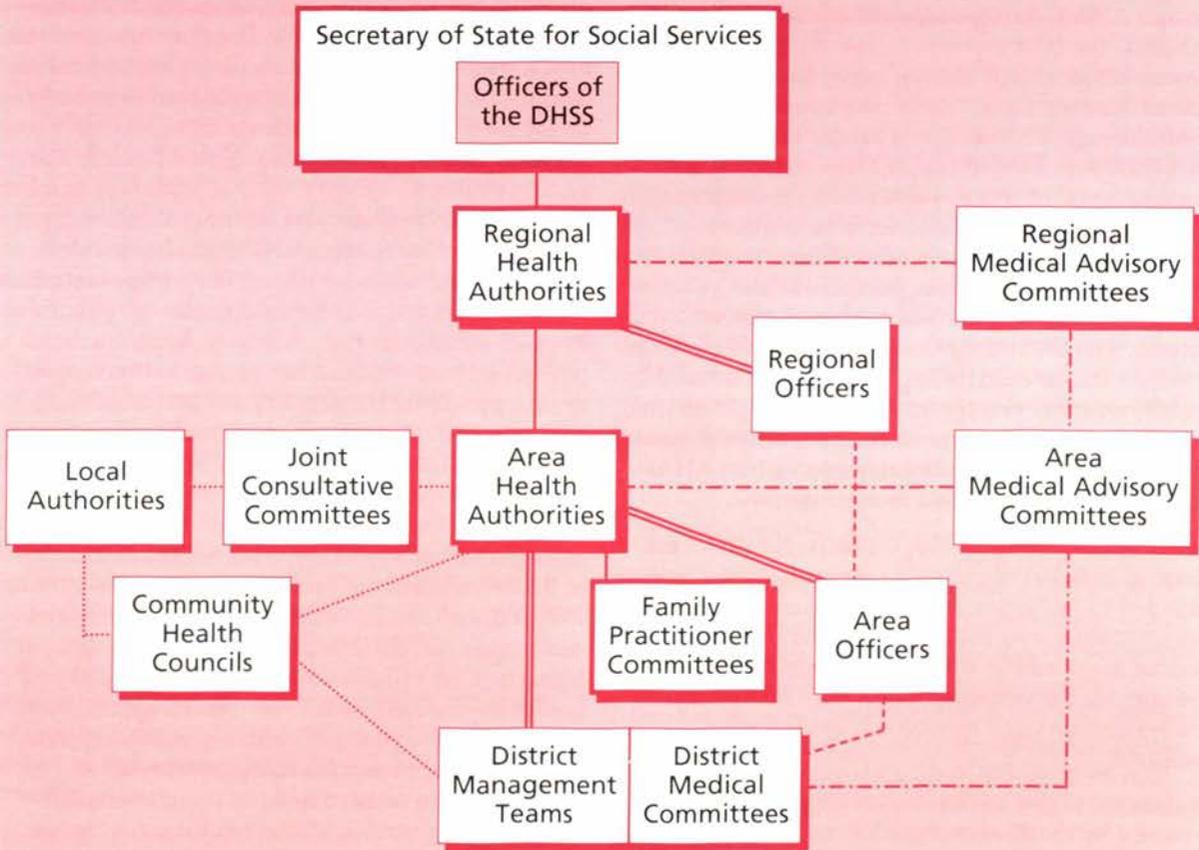
- a) Extensive health education powers were given to the new NHS authorities although the local authorities kept their responsibilities in this area with regard to environmental health and the Health Education Council also retained its existing role.
- b) The NHS took over registration of nursing homes, although the registration of nursing agencies remained a responsibility of the local authorities.
- c) Family planning was subsequently taken over by the NHS.

The services remaining outside the NHS included:

- a) The occupational health services of the Department of Employment.
- b) The environmental health services run by the local authorities.
- c) The personal social services, including hospital social work.
- d) Certain other health provision, eg prison health services and those of the armed forces.

**Framework of the NHS structure in England**

- Corporate accountability
- ==== Individual officer accountability and joint team responsibility
- - - - - Monitoring and coordinating between teams and individual counterpart officers
- . - . - Representative systems
- ..... External relationships



Source: (Figures 1-4) Management Arrangements for the reorganised National Health Service. HMSO 1972

simply reflect existing provision rather than need, and may thus reinforce any existing geographical imbalances. Instead, RAWP used SMRs as an independent proxy for need, and assumed a one for one relationship between SMRs and an authority's need for resources: for example, an authority with an SMR 10 per cent in excess of the national average was assumed to need 10 per cent more resources than average (Bevan, 1989). In fact there is neither a theoretical nor an empirical foundation for such an assumption. The unresolved issue of what resource weighting to give different populations has become even more pressing with the advent of the internal market, which requires allocations to be made to small population groups served by GP Fundholder practices.

Another important additional mechanism for strategic control of the NHS followed the 1974 reorganisation. This was the development of a comprehensive, and what critics later claimed was a highly cumbersome, planning system with an annual planning cycle involving all tiers in the administrative hierarchy. The system which emerged in the NHS was typical of the approach to corporate planning in government and business generally in the mid 1960s and early 1970s. This was a time when 'the end of ideology' was an idea in common currency. Many large public sector organisations were devoting substantial resources to devising management techniques such as programme planning and budgeting or programme analysis and review as a means of finding technocratic solutions to the problems of managing large budgets to achieve policy objectives.

The consensus model of NHS management which was adopted in the 1974 reorganisation came to be viewed, in retrospect, as highly bureaucratic and ultimately inconsistent with the goal of achieving strategic direction. Consensus management reflected a view of the NHS as a highly complex organisation in which the essential job of managers was to resolve tensions between the various professional groups and to provide an efficient working environment in which clinicians could get on with their jobs. It was a collegiate system, in which there was no clear focus of authority. Consultation within and between each of the three tiers of management (Area to Region to the Department of Health and Social Security) made decision making a lengthy process. As a further complicating factor, in addition to lines of accountability through those corporate structures there were also lines of professional accountability (from District officer to Area officer to Regional Officer) which bypassed them. Most important of all, the notion of challenging clinicians was alien to consensus management. Expressed another way, the 1974 reorganisation simply accepted the dominance of the medical profession in priority setting and decision making in NHS and sought to

create a more rational administrative structure under which the wide range of professional inputs might be co-ordinated in the interests of integrated health care provision.

Thus while the changes of the mid 1970s enhanced government's capacity in principle to control the NHS, whether by modifying financial allocations or through direct management accountability, there remained an absence of any truly responsive levers of control. Even more so than today, the NHS could be likened to a super tanker which continued to move in the old direction long after the signal to turn had been given.

In many ways, the mid 1970s proved to be the watershed of the British welfare state. A period of rapid price inflation following the first oil price shock led to the financial crisis of 1976 when the Labour government was forced to apply for financial assistance to the International Monetary Fund. The price for IMF assistance was rigorous control of government spending. A period of financial stringency followed, for health and social services as well as other public spending programmes. In 1979, a Conservative government was elected committed to reducing public spending and with a philosophy that challenged the welfare state.

### 2.3 Introduction of general management in 1984

The 1979 Conservative government's concern with value for money and desire for more streamlined public services found a ready target in what had come to be viewed as the overblown administrative structures created in 1974 by the previous Conservative administration. In 1982, Area Health Authorities were abolished and a new lower tier of District Health Authorities was created, based on the existing District Management Teams. The Conservative government's first, 1982, reorganisation of the NHS was largely a simplifying measure, though it also made the lower tier more accountable by the introduction of a top-down accountability review process which continues to operate. The Department of Health sets annual targets for each RHA and reviews achievements in a series of annual meetings. Each region in turn holds a series of accountability review meetings with its constituent districts. The accountability review process initiated in 1982 put in place one of the important building blocks for the subsequent introduction of general management in 1984 and the creation of an internal market in 1991.

The NHS has always been a 'producer' driven organisation. The search for an effective means of making producers responsive to strategic management decisions is the consistent thread in the history of successive governments'

reorganisations of the NHS. The 1974 reorganisation put in place the capacity for strategic planning. But this proved to be only a small step to establishing what in industry would have been referred to as 'management's right to manage'. The issue of limiting professional autonomy, particularly as exercised by hospital consultants, was not directly addressed until the 1980s and 1990s, with the introduction of general management in 1984 and the implementation of the internal market reforms in 1991.

Successive Conservative administrations from 1979 onwards, however, moved only slowly down this path. A key step was initiated in 1983 when Sir Roy Griffiths and three other businessmen were commissioned by the Secretary of State for Health and Social Security to consider management changes necessary to make the NHS more efficient. The first 'Griffiths Report', presented at the end of 1983, was extraordinarily different in style and presentation to past documents outlining proposals for the NHS. In the place of the weighty and lengthy report of the Royal Commission on the NHS (HMSO, 1979) set up by the previous Labour administration and ignored by the new Conservative administration when it was published, the first Griffiths report consisted of an incisive 24 page letter proposing the introduction of general management throughout the NHS. In order to minimise disruption, no institutional reforms were proposed by Griffiths below government level, though in the event the process of transition from old to new management structures consumed most of the NHS's management energy for more than a year.

At the apex of the NHS, two new bodies were created, the NHS Supervisory Board (later to become the NHS Policy Board) and the NHS Management Board (later to become the NHS Management Executive). The Supervisory Board was chaired from the outset by the Secretary of State. The job of NHS Chief Executive was introduced for the lead manager on the Management Board. General managers were appointed for each RHA and DHA and at sub-District level Unit General Managers were appointed to be responsible for the main units of management such as individual acute hospitals, mental health services and community health services. The introduction of general management for the first time created a clear line of accountability from the top to the bottom of the NHS in which identifiable managers became responsible for specified services and accountable for their performance to those above them in the hierarchy. It represented the decisive shift away from the old collegiate system of consensus management towards business principles of management.

Ancillary services, support services and hotel

services including cleaning, catering and estates became clearly subject to the authority of the appropriate general manager. However, in spite of the changes, the authority of general managers over the main function of the NHS, the production of healthcare, remained limited.

## 2.4 Limiting the autonomy of professional groups

How to exercise broad control over clinicians' activity became the key issue to be addressed when the Conservative government subjected the NHS to another, more fundamental, review some four years later. The 1980s witnessed a number of initiatives aimed at limiting the autonomy of professional groups and strengthening the ability of the NHS to manage clinical activity. Some took the form of involving doctors in management. Consultants were invited to apply for the new general manager positions in 1984. In the event, few did. In addition, the criteria for making distinction awards to consultants, which can as much as double their NHS salaries, were extended to include consultants' contribution to NHS management. This, however, was no more than a marginal change. Distinction awards remained, and still remain, in the gift of committees of consultants themselves and subject to their assessment of merit. The resource management initiative (RMI) introduced in the 1980s was another approach to involving hospital clinicians in management. The RMI was intended to provide doctors, nurses and other health professionals with a complete and immediately accessible picture of the resources used for treating hospital patients. The number of hospitals using RMI has continued to expand, but its effect in creating more effective management of clinical activity has so far been limited (Ham, 1993). The development of performance indicators (subsequently known as health service indicators) highlighted massive variations throughout the NHS in the efficiency of both non-clinical and clinical activities. In principle, this allowed apparently inefficient consultants to be challenged in their use of resources. But the leverage created by availability of data for challenging consultants was greatly restricted by the absence of any credible sanction that could be applied by general managers in the event of non-conformance. Consultants still retained job security for life and were adept at pointing out the possible dangers to life that may flow from any reduction in clinical autonomy. If they acted locally in concert, consultants could usually veto changes which they viewed as inappropriate.

Other initiatives in the 1980s involved confrontation with healthcare professions, in particular over nurse regrading and the GP

contract. In 1987, nurses working in the NHS were subjected to a regrading exercise. The nursing profession was not initially opposed in principle to regrading, but the effect of individual regradings was to bring nurses' representatives into conflict with the government. The aim of the exercise, which was more or less achieved despite opposition, was to create a system of nurse grading which was more amenable to general management.

The confrontation with GPs began with the White Paper *Promoting Better Health*, published in 1987. Though separate from the internal market reforms, it can be viewed as a parallel move to make family doctors more accountable to government. The new GP contract which emerged from *Promoting Better Health* introduced targeted incentive payments designed to promote specific clinical activities, including increased childhood immunisation and cervical screening payments. Financial incentives were also introduced to ensure older patients were offered regular routine examinations and Family Health Service Authorities (FHSAs) – which replaced FPCs in April 1991 – were given an element of discretionary funding with which to promote services which were aligned with Department of Health priorities. Medical audit of general practice, devised in the 1970s, was formally introduced. These and subsequent changes represented an incursion by the Department of Health into areas in which GPs had hitherto exercised clinical autonomy. GPs were also expected to take on more responsibility for controlling medicines expenditure. Opposition to the new contract stemmed mainly from GPs' misgivings about the additional work it would involve and the availability of necessary resources. Protracted negotiations between the government and the BMA broke down in May 1989. The government then published a new contract incorporating some amendments and imposed it unilaterally from April 1990.

*Promoting Better Health* also marked the introduction of a new element into government policy on the NHS. Government reforms had hitherto been about promoting efficiency in the NHS and developing the capacity of the Department of Health to achieve change. For the first time, in any substantive way, the new GP contract also incorporated the principle of promoting consumer choice. This was done by making it easier for patients to choose and change their GP. Until then, patients had first to approach their own doctor and the FPC to inform them that they wanted to change doctors. The government also sought to make the process of choice more informed by encouraging GPs to produce and distribute brochures about the services they offered. Finally, the payment system for GPs was changed to increase the capitation fee element from 46 per cent to at least 60 per cent, in order to increase GPs' incentive to attract patients.

Since the introduction of the new contract, the pursuit of central policy objectives in primary care through incentive payments to GPs has been further extended. For example, payments ranging up to £2015 per annum for health promotion programmes were introduced in July 1993 (replacing payments for health promotion clinics), for GPs who offered a full programme for the prevention of coronary heart disease and stroke. New incentive payments were also introduced for GPs to run chronic disease management programmes for people with asthma and diabetes, aimed particularly at minimising complications. These and other financial incentives offered to GPs under the new contract mark significant, if in themselves relatively small, steps towards enhancing government's ability to exercise strategic influence over the clinical activities of GPs in the furtherance of nationally determined *Health of the Nation* (HMSO, 1992) policies.

# 3 The 1990 NHS and Community Care Act - the internal market

Further reform of the NHS had not been in the Conservative Party's 1987 election manifesto. In the second half of 1987, however, there was widespread criticism of underfunding, particularly from the healthcare professions, culminating in a highly publicised case about children in Birmingham alleged to have been unable to have life saving heart operations because of shortages of resources. This precipitated a decision in early 1988 to set up an NHS Review to be chaired by the Prime Minister.

A wide range of options were discussed during the early stages of the review. The radical option of privatising the financing of the NHS was rejected. Such an option would have sought to tackle the perceived problem of underfunding directly by offering tax rebates towards the purchase of private medical insurance, in the same way that people in employment are now offered national insurance rebates to opt out of the State Earnings Related Pension Scheme. It was rejected as politically unacceptable, since it would have fatally undermined the principle of equal access according to need, which was believed to command overwhelming support amongst the electorate. Also, notwithstanding the arguments of some (Green 1988), the consensus view among experts was that privatisation of funding would run a grave risk of simply raising healthcare prices rather than increasing the volume of healthcare services.

In the event, the model chosen for reform was the internal market, a concept pioneered by Alain Enthoven and based on the relationship between health care maintenance organisations (HMOs) and providers of primary and hospital health care in the USA. The government decided not to attempt any experiments with the model prior to full implementation. The proposed changes to the NHS were outlined in the 1989 White Paper *Working for Patients* (HMSO, 1989a) and its supporting working papers. District Health Authorities were to evolve into purchasing agencies and NHS hospitals and other provider units were to become self governing NHS Trusts separate from DHA control. At the same time, a parallel secondary healthcare purchasing system was to be set up by allowing larger NHS general practices to apply for practice fund holding status which would enable them to purchase on behalf of their patients a range of elective surgery and hospital outpatient services, in addition to prescription medicines. The proposals were incorporated in the NHS and Community Care Act of 1990 and the provisions of the Act relating to the

NHS were implemented from April 1991. Provisions relating to community care were finally implemented in April 1993.

The NHS internal market was the most far reaching reform of the NHS since its inception in 1948. In some ways it can be viewed as a culmination of a process by which government has sought to assert control over one of its major areas of spending. The 1974 reorganisation created a new planning capacity. The 1982 reorganisation streamlined it and instituted the accountability review process. Accountability was strengthened by the introduction of general management from 1984. Viewed in this context the reorganisation of 1991 extends the government's capacity for direction and control by, for the first time, introducing the sanction of loss of revenue if providers fail to offer what purchasers want, placing purchasers at arms length from providers and accountable to the government. The effect has been to shift the balance of power over who should provide what sort of services away from health professionals in provider units.

In other ways, however, the internal market may lead to fragmentation and loss of central direction. In particular, GP Fundholding introduces a consumer dynamic which may grow to challenge priorities set by central government. GP Fundholders set their own priorities in spending their practice funds. Patients are free to find the GP of their choice, fundholding or otherwise. Therefore, it must be presumed that GP Fundholders' priorities in their purchase of secondary healthcare will ultimately reflect their patients' preferences, which are not necessarily aligned with government priorities. This fundamental tension in the internal market reforms is considered in more detail below.

The principal features of the NHS internal market and its associated administrative structures are illustrated in Figure 1, which takes into account not only the internal market reforms implemented in April 1991 but also the community care reforms implemented in April 1993. Figure 2 shows how the modified structure will look when the administrative streamlining proposals in *Managing the New NHS* (Department of Health, 1993a) are implemented. These are discussed below.

The key feature of the internal market changes is the separation of the purchaser and provider functions, replacing line management relations between purchasers and providers with contractual

Figure 1 Structure of NHS and Personal Social Services - 1993

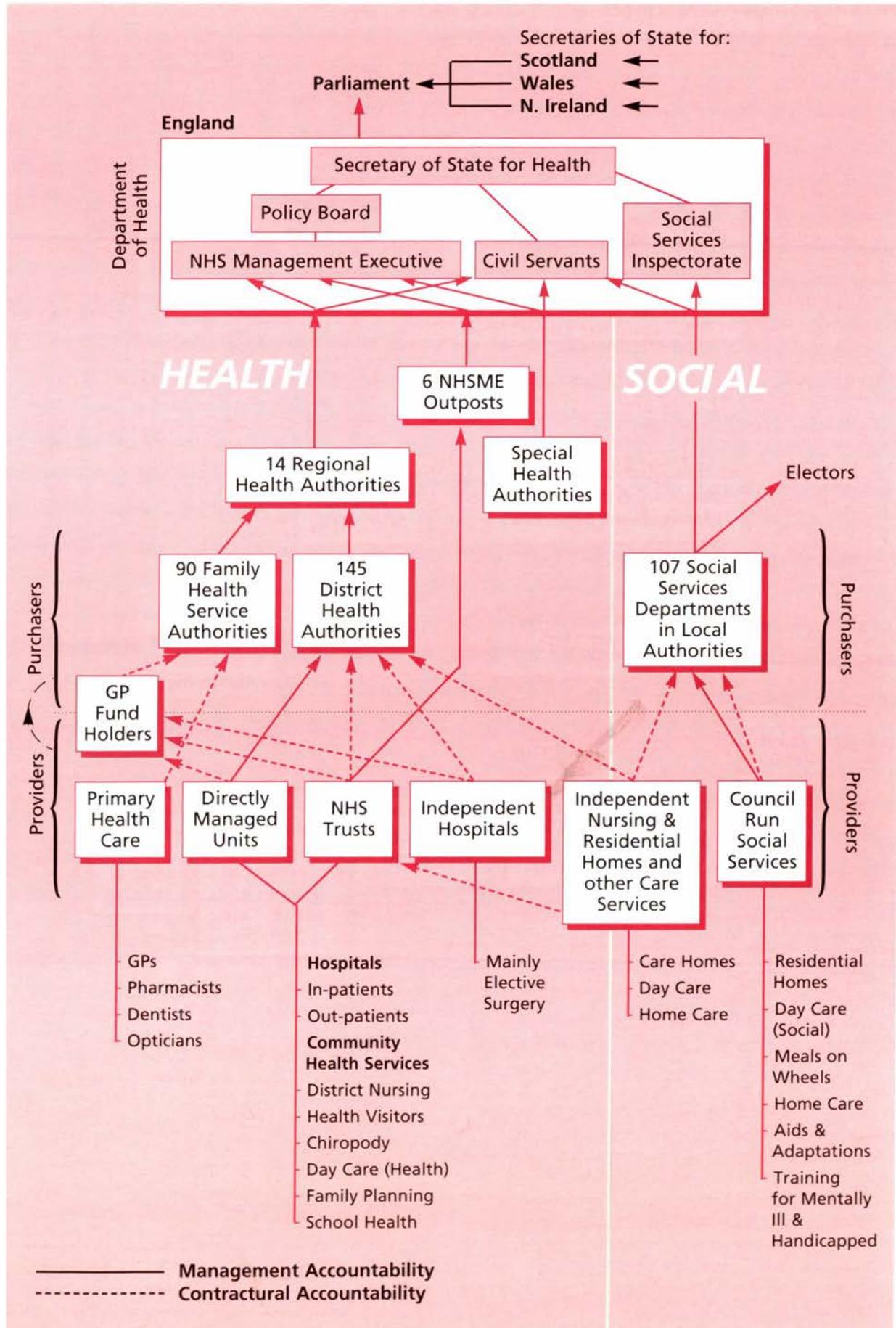
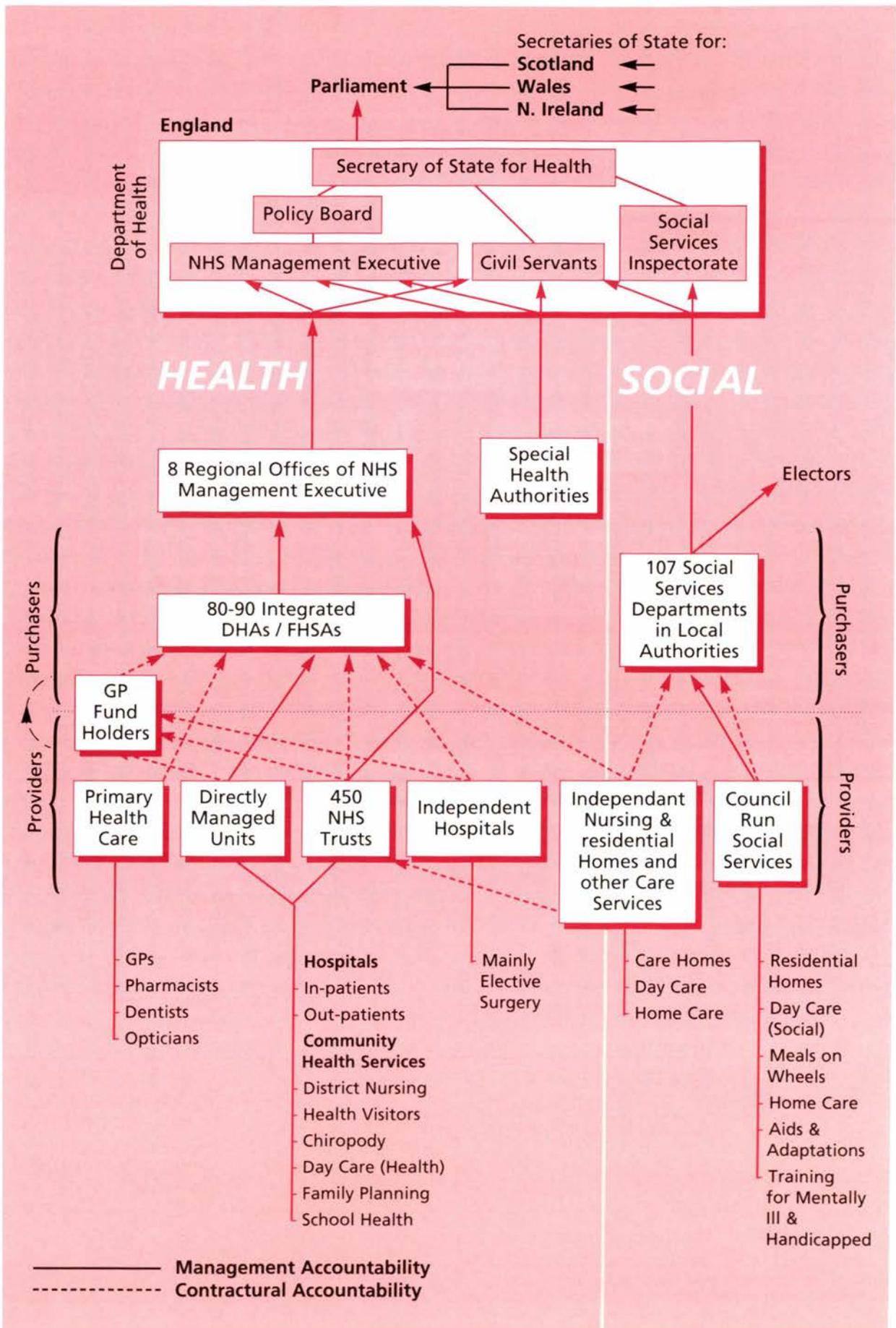


Figure 2 Structure of NHS and Personal Social Services - 1994  
Following changes proposed in Managing The New NHS



arrangements. The term ‘contract’ is something of a misnomer since contracts between NHS agencies are not enforceable at law. (The position of GP Fundholders is different, as they are separate legal entities). Disputes are arbitrated by the Secretary of State. The term ‘internal market’ came into common currency during the debate prior to the Act, signifying the presumption that the new arrangements would consist largely if not exclusively of NHS agencies trading between each other. From the outset, however, it has been possible for NHS purchasers to contract with independent healthcare providers, either non-profit or commercial (in which case contracts are enforceable at law). Few new contracts to date however, have been made between NHS purchasers and independent providers, although this may develop more rapidly in the future and significantly change the nature of the NHS. An alternative term to ‘internal market’ is ‘quasi-market’, which has been used by Le Grand and Bartlett (1993) to describe the new systems of purchasing and providing publicly funded services introduced by the Conservative government from the late 1980s in health, social care, education and housing.

Implementation of the community care provisions of the NHS and Community Care Act in April 1993 gave local authorities the lead responsibility for community care services. They include the arrangement of care in residential and nursing homes for elderly, mentally ill and mentally handicapped people as well as of non-residential personal social services (such as day care, home care, meals on wheels and aids and adaptations). Financed by central government grants to local authorities, these services do not form part of the NHS. For completeness, however, and because the new administrative arrangements for community care are an integral part of the NHS and Community Care Act, they are included in Figures 1 and 2. Box 2 contains a summary of the events leading to the 1993 community care reforms, and the principal changes that have been put in place.

### 3.1 NHS providers

At the base of the organisational structure in Figures 1 and 2 are the provider agencies, including NHS Trusts, directly managed units, independent family health services contractors (general practitioners, pharmacists, dentists and opticians) and independent hospitals, nursing homes and other care services.

#### NHS TRUSTS

NHS Trusts are self governing, public corporations within the NHS. They can only be dissolved by the Secretary of State, to whom their assets pass on dissolution. On establishment, each Trust takes on

an interest bearing debt based on the value of its initial assets, on which it must earn a 6 per cent return. It must also cover additional interest charges on future capital investment.

NHS Trusts provide a range of services. The largest operate one or more acute hospitals. There are also NHS Trusts which provide community health services, mental health services and ambulance services as well as ‘whole district’ Trusts which have taken over the provision of the full range of healthcare services previously provided by health authorities in directly managed units. First wave Trusts reporting for 1991/92 had annual revenues ranging from £4.6 million for the Royal National Rheumatic Hospital NHS Trust to £180 million for the Guys and Lewisham NHS Trust (Health Care Information Services, 1993).

Any NHS service grouping may apply to form an NHS Trust. The main criteria for approval by the Secretary of State are the presence of a competent management team and a viable business plan. A fresh wave of NHS Trusts has been created each April since the 1991. The creation of NHS Trusts took place more rapidly than many commentators had envisaged. By April 1993 there were 419 NHS Trusts in operation throughout the UK. By 1994, when the fourth wave of NHS Trusts commences operation, it is expected that about 450 NHS Trusts will provide more than 90 per cent of all NHS secondary healthcare services.

The relationship of NHS Trusts to the Department of Health via an intermediate tier of administration has been controversial. Initially, seven zonal outposts of the NHSME were set up to monitor Trusts, but they have never employed more than a handful of staff. Accountability of Trusts to central government has also been exercised through RHAs. Controversy arose because many NHS Trust chairs claimed that RHAs were attempting to exercise excessive and inappropriate control over Trusts’ operational activities. The issue of who should monitor Trusts has now been resolved by the government’s decision to abolish RHAs and create eight NHSME regional offices to undertake all the intermediate tier functions of both the RHAs and the NHSME outposts.

The relationship of NHS Trusts to DHAs is one of contracting parties. NHS Trusts receive the bulk of their revenue under DHA contracts. They are also reimbursed, usually by the relevant DHA, for extra contractual referrals (ECRs) – which may arise in the case of emergencies or where a general practitioner has referred a patient to a hospital with which the responsible DHA does not have a contract. Ninety-six per cent of first wave NHS Trusts’ core income in 1991/92 came from DHAs (Health Care Information Services, 1993). NHS Trusts also derived revenue in 1991/92 from contracts with GP Fundholders (1.2 per cent) and

## Box 2 COMMUNITY CARE

The NHS and Community Care Act of 1990 provides for a competitive market for community care services, with local authorities evolving into purchasing and enabling agencies with only a residual provider function. This parallels the evolution of health authorities into purchasing agencies for healthcare, but there the similarity in arrangements for the NHS healthcare services and local authority funded community care services ends.

No internal market has been created for community care. This reflects the very different stage of evolution that the community care market had reached in 1990 when legislation was enacted and the different politics of, and history of, community care in Britain, particularly in respect of services for the largest client group – frail elderly people in need of long term care.

**1948 NATIONAL ASSISTANCE ACT**

In the post war welfare state legislation, the National Assistance Act of 1948 gave local authorities the responsibility for providing personal social services, including, under Part III of the Act, accommodation in old people's homes on a means tested basis. The first 30 years of the welfare state witnessed a steady expansion of these services, almost exclusively provided in public sector facilities. However, with growing demand from an ageing population and provision constrained by public spending controls, access to local authority owned old people's homes became increasingly rationed and 'bed blocking' emerged as a major problem for NHS hospital wards unable to discharge elderly patients to alternative, local authority, care.

**SOCIAL SECURITY FUNDING FOR INDEPENDENT CARE HOMES**

The stresses in the system became overwhelming when, following Britain's financial crisis in 1976, capital for the expansion of Part III accommodation ceased to be available. In the years which followed, voluntary organisations also found their income from cash-strapped local authorities rapidly dwindling. In 1974 local authorities paid for about 60 per cent of voluntary sector residential home places in England. By 1983 it had dropped to 34 per cent. Responding to pressure orchestrated and articulated by voluntary organisations, local social security offices started to pay supplementary benefits to people unable to afford their own care home fees and for whom local authorities were unwilling to foot the bill. Initially there was no national policy governing what were known as board and lodging allowances, but the practice became so widespread that policy was formalised in 1983. The government in effect set up a voucher system for public funding of independent care homes. The rules that were introduced allowed any person with less than £3000 in capital and who qualified on income grounds to apply as of right for supplementary benefit up to specified weekly limits to pay for admission to a residential or nursing home of his or her choice, provided it was a private or voluntary home. The benefits were not available to pay for local authority residential homes nor, of course, could they be claimed to pay for NHS long stay hospitals, since the NHS could not charge for in-patient care of NHS patients. No assessment of need for residential or nursing care was required. In its essentials, this new source of public funding remained in place from 1983 until the April 1993 reforms. The initially generous local limits were, however, subsequently replaced by much lower national limits, annually

reviewed, while the £3000 capital limit was subsequently raised to £8000.

**THE SECOND GRIFFITHS REPORT AND THE COMMUNITY CARE REFORMS**

The availability of supplementary benefit, renamed income support with the 1988 social security changes, fuelled the rapid expansion of independent (private and voluntary) care homes throughout the 1980s. Government spending under this head grew from £10 million in 1979 to £900 million in 1988. Increasing concern that expenditure was escalating out of control, together with criticism that supplementary benefit gave a perverse financial incentive for people to enter care homes rather than receive support in their own homes, led to Sir Roy Griffiths being asked by the government to report on the whole issue of state funding of community care. His principal recommendations, detailed in the 'second' Griffiths report (HMSO, 1988), were that local authorities should become the lead agencies in arranging community care, funded by cash limited grants from central government, that needs assessment should be provided for all applicants for state funding and that the system of funding should be neutral between residential and non-residential care. A year later a White Paper was published (HMSO, 1989b) accepting most of the Griffiths recommendations and these were then incorporated in the 1991 NHS and Community Care Act.

Implementation of the community care provisions of the Act was staged. In April 1991, the new requirement for local authority inspection and registration units to extend their remit to include local authorities' own residential homes, and to ensure that this function operated at arms length from the department responsible for managing residential homes, was implemented. The main provisions of the Act, however, were not implemented until April 1993. From that date, local authorities became the principal budget holders for state funded community care, assisted by a 'Special Transitional Grant' from central government to add to their ordinary personal social services allocations channelled through the Revenue Support Grant on the basis of Standard Spending Assessments (SSAs). The Special Transitional Grant has become known as the 'Social Security Transfer', representing the 'care' element of income support money that would have been claimed by new residential and nursing home residents if the old income support funding system had been retained. The 'non-care' element of income support funding was not transferred to local authorities. Residents of care homes are still able to claim the ordinary 'non-care' level of income support, together with a Residential Allowance, from the Department of Social Security.

**CONTRASTS BETWEEN NHS AND COMMUNITY CARE ADMINISTRATION**

When the government enacted legislation in 1990, it was faced with a situation it had encouraged in which the market for residential long term care had been very largely 'externalised'. Two thirds of elderly people receiving long term care in one sort of residential setting or another (including long stay hospitals) were resident in independent care homes. The purchaser and provider function in community care was already largely separate,

*continued...*

**Box 2 COMMUNITY CARE** *continued*

for residential care services at least. Instead of creating local authority provider 'Trusts' the government has encouraged local authorities to privatise their own Part III homes or close them down. Unlike residents of independent care homes, residents of local authority Part III care homes are ineligible for the new Residential Care Allowance. The effect of this is to increase the costs borne by local authorities which choose to remain providers of residential care.

There are a number of points of similarity in the administrative structures for the NHS and state funded community care. In each case, central government grants to the purchasing authorities are strictly cash limited and in each case there is a yearly accountability cycle. In the case of health authorities this is through the accountability review process. In the case of local authority social service departments it is through the requirement for them to produce annual community care

plans. But the administrative structures also differ in important respects. Whereas the NHS Management Executive has developed into a massive organ of the Department of Health, the Social Services Inspectorate remains relatively small. Part of the reason may be that community care is inherently less complex than healthcare and thus requires fewer resources for monitoring and control. Another reason is the degree to which the delivery of community care is already contracted out to independent providers. The relatively streamlined administrative structure for community care may prove to be the model towards which the NHS internal market evolves in the future. If the NHS follows the path of community care, in the sense of contracting out the bulk of services to independent providers, the principal function of the NHS Management Executive, or any successor organisation, may change to one of monitoring quality through inspection and registration.

from the sale of private patient services (1.5 per cent). The experience of the first two years of the internal market is that DHAs have continued to buy nearly all of their hospital services on annual (April-March) contracts from those hospitals which they directly managed before 1991. With the bulk of their revenue assured for the year, NHS Trusts have concentrated their marketing activity on GP Fundholders and private patients.

Trusts have greater freedom to manage their own affairs than directly managed units of health authorities. They may, like health authorities, dispose of land and property. Unlike health authorities, they may borrow funds from the Secretary of State and other sources. However, the power to borrow from private sources was of little practical relevance in the first two years of the internal market since their total borrowing was limited by the Secretary of State and interest on money borrowed from government sources is always lower than on money borrowed from private sources. At the end of financial year 1991/2, no first wave Trust showed any borrowings from private sources in its annual accounts. It remains to be seen whether the government's private capital initiative announced in April 1993 will lead Trusts to borrow from private sources in the future. NHS Trusts also have greater discretion than health authorities and directly managed units to determine staff terms and conditions. They need not follow national agreements.

NHS Trusts have been created as business style organisations. Their boards consist of 5 executive directors, 5 non-executive directors and a Chairman. Chairmen and non-executive directors are paid according to a statutory formula.

**DIRECTLY MANAGED UNITS**

Directly managed units (DMUs) are provider units which have not become NHS Trusts and which, therefore, remain under the administration of DHAs. Under the internal market they are intended to operate at arms length from the purchasing activity of DHAs. The issue of whether it is really possible to place 'chinese walls' between two functions (purchasing and providing) of the same DHA organisation has become largely academic since, if all the new applications for Trust status starting in April 1994 are successful, there could be as few as 44 DMUs remaining in England.

**SPECIAL HEALTH AUTHORITIES**

A number of health authorities with special responsibilities are directly accountable to the Secretary of State, including the Health Education Authority, the Mental Health Act Commission and the Special Hospitals Services Authority. The post-graduate teaching hospitals in London also have the status of special health authorities.

**INDEPENDENT CONTRACTORS FOR FAMILY PRACTITIONER SERVICES**

General practitioners, pharmacists, dentists and opticians remain as independent contractors to the NHS under contracts negotiated centrally by the Department of Health and administered by Family Health Services Authorities.

**INDEPENDENT HOSPITALS, NURSING HOMES AND OTHER CARE SERVICES**

Though independent providers do not form part of the NHS, they clearly belong in any illustration of

the new structure of the NHS which shows contractual as well as line management relationships. Though neither DHA purchasers nor GP Fundholders have yet made significant use of independent providers for acute hospital services, contracting with independent providers may grow over a period of years. Most new contracting with the independent sector since 1991 has been concentrated in areas where the NHS has specific problems in supplying services of its own, including psychiatric care (where there have been large numbers of extra contractual referrals to independent providers), the purchase of services for behaviourally disordered mentally ill and mentally handicapped patients and long term contracts for care of elderly people in nursing homes.

### 3.2 Purchasers

With the internal market reforms, a new method was adopted for allocating government funds for hospital and community services to each of the English regions. From 1991, the RAWP formula was discontinued and RHAs were funded on a simplified capitation basis, weighted to reflect the health and age distribution of the population, including the number of elderly people, and the relative costs of providing services. Similar formulae are used by RHAs to distribute funds to their constituent DHAs and GP Fundholders. The government's view was that RAWP had largely achieved its goal of equalising resources between regions. Consequently, the separate 'target' allocations which had been part of RAWP were abandoned.

#### DISTRICT HEALTH AUTHORITIES

District health authorities purchase the full range of hospital and community health services for that part of their resident population registered with non fundholding GPs. This comprised about 75 per cent of the country's population in 1993 but is expected to fall to below 50 per cent over the next few years. For the remainder of their resident populations, DHAs share purchasing responsibility with GP Fundholders. The latter buy elective surgery, out patient services, diagnostic investigations and (from April 1993) some community health services directly on behalf of their patients, using money topsliced from DHAs' weighted capitation allowances.

DHAs are accountable, through RHAs, to the Secretary of State. DHAs agree corporate contracts with RHAs, following annual review meetings, and their performance is subsequently assessed against these contracts. DHAs, therefore, are clearly subject to a centralising dynamic rather than consumer pressure. Consumers of healthcare cannot choose between health authorities, unless they move

house – in the same way that some people choose to move to local authority areas where state schools enjoy a high reputation. Consumer pressure, therefore, is mainly expressed through 'voice' (via DHA consultation with Community Health Councils, local authorities, FHSAs, voluntary organisations and other informal local interest groups) rather than 'exit' (*ie* seeking another service provider)<sup>1</sup>.

Local representation on health authorities, moreover, has been diminished. Local authorities no longer have the right to nominate DHA members. Under the NHS and Community Care Act, each DHA consists of a chairman appointed by the Secretary of State, five non executive members appointed by the RHA and up to five executive members selected from senior management.

DHAs are responsible for assessing their population's need for healthcare. On the basis of information available to them they contract for the provision of healthcare services with NHS Trusts and with any remaining directly managed units. The White Paper *Working for Patients* envisaged increasing pressure for DHAs to merge as their DMUs floated free, in order to achieve economies of scale and to enhance their purchasing power. In April 1991 there were 190 DHAs in England. By mid 1993 there were 145 and there are proposals to reduce the number of DHAs to 108 by April 1994 and to between 80 and 90 in the longer term, which would mean an average DHA population of over 500,000. As an alternative to merger, some districts have formed purchasing consortia or 'health commissions' with neighbouring DHAs. FHSAs may also participate in purchasing consortia and a number of geographically coterminous DHAs and FHSAs have merged administration and share a single chief executive.

It is not currently possible for DHAs and FHSAs to merge formally, though proposals have now been published for legislation to permit such mergers. Mergers will be actively encouraged – though not required – by the NHSME. The advantages of merger are stated by the government to be the establishment of single, stronger purchasers at local level with responsibility for implementing national health policy, the integration of purchasing across primary and secondary care boundaries and management cost savings. (Department of Health, 1993a).

#### FAMILY HEALTH SERVICE AUTHORITIES

FHSAs, which replaced FPCs in April 1991, administer family health services. They are accountable to RHAs through corporate contracts. Family practitioners (GPs, pharmacists, dentists

1. For a full explanation of the terms 'voice' and 'exit', see Hirschman, 1970.

and opticians) are not employees of the NHS but are engaged under contracts, the terms and conditions of which are fixed centrally by the Department of Health after negotiations with the professional groups concerned. Because contracts are negotiated centrally, FHSAs have limited discretionary powers. These limited powers were, however, enhanced by the NHS and Community Care Act. FHSAs were given health authority status and a new management structure in April 1991. They were also given an element of finance to be used at their discretion to promote good practice.

There are 90 FHSAs in England serving populations which range from 130,000 to 1,600,000. For historical reasons their boundaries differ from DHAs. Almost half of FHSAs relate to one DHA but the remainder relate to between two and seven (Ham, 1993). Each FHAS consists of a paid chairman appointed by the Secretary of State, the paid general manager or chief executive, five lay (*ie* non independent contractor) non-executive directors and four professional non-executive members appointed by the RHA, a GP, a dentist, an optician and a community nurse. Each group of independent contractors has a powerful voice articulated through local professional committees. Pharmacists, for example, may lobby through their local committee to prevent new pharmacist contracts from being let in the locality.

Three government initiatives have transformed the role of FHSAs in recent years: with their statutory health authority status and new management structures, they have moved away from being passive administrative clearing houses and have adopted a more proactive role; they have played an active role in encouraging GP Fundholding; they are accountable for the prescribing expenditure of GPs, setting Indicative Prescribing Amounts (IPAs), monitoring expenditure and employing medical and pharmaceutical advisors to discuss prescribing with GPs.

#### GP FUNDHOLDERS

The GP Fundholding initiative, introduced under the NHS and Community Care Act in April 1991, has created a second purchasing system which overlaps with DHA purchasing. One of the unique features of GP Fundholding is that for the first time it empowers consumers to express their preferences for a range of hospital and community health services by transferring their GP registrations (*exit*) rather than by the traditional (*voice*) methods of complaining, lobbying or using personal influence. The introduction of market mediated accountability to consumers for some hospital and community health services potentially conflicts with the accountability of DHAs to the Secretary of State for the same range of services. There is no guarantee that preferences emerging through GP fundholding will be aligned with centrally determined

healthcare priorities. Tensions arising from the relationship between DHAs and GP Fundholders may become one of the central issues of the internal market and are considered in detail below.

GP Fundholders operate under the same centrally negotiated primary care contract as other GPs. In addition, they are granted their own budgets, topsliced by RHAs from DHA allocations, to pay for a range of services for their registered patients which would otherwise be purchased by DHAs. These include elective in-patient referrals to acute units up to a cumulative cost of £5000 per person per year (the limit designed to prevent very high costs from one or two individuals swallowing a major part of the budget), all out patient visits (except antenatal and obstetrics) and diagnostic investigations. In all these cases, GP Fundholders are free to contract with independent healthcare providers as well as NHS providers. Practice budgets also cover prescribing costs and a proportion of practice staff costs (including training), with a separate allowance for management and computing costs. GP Fundholders' annual budgets are calculated by RHAs (for that element to be topsliced from DHAs) and by FHSAs (for that element covering prescribing and other costs). GP Fundholders are entitled to *vire* (transfer funds) between different budget elements. The only restriction is that they may *vire* into but not out of community health services. That element of their practice funds which is topsliced from DHAs' community health service budgets is, therefore, said to be 'lobster potted'<sup>2</sup>.

GP Fundholders may keep any surpluses generated to spend on practice facilities but the partners may not derive any personal financial benefit. Fundholder budgets continue to be based on historical use of resources, in order to facilitate entry into the scheme. A gradual change to weighted capitation funding, however, is now likely and benchmark capitation amounts have been published in Department of Health guidance.

From April 1993, practice funds were extended to cover the purchase of a range of community health services previously purchased exclusively by DHAs, including district nursing, health visiting, dietetics and chiropody (Department of Health, 1992a and 1992b). In the case of these community health services, however, GP fundholders may purchase only from NHS providers of community health services (*ie* community health service DMUs or NHS Trusts which provide community health

2. Just as lobsters can get into but not out of the pots in which fishermen catch them, so money can be transferred into GP Fundholders' community health services 'pots' but cannot be transferred out to fund other services. 'Lobster-potting', therefore, not only protects potentially vulnerable budgets, as would simple 'ring fencing', but also offers the possibility of budget enhancement by accretion from other elements of spending.

services. They cannot buy community health services from acute NHS Trusts and they cannot buy them from any independent provider.

RHAs are responsible for approving GP Fundholders, setting their budgets, holding them to account for their use of practice funds and removing them if necessary. These functions will be taken over by the proposed new NHSME regional offices when they replace RHAs as the intermediate tier of administration, see below. FHSAs are responsible for day to day monitoring of expenditure and activity of GP Fundholders and they report on underspends or overspends to RHAs. With the reduction in RHA manpower in 1993, FHSAs are assuming some of the responsibilities relating to the administration of the GP Fundholding scheme previously discharged by RHAs. Provided GP Fundholders keep to the rules of the fundholding scheme, the powers that RHAs (or in due course NHSME regional offices) and FHSAs have to influence their priorities and purchasing patterns are limited to persuasion. Though RHAs may hold regular meetings with GP Fundholders, there is nothing corresponding to the annual cycle of accountability reviews through which the intermediate tier of administration may require individual DHAs to follow specified priorities such as those set out in *Health of the Nation*.

Initially, GP Fundholding was restricted to larger GP practices with over 9000 patients. In the first year, 306 'first wave' fund holding practices were established with a further 285 following in the second wave established in April 1992. From April 1993 the size of practice eligible for fundholding status was reduced to 7000 and it was made possible for smaller practices to group together in order to attain eligibility. A further 650 practices were granted fundholding status in April 1993 bringing the total number to over 1200, covering one in four of the population. By April 1994 they are expected to cover one third of the population (Department of Health, 1993a) and, if government policy remains unchanged, it is expected that GP Fundholding will continue to expand to cover over 50 per cent of the population over the next few years. In some suburban and rural areas, fundholding penetration will approach 100 per cent but it will continue to be slow to develop in inner city areas.

Fundholding practices have started to co-operate in order to enhance their purchasing power and achieve economies in the collection and analysis of data necessary to make informed purchasing choices. For example, there are plans – with Department of Health approval – to form 22 GP Fundholding practices in Kingston and Richmond into a multi-fund from April 1994. Even without such multi-funds, the expansion and increasing purchasing sophistication of GP Fundholders presents a formidable challenge to DHAs. In an

increasing number of areas, GP Fundholders together now dispose of the bulk of the NHS elective surgery, out-patient and community health services budgets. Their control of elective surgery budgets poses a particular challenge to DHAs because, in the past, DHAs have used elective surgery activity as a regulator of overall spending, decreasing the level of activity in the latter part of the year if necessary in order to avoid over-spending. It is significant that the government has stated its intention in *Managing the New NHS* that strengthened DHA/FHSAs 'will not undermine the role of GP Fundholders in providing a cutting edge in purchasing'. This will be achieved by giving NHSME regional offices, not DHAs, responsibility for approving applications for fundholder status and setting GP Fundholder budgets.

In Figures 1 and 2, a dashed line is shown linking GP Fundholders qua purchasers with GP Fundholders qua providers. This represents services outside the GP contract which Fundholders wish to provide at practice level but which they are unable to buy from an existing accredited local provider (for example the use of an item of equipment). Initially, the regulations were such that GP Fundholders could not use practice funds to reimburse themselves directly for the expenses of such services. As a result some GP Fundholders set up independent companies, with RHA approval, to handle such transactions. These arrangements were one manifestation of the tendency among GP Fundholders to seek to organise the provision of new kinds of service at a practice level rather than purchasing the possibly limited range of service packages on offer from existing providers. Regulations were changed in 1993 to allow GP Fundholders to use practice funds to reimburse themselves directly and there should be no further need for independent companies to be set up.

### 3.3 The consumer voice – Community Health Councils

Community Health Councils (CHCs) were first created under the 1974 NHS reorganisation. They are statutory bodies whose role is to represent the public's interest in local NHS services. They have no executive powers and no budgets for purchasing health services. Members of CHCs are drawn from the local community, including representatives of local authorities and voluntary organisations. CHCs are administered and supported by RHAs which employ their secretariats, each consisting of a director and one or more assistants. With the proposed abolition of RHAs, see below, the government has indicated its intention to discuss future arrangements for the establishment and funding of CHCs with the Association of Community Health Councils for England and Wales.

CHCs have a duty to publish an annual report and to meet to discuss it with relevant health authorities. They have statutory rights to be consulted by DHAs and FHSAs over substantial developments or changes in local services, to receive information from DHAs and FHSAs, to send observers to DHA and FHSA meetings and to visit NHS premises. Some CHCs act primarily as a source of information on local services, or as an advice centre for members of the public seeking to make complaints. Other CHCs have concentrated their activities on lobbying health authorities and NHS Trusts and organising public campaigns.

### 3.4 Existing upper tiers of administration and the October 1993 functions and manpower review reforms

In October 1993 the government published its proposals (Department of Health, 1993a; 1993d) to abolish RHAs and replace them with regional offices of the NHSME. This section describes the upper tiers of administration currently (1993) in place before outlining how this will be changed by the government proposals.

#### REGIONAL HEALTH AUTHORITIES

Fourteen regional health authorities (RHAs) currently (1993) provide the intermediate tier of administration between the Secretary of State for Health and DHAs and FHSAs in England. With their smaller numbers of purchasing authorities, Scotland, Wales and Northern Ireland have no regional structure. Welsh health authorities, Scottish health boards and Northern Irish health and social services boards are administered, respectively, by the Welsh Office, the Scottish Home and Health Department and the Northern Irish Department of Health and Social Services (Box 3).

RHAs appoint members to NHS bodies (all the non executive members of DHAs and FHSAs; two of the non executive members of NHS Trusts; and those members of CHCs not nominated by local authorities and voluntary organisations). They plan and pay for non medical training and education and they manage regional programmes of healthcare research and development.

RHAs are responsible for allocating funds to DHAs and FHSAs (including the GP Fundholding scheme) and for holding them to account for their expenditure of NHS resources. Since the establishment of the internal market in 1991 they have had a role in overseeing both the purchaser and provider side of the NHS. In the first two years, the establishment of NHS Trusts was the principal focus of attention of both the Department of Health

and the RHAs. More recently, the development of effective purchasing was recognised as the primary role for RHAs (Department of Health, 1993b). In early 1993, four speeches by Dr Brian Mawhinney, Minister for Health, and Sir Duncan Nichol, NHS Chief Executive, signaled that the focus of government attention had switched to the purchasing arm of the NHS (Department of Health, 1993c).

With the elimination of directly managed units in England and the evolution of DHAs to pure purchasing agencies, the content of RHAs' monitoring and control of DHA activity has been substantially modified and reduced. The requirement for functions such as estate management to operate at regional level has consequently diminished. In February 1993 the Secretary of State initiated a streamlining exercise, under which manpower employed by each region was to be reduced from an average of 560 to a maximum of about 200.

In the early stages of the internal market, when RHAs retained a substantial interest in the provider side of the NHS through their reporting relationship with DHAs with directly managed units, there was criticism from some NHS Trust chairmen that RHAs were inappropriately interfering with the freedom of action of NHS Trust providers. Criticism subsequently diminished as scaled down RHAs backed away from routine regulation of the provider arm. RHAs have no formal relationship with NHS Trusts, though the Secretary of State stated in February 1993 that RHAs 'must maintain strategic oversight in their region to ensure that a comprehensive range of NHS services remains available to all' (Department of Health, 1993b). Formally, monitoring of the provider arm of the NHS is undertaken by the NHS Management Executive, directly from its Leeds headquarters and through its seven zonal outposts, though the limited manpower of the zonal outposts means that RHAs may act as agents for them.

According to the Audit Commission (1993) uncertainty in the provider monitoring role of RHAs has arisen because the responsibilities for some elements of supervision and regulation of the internal market have never been clearly defined. Intervention from an upper tier may be needed where provider units face financial difficulties because of withdrawal of contracts, where contract disputes require arbitration and where providers cease to offer services. So far, according to the Audit Commission, supervision and regulation have been shared between RHAs and NHSME zonal outposts by default according to which of the bodies has the powers (to top-slice funds, to force acceptance of contracts and to intervene in capital allocation) to resolve the problem.

In order to address these and related issues, in February 1993 the Secretary of State announced a

**Box 3 THE NHS IN SCOTLAND, WALES AND NORTHERN IRELAND****SCOTLAND**

Under the 1978 NHS (Scotland) Act, the NHS in Scotland is accountable to the Secretary of State for Scotland, acting through the Home and Health Department of the Scottish Office. Management leadership is provided by the Management Executive, consisting of a chief executive and 6 directors, which is located within the Home and Health Department. It thus corresponds to the English NHS Management Executive within the Department of Health, though it is much smaller than its English counterpart. There is also a Common Services Agency within the Home and Health Department which provides a number of services centrally on behalf of the Scottish NHS, including ambulances, blood transfusion, research and development, supplies purchasing, computer services, statistics and information, estates and legal services and epidemiological advice. In England, these services are split between the NHS Management Executive, special health authorities, RHAs, DHAs and NHS Trusts.

Because of its smaller population, there is no intermediate regional tier in Scotland. Rather, the 15 health boards report direct to the Management Executive which reports in turn to the Secretary of State. On the provider side, NHS Trusts in Scotland are also monitored direct by the Management Executive, with no tier corresponding with the zonal outposts of the English NHS Management Executive. The Scottish administrative structure also differs from England's in that there are no separate FHSAs. Health boards are responsible both for purchasing hospital and community health services (from NHS Trusts and directly managed units) and for contracting with GPs, pharmacists, dentists and opticians for the supply of family health services. In this sense, the Scottish NHS presents a more unified structure than the NHS in England. Joint working with local authority personal social services is also simplified in Scotland by the coterminosity of health boards with the Regional Councils which operate social services. Corresponding to English CHCs, there are 45 local health councils in Scotland with the role of representing the interests of the public.

Though the internal market provisions of the 1990 NHS and Community Care Act apply equally to all four constituent parts of the United Kingdom, the Scottish NHS enjoys some significant elements of independence.

Most important, funding of the NHS in Scotland has historically been separate from England. When RAWP was introduced in England in 1976 it did not apply to Scotland. The Scottish NHS thus escaped the gradual process of resource equalisation and it continues at present to spend substantially more per capita than the English NHS.

**WALES**

The NHS in Wales is accountable to the Secretary of State for Wales. As in Scotland, there is no regional tier and the purchasing arm of the NHS is held to account directly through NHS Directorate within the Welsh Office, which is in turn accountable to the Secretary of State for Wales. The NHS Directorate also monitors the provider arm (NHS Trusts) directly. As in England, and in contrast to Scotland, family health services are administered by separately constituted FHSAs in Wales. Corresponding to the Scottish Common Services Agency, there is a Welsh Health Common Services Authority, providing a similar range of services. Health promotion in Wales, however, is provided by a separately constituted authority, the Health Promotion Authority for Wales.

**NORTHERN IRELAND**

The NHS in Northern Ireland is accountable to the Secretary of State for Northern Ireland. As in Scotland and Wales, there is no regional tier and the purchasing arm of the NHS is held to account directly through a management executive within the Department of Health and Social Services of the Northern Ireland Office, which is in turn accountable to the Secretary of State. The management executive also monitors the provider arm (NHS Trusts) directly.

The principal difference between the NHS in Northern Ireland and the three other constituent parts of the UK is that purchasing of all NHS and personal social services is unified under the four Health and Social Services Boards. They are responsible for purchasing hospital and community health services, administering family practitioner services and purchasing personal social services, which in the rest of the UK are purchased by local authorities.

functions and manpower review (the 'Jenkins/Langlands review') to look at the functions of the intermediate tier of NHS administration, including RHAs and NHSME zonal outposts and their relationship with the NHSME head office. The resulting proposals published in October 1993 (Department of Health, 1993a) included the eventual abolition of the 14 English RHAs following the necessary legislation. In the interim, the number of RHAs will be reduced to eight through boundary changes. These transitional RHAs will have the same boundaries as the eight new regional offices of the NHSME which will be established in April 1994 to provide a new intermediate tier of administration. The Regional Directors of the new NHSME regional offices will also be the Regional General Managers of the

transitional RHAs and the regional offices will incorporate the functions of the existing NHSME outposts. Following legislation, it is expected that RHAs will finally be abolished on 1 April 1996.

**THE NATIONAL HEALTH SERVICE  
MANAGEMENT EXECUTIVE**

The NHS Management Executive (NHSME) is at the top of NHS managerial hierarchy in England. Its Chief Executive and senior staff are professional NHS managers. As the Accounting Officer for the NHS in England, the Chief Executive accounts to ministers and parliament for the performance of the NHS in achieving the goals and targets that have been set by the Secretary of State for Health through the NHS Policy Board. The NHSME

monitors and controls both the provider and purchaser arms of the NHS. Currently the former function is largely carried out through zonal outposts and the latter through RHAs and the accountability review process.

In the proposals for reforming the intermediate tier of the NHS published in October 1993 the government's stated intention is to 'create a clear identity for the NHS Management Executive, within the Department of Health, as the new headquarters of the NHS' (Department of Health, 1993a). As noted above, it is planned to establish eight new regional offices of the NHSME from April 1994 to take over the intermediate tier functions of RHAs, with each Regional Director reporting to the Chief Executive of the NHS. The regional offices of the NHSME 'will be much smaller than the present RHAs, employing fewer staff'. They will be responsible both for developing the purchasing function and monitoring NHS Trust providers, though these functions 'will be kept clear and distinct'. The government also states its intention that the NHSME regional offices 'will not become involved in detailed operational matters which are the responsibility of local Health Authorities and Trusts'.

In order to strengthen communication between Ministers at the Department of Health and local DHA, FHSAs and Trust chairmen, it is proposed that eight non-executive members should be appointed to the NHS Policy Board, which advises the Secretary of State for Health on health policy and management issues. Each of these new Policy Board members will be associated with the geographical area covered by one of the NHSME regional offices.

### 3.5 Consensus on key recommendations from the functions and manpower review

The functions and management review initiated by the Department of Health in February 1993 stimulated a number of reports and recommendations from interested parties. Proposals from bodies involved in NHS management had much in common. Both the National Association of Health Authorities and Trusts (NAHAT) and the Institute of Health Services Management (IHSM) argued that strengthened parliamentary accountability is entirely consistent with devolving decision making as far as possible to local managers in DHAs and Trusts (NAHAT, 1993a; IHSM, 1993). NAHAT and IHSM were expressing what have now become universally accepted management principles across the public and private sectors. They called for regulation of the provider arm in particular to be lightened and for there to be an accompanying substantial reduction in staffing of the upper tiers.

Both NAHAT and the IHSM also favoured establishing the NHSME as a semi-autonomous 'Next Steps' management agency, as a means of formally separating Ministers' policy role from the head office management function of the NHSME. According to the IHSM report, there should at the same time be a shift away from line accountability between the upper and lower tiers and towards regulation by means of clearly defined rules. Both IHSM and NAHAT recommended that there should be a single intermediate tier at regional level to regulate both purchasers and providers. In support of this proposal, NAHAT pointed to the risk of separate intermediate tiers being protective towards 'their' authorities or Trusts and thus failing to resolve disputes rapidly. Both IHSM and NAHAT also favoured legislation allowing the merger of DHAs and FHSAs, and IHSM went further in proposing that consideration be given to merging health and social services purchasing.

Views expressed by other professional groups shared much common ground with NAHAT and IHSM, for example on the desirability of decentralisation of decision making. The BMA, however, warned against making the NHSME a semi-autonomous 'Next Steps' agency, arguing that accountability of the NHS to the Secretary of State and parliament would be seriously compromised.

In the event, the government's published proposals were in accord with most of the key recommendations of the NAHAT and IHSM reports, including maximum delegation to local managers, a single intermediate tier agency for purchaser and provider regulation, merger of DHAs and FHSAs and reductions in upper tier staffing (if this is taken to include the intermediate tier). The only significant exception was the government's rejection of a 'Next Steps' agency status for the NHSME, where the government shared the BMA's concern about the threat to parliamentary accountability. According to *Managing the New NHS* (Department of Health, 1993a) the NHSME will remain within the Department of Health, though with a clear identity as the headquarters of the NHS.

### 3.6 Management issues unresolved by the functions and manpower review

There are some important issues on which *Managing the New NHS* does not offer any definitive recommendations. In some cases it is indicated that recommendations will be made after further study. In particular, the need to define clearly the respective roles of the NHSME and the wider Department of Health are acknowledged, with a 'Statement of Responsibilities and Accountabilities' to be published by 31 July 1994.

In other cases, statements on the intended effects of the management changes are not supported by proposals on how they may be achieved. In particular, the intention to 'delegate responsibility as far as possible to the level of local purchasers and providers' and for the NHSME's role to be 'strategic rather than operational' is frequently reiterated, but without addressing the issue of the scale and staffing of the NHSME itself, which if unchanged may militate against effective decentralisation of decision making. It is notable that the only reference to the scale of the NHSME in *Managing the New NHS* relates to the proposed new regional offices which will be 'much smaller than present RHAs, employing fewer staff'. There is no stated intention to reduce employment on existing NHSME functions. The NHSME is viewed by many commentators as having grown too big. There is concern that Sir Roy Griffiths's recommendation in his 1983 Management Enquiry report that there should be a small head office function to set NHS objectives and monitor their achievement, has manifestly not been realised. There is also concern about duplication between the NHS Management Executive, staffed by professional NHS managers, and the administrative grade of civil servants within the Department of Health. Advocates of decentralisation argue that much of the stream of circulars and directives issued by the NHSME is not useful and simply reflects government's fear of the political risks of relinquishing operational control, allied to a bureaucratic tendency to create work. They go on to recommend that central line management controls should be replaced as far as possible by regulatory controls monitored by a slimmed down NHSME.

# 4 Forces for change in healthcare – impact on NHS administration

Three underlying forces for change in healthcare are identified in this section. The continuing advance of medical technology is probably the most powerful force for change, and the one with the most direct implications for the administrative structure of the NHS. Consumerism is another powerful force that NHS administration will have to respond to in future years. Finally, part of the current received wisdom is that the ageing of the population will have an effect on all aspects of the NHS, including its administration. The importance of the demographic factor, however, has sometimes been exaggerated.

## 4.1 Medical Technology and reconfiguration of healthcare services

The establishment of the NHS internal market has come at a time when the pace of change in medical technology appears to be quickening. This is a worldwide phenomenon which is driving fundamental changes in the configuration of healthcare services. In turn it has implications for the types of buildings within which services are delivered and, ultimately, the administration of healthcare as well.

There are four overlapping changes in medical practice which are particularly significant. First, the need for acute hospital beds is declining as length of stay continues to decrease and more services are being provided on a day or out-patient basis. Hospitals are becoming places where more highly intensive care is being provided for shorter durations of time. With or without the internal market, this will inevitably lead to substantial further reductions in the number of acute wards and hospitals during the 1990s.

Second, there is a move to day surgery and the replacement of open surgery with minimally invasive alternatives such as laparoscopic or endoscopic procedures. It is now being suggested that some 80 per cent of elective surgery could be carried out on a day case basis – safely, economically and at greater convenience to patients. The Audit Commission (1990) has also been a powerful advocate of day surgery. As a consequence, recent years have witnessed a substantial investment in the development and upgrading of day surgery facilities. Nearly all British day surgery investment to date has taken

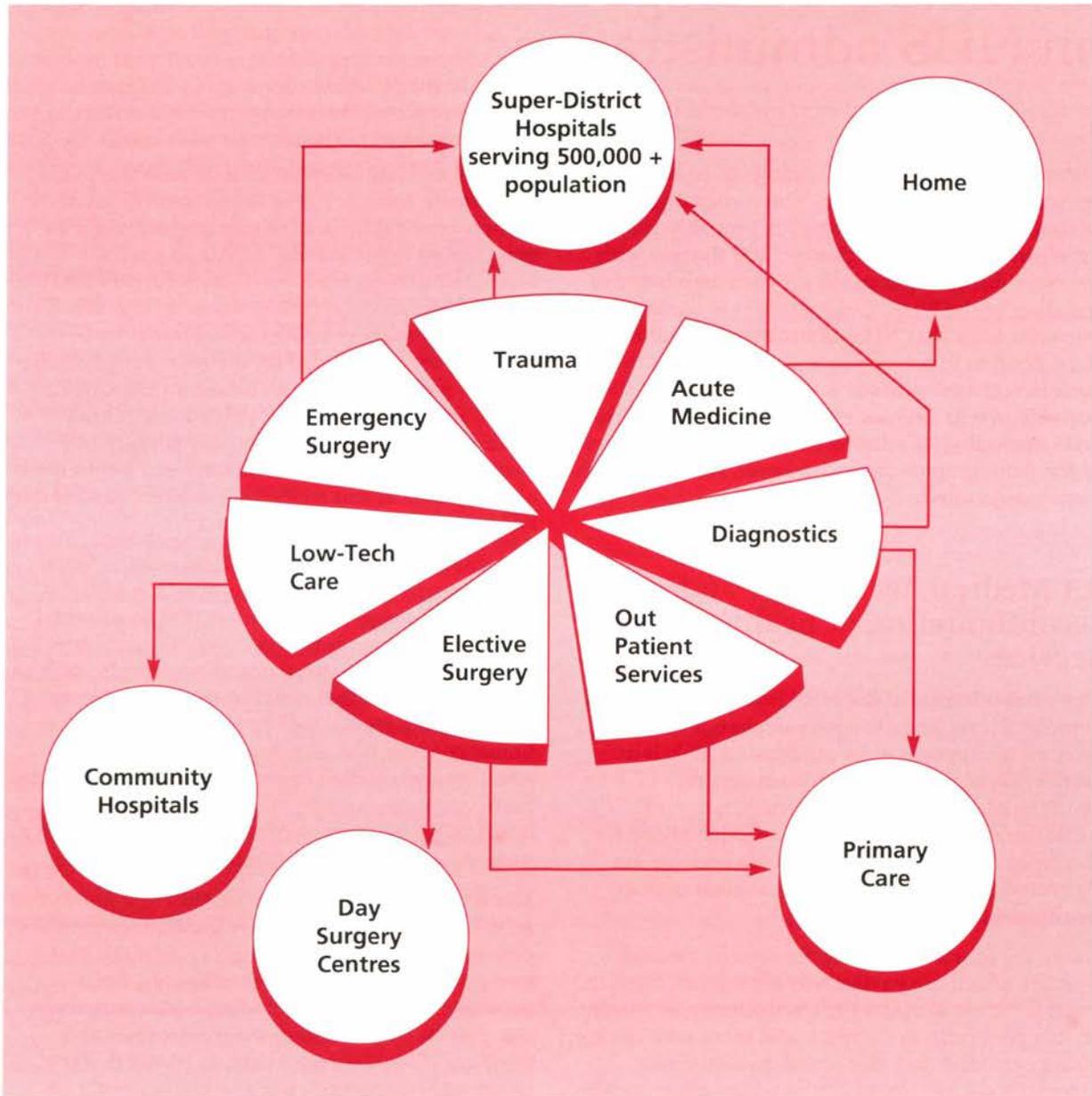
place on existing hospital sites, in both the public and private sectors. But in the process it has been demonstrated that elective day surgery can, and most would argue should, be run as a wholly separate business from emergency surgery and trauma. The medical consensus in Britain is still against day surgery being carried out at free-standing centres located off the main hospital site, but this may change in the future. In the United States and other countries with a more plural system of healthcare delivery, day surgery in dedicated, freestanding units has been found to be a safe, practical and cost effective alternative to day surgery in full service hospitals.

The third major change in medical practice is the move towards home care. This overlaps with the shift to day surgery, in the sense that an essential element of day surgery is recuperation at home. But there are also specialist medical treatments, such as infusion therapy, that could be transferred from hospitals to patients' own homes, the 'hospital at home' concept. The common factor is the more effective organisation of community health facilities, particularly community nursing. In the future, a much larger proportion of nurses – perhaps even a majority – could be based in the community.

The fourth major change is the shift of a number of activities from secondary care locations to primary care locations. It is increasingly recognised that many services which have traditionally been provided in hospitals, including minor surgery, out-patient consultations, diagnostic tests and ancillary clinical services such as physiotherapy, might safely, economically and conveniently be provided in suitably upgraded primary healthcare centres or 'polyclinics'. Developments in information technology (IT) and electronic data transmission will continue to be particularly important in facilitating the shift of activities from secondary to primary care locations, for example by allowing transmission of medical records and diagnostic data from primary care to specialist centres and back again, and by easing access to specialist advice from distant locations.

There is a growing awareness of the quite radical implications for Britain's healthcare system, as discussed for example in NAHAT's (1993) report *Reinventing Healthcare*. The changes noted in medical practice are leading to a fragmentation of the services traditionally provided in the typical full service district general hospital (DGH), as illustrated in Figure 3. It is increasingly recognised

Figure 3 Fragmentation of the District General Hospital



that key elements of healthcare services – specialist staff, medical equipment, data – need not be tied to DGH settings and may be accessed in a variety of community settings – community hospitals, primary care centres, mobile services and people’s own homes. Moreover, the internal market is causing the technology driven process of service fragmentation to take place more rapidly. Under the pre-1991 administrative system, where each health authority was responsible for purchasing and providing, it was natural to think in terms of providing the full range of district secondary healthcare services on a single district general hospital site. Some of the assumptions that went

into district level planning may, however, have been unfounded. For example, it was widely believed – and still is – that most people do not wish to travel for elective surgery, even if they cannot receive it at the time of their choice locally. With the advent of GP Fundholding, this assumption is now being tested and is often found to be baseless. Moreover, there is a growing body of evidence from Britain and the USA indicating that surgical success rates could be greatly increased by concentrating throughput in a smaller number of elective surgery facilities, each possibly serving a regional catchment area (eg Maerki, Luft and Hunt, 1986).

The NAHAT report, *Reinventing Healthcare* identifies another specific example of how new technology is undermining the assumptions upon which the DGH concept is based. The report points out: 'The growing sophistication of the care provided by the paramedically trained ambulance service (all accident and emergency ambulances will carry at least one paramedically trained crew member by 1995) means that patients can be stabilised immediately and transported significant distances while the crew is in contact with the receiving trauma or accident and emergency centre.' The implication is that a major component of a medium sized town's DGH may be redundant.

The greater fluidity of the post 1991 contractual (or quasi-market) system means that alternative solutions to service configuration problems can be tried out more easily. GP Fundholders have used their new purchasing power to contract for consultants to offer out-patient consultations at GP practice premises. Both GP Fundholders and DHA purchasers may place more elective surgery with distant providers (though they have not done so to a significant extent yet). Acute service NHS Trusts, despite being obliged to provide core services, have started to specialise to a certain extent in market niches where they may have or develop a competitive advantage. In some cases, such as the rationalisation of London teaching hospitals, reconfiguration of services has been so politically sensitive that it has been managed directly by government. There will also be 'mini-Tomlinsons' in other metropolitan areas. But outside these high-tech areas, reconfiguration of services is now being led by decisions of purchasers rather than being planned at regional or national level.

It is widely believed that the future will see a smaller number of acute hospitals, each serving larger populations, specialising in highly intensive and expensive services including trauma, emergency medicine and surgery and certain super-specialties. There will also be a relatively small number of day surgery facilities, some of which may be freestanding. At local level there will be primary care centres and some community hospitals. But there may be little at the intermediate level now occupied by district general hospitals serving what used to be the 'natural' districts of some 250,000 people. This in turn has implications for the size of DHAs and will reinforce the current trend towards DHAs covering larger geographical areas.

The reconfiguration of British health services will require massive capital resources which may not be available from the Treasury. The scale of the public sector deficit which emerged in the early 1990s will create strong pressure for economies in both current and capital expenditure in all public services, including the NHS, until at least the mid 1990s. In

what may prove to be a highly significant policy change, the Department of Health announced in April 1993 a relaxation of the rules which had hitherto discouraged the investment of private capital in the NHS, following a Treasury initiative to encourage private investment in public sector projects generally. The prospect has now been raised of a variety of collaborative ventures which will increasingly involve commercial organisations as providers of clinical services for NHS patients (Willets, 1993). As a consequence, it is now possible to envisage an NHS of the future where services continue to be publicly funded but where the supply of services is substantially or even predominantly in the hands of private organisations.

This in turn has profound implications for the administration of the NHS. Privatisation of the supply of health care services would inevitably involve privatisation of day to day management as well. People entering healthcare management as a career would no longer be entering a public service. Rather, they would be entering a sector in which they would be likely to transfer between public and private employers. Ultimately, the public sector element of NHS administration might be limited to a residual purchasing and strategic planning role carried out by a small core of personnel. Such a scenario would involve fundamental changes in lines of accountability from providers of services to the centre, requiring a different sort of central body to oversee the provider side of the NHS. Currently, the bulk of healthcare services are provided by NHS Trusts. Trusts are accountable to the Secretary of State as public corporations with an endowment of public sector capital, as well as being contractually accountable to DHA and GP Fundholder purchasers. Private providers of clinical services, on the other hand, have a contractual accountability only. In this way, an administrative system that is appropriate where providers are predominantly public sector organisations may not be appropriate where there is a large private element of provision. In the latter case, an inspectorate would be the more appropriate model for regulation of the provider side, supported by an accreditation system to act as a further assurance of minimum standards that might not be achieved because of failings in the local exercise of the purchaser function. An agency similar to OFTEL or OFGAS may also be necessary to ensure fair trading in those areas where there are strong monopoly elements of supply.

## 4.2 Consumerism and rationing

Aside from medical technology, the consumer movement is the other major force for change to which NHS administration will have to adjust in the 1990s. Consumer expectations have risen across the whole range of publicly and privately produced

goods and services and there is every reason to believe that expectations regarding healthcare services will continue to rise throughout the 1990s and beyond. Most healthcare usage is concentrated amongst older people, and the 1990s and first decade of the twenty-first century will witness the replacement of the present elderly generation (whose formative years coincided with the depression) with a generation whose attitudes were formed at a time of more favourable economic conditions and whose expectations are consequently higher. Moreover, consumers have generally become less willing to accept without question that professionals know best and healthcare has not escaped this sea change in attitudes. There is broad agreement that the delivery and administration of healthcare – like other public sector services – will need to become more responsive to consumer choice. In a recent report on the future of European healthcare compiled by Andersen Consulting and Burson-Marsteller, the issue of how to enhance consumer choice was identified as one of the principal challenges for the NHS by a panel of British experts made up of senior healthcare managers in the public and private sectors, academics and a clinician. The *Patient's Charter*, which may be viewed as an expression of consumerism, or at least as a recognition of its growing importance, was viewed by the panel as the main guarantee of quality and accessibility in the NHS (Andersen Consulting, 1993).

In some ways the internal market has increased the opportunity for consumers to exercise preferences through choice of provider, in particular primary care providers. Changes implemented at the time of the new GP contract in 1990 made it easier for patients to change GP while the introduction of GP Fundholding in 1991 for the first time allowed patients to express their preferences for some secondary care services through choice of GP. In other ways, however, the internal market has restricted choice, for example by increasing pressure on non fundholding GPs to refer to specialists employed by providers with which the purchasing health authority has a contract.

Andersen Consulting's panel of experts concluded that patient choice is less likely to be expressed in the selection of providers than in ensuring that preferences for treatment are respected – whoever the provider – for example about alternative therapies for cancer or different models for childbirth. This conclusion reflects the broad consensus view that patients have insufficient knowledge to judge the quality of alternative providers by themselves, and that even where they can judge quality patients cannot realistically be expected to exercise choice effectively when in urgent need of treatment. Because of this, it is generally assumed that responsiveness to consumer preferences in healthcare is best sought by

enhancing the agency relationship between patients and doctors – in which the doctor (in particular the GP as the patient's advocate for secondary care) would ideally act as a perfect agent for the patient by expressing perfectly what the patient would have chosen if he or she had the requisite medical knowledge.

The conventional view, therefore, is that placing cash in the hands of patients has limited application in healthcare. While this may not be an entirely valid view (see Box 4) it is clear that patient choice and empowerment in the NHS will not be achieved through the exercise of direct patient purchasing power alone. Rather, it will have to be pursued in the NHS in a variety of ways, through professional channels, through standard setting by the Department of Health, through purchasers' vigilance and through providers' own search for management excellence. This is already starting to take place. Some of the newer approaches to managing the process of healthcare, such as care protocols and patient focused care, have at their heart the objective of patient empowerment, of sharing information with patients so that they can play an informed part in clinical decisions.

Increasing consumer awareness also has major implications for the rationing of healthcare, which will be an issue of growing concern for healthcare administrators in Britain and other countries during the 1990s, as the introduction of new treatments continues to outpace available public funding. As the concept of patient empowerment becomes more widely accepted in the NHS the greater will be the pressure for rationing to be discussed openly at each level of administration. Traditionally – because the NHS is subject to cash limited budgets and because of the unwillingness of government to be embroiled in local decisions on priorities – rationing of healthcare in Britain has been pushed down to local level, where it is carried out non explicitly by clinicians. In contrast, rationing of healthcare services in countries with insurance based funding systems tends to take place at a higher level of the administration and is more likely to be based on explicit rules governing entitlements (ABPI, 1993). The prioritised list of interventions proposed by the State of Oregon for its Medicaid scheme is the best known and most intensively debated example of an explicit rationing system. Transparency is important for insurance funded systems, if for no other reason, because rules on entitlement must be sufficiently explicit to avoid a welter of litigation arising from ill defined insurance contracts.

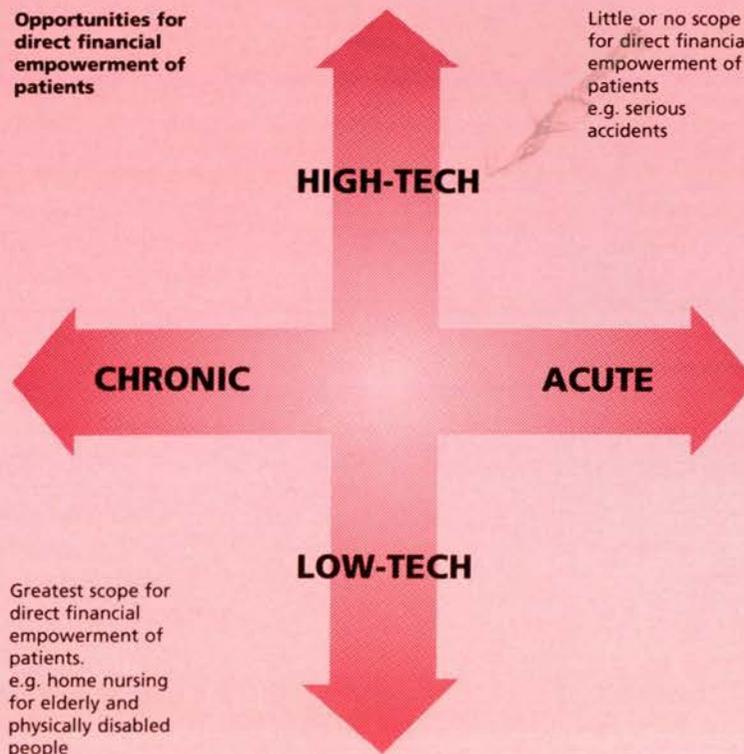
Pressure for British healthcare rationing to become more explicit will be reinforced by the development of more sophisticated purchasing. More than two years into the internal market, block contracts between health authorities and Trusts are still the norm and these contracts rarely contain any specific

**Box 4 FINANCIAL EMPOWERMENT OF NHS PATIENTS**

There is a broad consensus view that financial empowerment of consumers, *ie* giving people cash or vouchers with which to pay for services of their own choice, has limited application in healthcare. This is based on a number of assumptions; that consumers have insufficient knowledge to judge the quality and appropriateness of medical treatment; that even if they could judge quality, the prices paid by individual and infrequent users of frequently monopolistic specialist services would be higher than if the services were bought by professional, large scale purchasers of healthcare; that consumers are subject to moral hazard – that is they have an incentive to overconsume if there is a third party payer (whether the NHS or an insurance company). Closer examination, however, reveals that while some or all of these objections to patients as purchasers of healthcare services may be valid in some cases, in other cases none of the objections may be valid. Community care is one element of healthcare, broadly defined, where direct financial empowerment is a practical option, particularly for people who have a predictable and long term need for healthcare services. In a report published by Age Concern, Laing (1993) argues that local authorities which are now responsible for paying for state funded community care should offer the option of making cash available to service users themselves, for them to spend on care services of their own choice with the aid, if they wish, of care service brokers who would be accountable to them as service users, not to the funding local authorities. In the minority of cases where state funded care users have been financially empowered in this way, outcomes have been found to be superior (Morris, 1993). Though examples are restricted to community care, there appears to be no reason why the same principles should not be relevant to a wider range of healthcare services.

The figure below illustrates how plotting illness and treatment against the two dimensions of acuity and complexity may help to identify those areas where direct financial empowerment of patients may be a practicable option and those areas where it clearly is not. The greatest scope exists in the segment where low-tech interventions are used for chronic illness (*ie* the bulk of community care). In this segment, none of the standard efficiency objections to direct financial empowerment of patients applies. Long term users of services are capable of judging the quality and appropriateness of low-tech services themselves; the supply of low-tech services (such as home nursing) is typically highly competitive with many small providers, thus minimising the risk of individuals paying higher prices; moral hazard is avoided by making financial empowerment subject to prior assessment of need.

There is also a *prima facie* case for examining the practicability of financial empowerment of patients in higher-tech areas of chronic healthcare. In the case of renal dialysis, for example, patients might be financially empowered following assessment to choose any appropriate and accredited package of care – thus allowing them to express their preferences for provider and location of treatment and even modality of care, subject to the limit of funding they are offered. Accreditation together with the existence of a broker (an advising doctor) would resolve the consumer knowledge problem. Moral hazard is avoided because financial empowerment would be subject to prior assessment of need. What is required is to separate the purchasing process into its constituent elements, the allocation of funding to an individual and the choice of provider – which is standard practice in state funded community care.

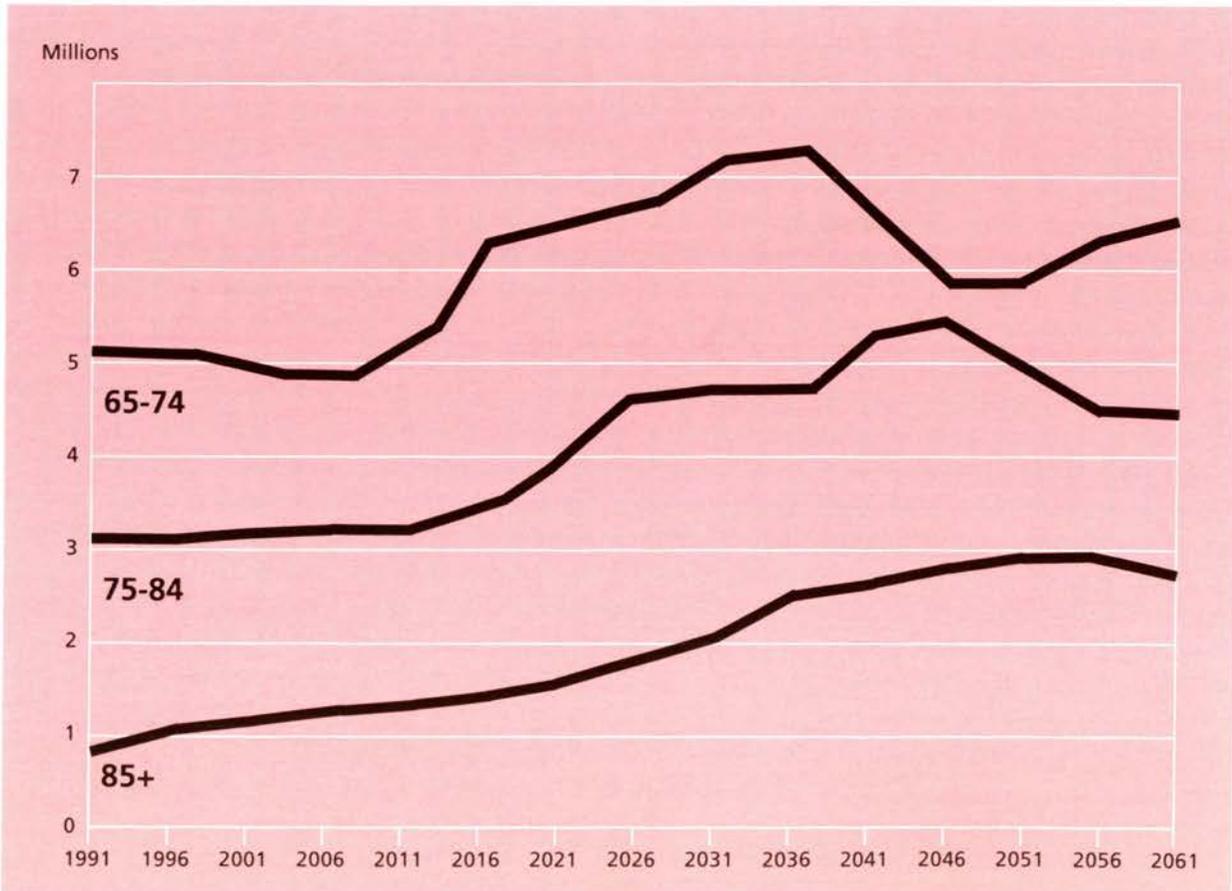


requirement to provide access to treatment for given diagnoses. In 1993, however, the development of purchasing has been placed at the top of the Department of Health agenda for the NHS. The process that has been set in train by the internal market will, if allowed to develop to its logical conclusion, mean the setting of of much more precise purchasing objectives as the focus of attention switches from technical efficiency (increasing work done per unit of cost) to allocative efficiency as well (which involves using resources to provide those services that reflect consumer priorities). Ultimately it may lead to NHS purchasing agencies starting to enforce treatment protocols of their own, arrogating the bulk of rationing decisions to themselves and in the process relieving individual clinicians of much of the responsibility for day to day rationing which they currently bear. As rationing decisions are pushed upwards to district purchasing level and made more explicit at the same time (being based on defined protocols) there will inevitably be more public – and political – debate on the local healthcare choices being made. Moreover, the inevitable differences that would emerge in local rationing choices would be bound to stimulate

wider debate at the national level. Ultimately, it is possible to envisage the Department of Health being forced to establish national protocols governing access to specified medical care services. This would involve a significant centralisation of the purchaser function in the NHS, at odds with the present government commitment (Department of Health, 1993a) towards decentralisation.

The Conservative government has as yet been unwilling to recognise explicitly that rationing of healthcare, in the sense of some people being denied potentially beneficial treatment, is an inevitable consequence of a budget capped health care system. Rather, the government’s position appears to be that any local non-availability of services should be addressed by seeking to enhance the efficiency with which existing resources are used. The Conservative government has also resisted involvement in setting benchmarks for the local availability of specific services and procedures. Services for people with renal failure can be used to illustrate the issue. At present the chances of a diabetic with renal failure aged over 55 receiving life saving treatment differ widely in different parts of Britain. If rationing

Figure 4 United Kingdom Elderly Population 1991-2061



Source: National population projections. Series PP2 No. 18, Office of Population Censuses & Surveys.

decisions are made explicit there will inevitably be pressure to raise the level of access close to the highest already achieved, with all the inflationary consequences that implies. The notion of the government setting clinical criteria for access to treatment is not fanciful. It is no more than is already done in other comparable health care systems, such as health maintenance organisations (HMOs) in the United States.

### 4.3 Demography – the ageing population

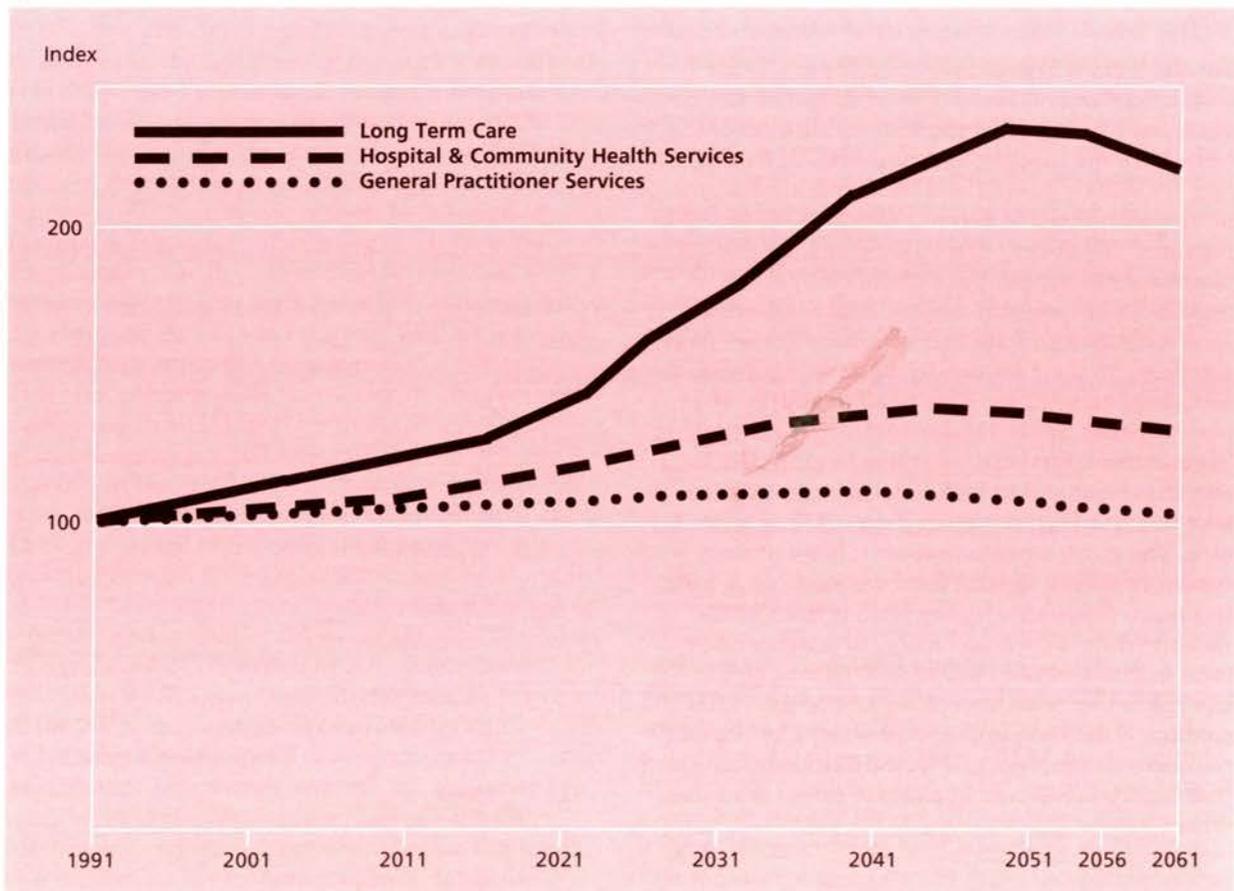
It is well known that the UK has an ageing population. Currently, 15.8 per cent of UK citizens are aged 65 or over, compared with 4.7 per cent in 1901. Elderly people are high users of health services and they tend to suffer from degenerative conditions where more resources may be spent on long term management than on acute treatment. The shift in emphasis to management of chronic illness is one

of the underlying forces driving the transfer of resources from hospital to primary and community health services, which is in turn being reinforced by changes in medical technology noted above.

What is less well known, however, is that the overall number of people aged over 65 started to plateau in the 1980s and that the 1990s will witness, for the first time this century, a significant drop as the generation from the low birth rate depression years passes the age of 65. The upward trend in over 65 year olds will not be re-established until the second decade of the twenty-first century, when the post war baby boom generation enters retirement, as shown in Figure 4. As a consequence, and subject to certain caveats identified below, it seems likely that demographic pressure alone will be a less potent force for change in the NHS in the 1990s than it was in the 1970s and 1980s.

The principal demographic change of the 1990s and early 2000s will not be an increase in overall numbers of pensioners but rather a rapid expansion

Figure 5 Resources required to keep pace with demographic change in the UK assuming constant age specific utilisation, Index 1991 = 100



Sources:

HCHS specific utilisation rates taken from the programme budget by age group for hospital and community health services in England 1986-87, from "Public expenditure on the Social Services: a Memorandum received from the DHSS". House of Commons Session 1987-88. HMSO, 1988.

GPs Age specific consultation rates published by the General Household Survey 1990, Table 5.3.

Long Term Care Age specific risk of being resident in a care home or a long stay hospital from Laing & Buisson (1993).

of one segment of the pensioner population – the very elderly, aged 85 or more. By 2001, according to official projections set out in Figure 4, the number of people aged 85 and over in the UK will have risen to 1,202,000, an increase of one third over the 1991 figure of 897,000. The projection for the middle of the next century is over 3,000,000.

An important conclusion that can be drawn from these projections is that demography generated demand for additional resources will be substantially greater for long term care services than for the range of services purchased under the NHS. The reason for this is that whereas per capita consumption of hospital and community health services (the most costly component of the NHS) is about 11 times as high for the 85 plus age group as it is for the population as a whole, per capita consumption of long term care services in care homes or long stay hospitals is almost 600 times as high for the 85 plus age group as it is for the population as a whole. Figure 5 illustrates the potential impact on demand, on the conventional assumption of constant age specific utilisation of services. Projections published by other researchers give similar results (eg Robins and Wittenberg, 1992).

But the NHS will probably not have to pay for increased demand for long term care. The last 20 years have witnessed a gradual withdrawal of the NHS from the funding and provision of long term care for elderly people and the trend has become more pronounced in recent years. In 1970 the NHS provided 28 per cent of all long stay institutional places for elderly people without charge; the remainder of long stay institutional residents in local authority, private and voluntary homes paid according to their means. By 1992 NHS provision had dropped to 12 per cent of all institutional places (Laing, 1993). Health authorities continue to have a strong financial incentive to minimise long stay provision and to look to local authorities to take responsibility for most if not all long term care. The government, moreover, has a strong reason to accede to such local changes, since long term care purchased by the NHS is 'free' to the patient while most long term care purchased by local authorities is means tested. Demographic change in the 1990s, therefore, and in particular the continued increase in the 85 plus population, will reinforce the tendency of the NHS to focus on its core business of acute healthcare rather than long term care.

# 5 Agenda for the future

The earlier sections of this paper which dealt with the historical evolution of the NHS focused on the theme of government seeking to assert strategic control of one of the major areas of spending in the welfare state. This culminated in the 1991 internal market reforms which tipped the balance of power away from provider groups, including hospital doctors, and towards separate purchasing agencies which are accountable to a greater or lesser extent to the Secretary of State.

The NHS internal market reforms must also be placed in the context of a series of initiatives commencing in the third term of Margaret Thatcher's government, in which quasi-markets were introduced into four areas of the welfare state – housing, education, health services and social care services. This set of reforms has been described and analysed by Le Grand and Bartlett (1993). The principle of public funding was retained in each case, though the way in which state finance was distributed was altered. For the most part, a centralised state agency continued to act as the principal purchaser. In some cases consumers of services themselves were given direct financial empowerment (as in education). In other cases funding was given to agents acting on behalf of consumers (as with GP Fundholders buying services on behalf of their patients). Purchasing and provision of each of the reformed welfare services were administratively separated and a system of independent providers was set up, each provider competing in an internal or 'quasi' market. Quasi-markets, according to Le Grand and Bartlett, are markets in the sense that they replace monopolistic state providers with competitive independent ones. They are 'quasi' in the sense that providers are typically non profit organisations; funding is not in cash but takes the form of an ear marked budget or voucher; and spending decisions are typically taken by agents acting on behalf of consumers rather than directly by consumers themselves. In the case of the NHS, the separation of providers and purchasers has enhanced the capacity of the government for strategic control. But the other key innovation of the NHS quasi-market – the GP fundholding scheme – contains within it the seeds of a diametrically opposite tendency, towards fragmentation and loss of central control over the purchasing function.

Le Grand and Bartlett set out five conditions that quasi-markets need to satisfy if they are to achieve the goals of improved efficiency, responsiveness, choice and equity. These are: a competitive market

structure (except where natural local monopoly providers exist, which have to be matched by strong local purchasers capable of exercising countervailing power); access to accurate information on costs and quality; appropriate motivation on the part of both purchasers and providers; absence of incentives for either purchasers or providers to 'cream-skim'; and a reasonable level of transaction costs. This paper offers no view on the extent to which these conditions are or can be met in the NHS. To attempt to do so would require a separate paper. It is important, however, to flag these conditions, which are central to the broader debate on the merits of the NHS quasi-market.

There can be little doubt that as long as a Conservative government remains in office, the agenda for the future of the NHS in Britain will relate to how the NHS quasi-market should evolve in the context of the demands of parliamentary accountability. With a Labour government, many of the elements of the NHS quasi-market would probably be retained, including the purchaser/provider split, though there would probably be a formal re-introduction of some element of accountability of Trusts to DHAs, and the GP Fundholder system would presumably be discontinued in its present form. In this political context, exploration of the ways in which the NHS quasi-market may evolve provides a valid agenda for the management and administration of the NHS in the 1990s.

## 5.1 The degree of regulation

Reduced to its essentials, the NHS quasi-market framework set out in *Managing the New NHS* envisages a smaller number of stronger purchasing agencies (merged DHAs and FHSAs) whose principal focus will be the purchase of the high-tech core of non-elective in-patient services. Two parallel purchasing agencies, DHAs and GP Fundholders, will continue to operate for the purchase of elective in-patient services, out-patient services and a range of community health services, with GP Fundholders' share of purchasing increasing as the scheme continues to expand. GP Fundholders will be 'protected' from DHAs by having their applications for fundholder status approved and their budgets set by NHSME regional offices.

The two main issues regarding the appropriate degree of regulation relate to the management of

change (when reconfiguration of local health services results from new contracting patterns) and possible tensions between DHA/FHSA purchasers and GP Fundholders.

#### MANAGEMENT OF CHANGE

Some commentators have expressed concern about the turbulence that may be created in local health services if providers fail to win contracts and are forced to discontinue services. Such concerns may have been overstated since the structure of the NHS quasi-market will in itself strongly encourage 'managed' change where there is only one or a small number of sources of supply. Attention was drawn in the previous section to the forces leading to reconfiguration of secondary and tertiary health-care services. The growing consensus is that DGHs serving about 250,000 people will increasingly be replaced by high-tech in-patient centres providing emergency treatment and trauma services for populations of 500,000 or more. Much of the fixed capital investment of the NHS will be concentrated in such 'super hospitals' which will be local monopolies to an even greater extent than existing DGHs are. There will also be a strong element of monopoly on the purchasing side, with DHA/FHSAs accounting for most of their revenue. It is inevitable, with this highly monopolistic quasi-market structure, that changes in service configuration will be determined by a process of negotiation between purchasers and providers, rather than through arms length spot purchasing or tendering, leaving providers to sink or swim.

Elective surgery and out-patient services, in contrast, form an essentially separate tier of the NHS quasi-market with a significantly different market structure. Here the conditions for a truly competitive quasi-market exist, at least potentially. There are many purchasers (GP Fundholders) and though there may not at present be a multiplicity of providers in any given locality, the forces leading to fragmentation of DGHs noted in the previous section may bring them into existence. Out-patient services are becoming increasingly fluid in their location as electronic data transmission facilitates their delivery in community hospitals and primary care centres. Elective surgery may also be delivered in a multiplicity of locations – in larger hospitals, community hospitals, day surgery centres, primary care centres (minor surgery) as well as in private hospitals. Moreover, as GP Fundholders' initiatives have shown, and has been evident for many years in the private sector, it is possible for surgeons and anaesthetists to move between a number of different locations. For out-patient and elective surgery work, therefore, changes in local service configuration are likely to be less heavily 'managed', but arguably it is less important for them to be so in the presence of a number of alternative local sources of supply. The same

general proposition applies to an even greater extent to primary care and relatively low-tech community health services.

In summary, the need for 'managed' competition in the NHS quasi-market is not really in doubt. It fits naturally with the monopolistic structure of the high-tech component of healthcare services. Moreover, tax funding of the NHS and the requirements of parliamentary accountability make a strong element of managed competition inevitable. The real question is not so much the degree of regulation or management of the quasi-market, but how much of the regulatory function should be devolved from the NHSME to DHA purchasers and what ground rules should be put in place to avoid ministers overruling purchasing decisions for short term political reasons. The extent to which regulation of NHS purchasers and providers can in fact be devolved and decentralised, as proposed in *Managing the New NHS* – in line with current management orthodoxy, is discussed in the following section, below.

#### TENSIONS BETWEEN DHA/FHSA PURCHASERS AND GP FUNDHOLDERS

Tensions may arise from the coexistence of two potentially incompatible purchasing systems running side by side. There are two elements of tension. One relates to the desirability of consistent and compatible purchasing goals throughout the NHS. The other relates to the possible threat to the survival of specific providers (which may have been identified by the NHSME as strategically important resources) if GP Fundholder purchasing patterns are not aligned with those of the DHA/FHSA.

The latter tension can be ignored. The issue of which providers survive is one that can properly be left to the internal market, where both DHA and GP Fundholder purchasers are accountable to the Secretary of State for the cost effectiveness of their contracting decisions. It has been argued that the totality of services at a strategically important hospital may be put at risk because of marginal loss of revenue in those service areas covered by GP Fundholders' budgets. But such an argument must ultimately be untenable if the hospital can only be kept in operation at the cost of an unsatisfactory service to one set of purchasers.

The more interesting question relates to consistency and compatibility of purchasing goals. DHAs have a clear line of accountability to the Secretary of State, through which Health of the Nation and Patient's Charter goals are pursued. GP Fundholders' accountability to the Secretary of State is, in contrast, relatively weak. GP fundholders are responsive to their patients, not to central policy objectives. The issue is whether the purchasing tension between DHAs and GP Fundholders can be contained without detriment *either*

to Health of the Nation and Patient's Charter central policy aims or to the policy aim of promoting responsiveness of NHS services to consumer preferences? At present, the answer to the question is probably 'Yes'. Tensions can be contained because the government has no declared priorities within the set of budget heads over which GP Fundholders have purchasing discretion. The Department of Health does not tell DHAs how much of their budgets to spend on elective surgery, out-patient treatment and diagnostics, therefore no central policies are threatened by GP Fundholders viring in and out of these areas of expenditure. Nor does the government have a view on how much or little of GP Fundholder budgets should be spent on prescription medicines, provided the overall budget is not exceeded. In the case of community health services, the central policy objective of protecting community health service budgets from being transferred to acute services is not threatened by GP Fundholding, because Fundholders' community health service budgets are 'lobster potted'. It is hypothetically possible that GP Fundholders may vire their elective surgery and out patients allocations into community health services and prescription medicines, thus threatening Patient's Charter standards on waiting times. But this is an unlikely scenario because the priority that GP Fundholders' patients place on keeping waiting time down is likely to be just as great as, if not greater than, the priority the government gives to this element of healthcare.

Thus the issue of accountability to whom – patients or central government – does not at present create unacceptable tensions. The Department of Health can afford to allow GP Fundholders to exercise their purchasing discretion without significant risk to strategic purchasing objectives. Early reports have suggested that despite concerns about equity (two tiers of service – one for GP Fundholder patients and one for others) the GP Fundholding scheme has had a beneficial effect in achieving more responsive secondary care for Fundholders' patients and in stimulating experimentation in service delivery (Glennister et al, 1992). It is, however, unfortunate that the government has not collected or published the data which would assist further public debate on the cost effectiveness of GP Fundholding as an alternative purchasing system for the range of elective surgery, out patient, diagnostic and community health services covered. For example, no data are collected centrally which would allow comparison of elective surgery waiting times among populations registered with GP Fundholders or other GPs. Such information may well be subject to misinterpretation, but that is not an adequate reason for not collecting or publishing it – given the importance of the fundholding scheme and the existence of Patient's Charter standards for waiting times.

The tensions arising from the coexistence of two overlapping purchasing systems may grow in the future. It has been noted that rising consumerism and the increasing sophistication of NHS purchasing itself may force central government to develop policies on priorities to be given to specific procedures purchased by GP Fundholders and to start setting access standards for the treatment of specific conditions. To the extent that this happens, government will have to choose which is the more important objective, promoting responsiveness to patient preferences by continuing to regulate GP Fundholders with a 'light touch' or seeking to maintain strategic control over all NHS purchasing, in which case government would have to restrict GP Fundholders' purchasing discretion, whether by regulatory rules or by some form of line management control akin to the accountability review process through which the Department of Health controls DHA purchasing.

## 5.2 Scope for decentralisation in the NHS

Current business management orthodoxies emphasise that responsibility for decision making in any organisation should be delegated as far as possible to operational managers provided this is consistent with accountability and the achievement of head office goals. This is the declared aim of the government in *Managing the New NHS*, its blueprint for future administration. There is a widespread consensus within NHS management that this aim has not yet been achieved.

The report by the National Association of Health Authorities and Trusts in response to the functions and manpower review (NAHAT, 1993b) illustrates the essence of the dilemma of accountability and decentralisation, using an exchange between the Committee of Public Accounts and the Chief Executive of the NHS in Northern Ireland. In the exchange, originally cited by Professor David Hunter, members of the Committee of Public Accounts were 'greatly concerned' by the Chief Executive's argument that since day to day management had been delegated to Health and Social Services Boards this absolved him from being answerable to the Committee on his full accounting responsibilities, although he accepted that he was responsible for ensuring that services are provided in an efficient and cost effective way. The Committee's rejoinder was that, in any large organisation, delegation in no way removes the requirement for ultimate responsibility to be accepted. As Hunter (1992) points out, the example encapsulates the problem of finding an optimal balance between top-down political oversight on the one hand and devolved managerial freedom on the other.

NAHAT's view, and the view of other NHS management organisations such as the Institute of Health Services Management (IHSM, 1993) is that the optimal balance has yet to be found in the NHS and that the Department of Health is failing to concentrate on its core role of providing strategic direction by continuing to produce unwelcome and unnecessary guidance and advice on matters of day to day management.

While presenting a powerful critique of top-heavy central management exercised through an overblown NHSME, the NAHAT report perhaps fails to distinguish clearly enough between the different degrees to which the purchasing and providing arms of the NHS can be decentralised.

#### DECENTRALISATION OF PURCHASING: THE PROBLEM OF LEGITIMACY

NAHAT argues that management of the purchasing arm of the NHS should be 'light touch', similar to that for NHS Trusts, and that it should operate within a framework of broad strategic goals set by the Department of Health. This would be unexceptionable if purchasing were simply a matter of buying best value services, as it is for most private and public sector organisations. But purchasing of healthcare for populations has an additional dimension, that of deciding between the competing claims of individual users. At present, 'light touch' head office management of NHS purchasing may well be appropriate, since NHS purchasing goals are still largely process related and non controversial and issues relating to entitlement to specific services have not yet crystallised in the public debate on rationing healthcare. Indeed, a 'light touch' approach to purchasing is consistent with the Department of Health's preference in recent years for devolving decision making on priorities to local DHAs. But it has been noted, above, that the content of purchasing goals is likely to become more highly political as purchasing skills develop in the future and as rationing of healthcare becomes more explicit. Local variations which are revealed in access to specific treatments may come to be viewed as inconsistent with the concept of a 'national' health service and the Department of Health may ultimately find itself forced to establish national protocols governing access to specified medical care services. In the longer term, therefore, it may not be possible to sustain administrative changes which involve extensive delegation of purchasing decision making to local NHS managers.

It may also be asked what it is that legitimizes the setting of purchasing priorities by decentralised decision making. In the case of provision of health services, decentralised management decisions are legitimized by the fact that they are made in the framework of contractual arrangements, with the

purchaser in turn accountable to parliament through the Secretary of State. In the case of GP Fundholder purchasing, their devolved decisions on priorities are legitimized by their accountability to patients – who may choose to change GP practice if they are dissatisfied. In the case of DHA purchasers, however, delegation of responsibility for setting priorities risks a loss of legitimacy. Members of health authorities can in no valid way be said to represent their communities. Nor do CHCs have any legitimacy as elected bodies, and in any case most have little influence over DHA purchasing decisions. It may be argued, therefore, that a lighter touch in regulation and control of the new, more powerful DHA/FHSAs proposed by the government is inappropriate because it dilutes accountability.

One possible solution to the problem of legitimacy is for Ministers through the NHSME to set clear ground rules by which DHAs/FHSAs must determine purchasing priorities. But this would almost certainly involve Ministers acknowledging the reality of rationing healthcare services, which they have been unwilling to do in the past. Another possible solution is for funding for a wider range of healthcare services to be transferred to GP Fundholders, whose rationing decisions have legitimacy conferred by accountability to patients. This option has special appeal for commentators who see the agency relationship between GPs and their patients as the most promising focus for making the NHS more responsive to consumers and who view 'exit' (changing GP) as a more appropriate mechanism than 'voice' (political pressure) for building consumer choice into the development of local health services. But there is a limit to the range of services whose funding could be transferred to GP Fundholders, because of the need for monopoly suppliers of core emergency in-patient services to be matched with similarly powerful large scale purchasers.

Yet another possible solution to the legitimacy problem is to transfer the functions of DHA/FHSA purchasers, and their funding, to the 107 counties and metropolitan boroughs in England, whose rationing decisions would have legitimacy conferred by accountability to elected councillors. This option has special appeal for those who view 'voice' rather than 'exit' as the more appropriate mechanism for building consumer choice into the development of local health services. The proposal to transfer healthcare purchasing to local authorities was revived in June 1993 by the incoming President of the Institute of Health Services Management, David Knowles, in his inaugural address, drawing on an analysis of this and other options published by the IHSM Policy Unit (Ensor, 1993). Knowles pointed out that the purchaser provider split had eliminated the old objection that local authorities would not be competent to administer health services, since NHS Trusts would

continue to supply health services independently and local authorities would concentrate on the purchasing role, where they have broad experience.

The strongest argument for local authority purchasing of healthcare is responsiveness to local priorities. What is claimed as an advantage by some commentators, however, may be viewed as a disadvantage by others since it implies that local variability in access to services would be an acknowledged and in-built feature of the system. This may run counter to public expectations regarding what a national service should offer.

Advocates of local authority purchasing of health care also emphasise the benefits from integrating the purchase of health and long term care services under a single local authority. What this fails to recognise, however, is that approaching 50 per cent of long term care for frail elderly people, the main client group, may be personally funded by the end of the century. This is because state funding of long term care in residential settings is means tested and more recent cohorts of elderly people at risk of needing long term care contain higher proportions of property owners, who are ineligible for state funding until their assets fall below £8000. In a situation where a local authority will typically be only one purchaser among many, the potential benefits from service planning and from integration of health and long term care purchasing are less evident. An equally valid alternative model for dovetailing health and long term care services locally would be to build publicly funded long term care purchasing around the consumer as the key decision maker, with the NHS organising relevant community health services (such as district nursing) to respond to consumer preferences as well. The extension of GP Fundholder budgets to cover district nursing services provides a basis for such a change in emphasis away from formalised, authority wide planning of long term care services.

Whatever the technical merits and demerits of local authority control of NHS purchasing, the main objection is a political one. No Conservative government is likely to accept the case for transferring health purchasing to local authority control. It was with great reluctance that the Conservative government accepted the logic of making local authorities the lead agencies for state funded community care. But in the case of the NHS, a fully functioning administrative system exists and transfer of NHS purchasing to local authorities, as well as being politically unacceptable, would run counter to the entire thrust of government policy since 1979, which has been to gain effective central strategic control of the NHS. The Labour party is likely to be more sympathetic to the proposal, though there was no mention of transferring control of the NHS to local authorities in the 1992 Labour election manifesto.

Since neither GP Fundholders nor local authorities offer a complete and practicable solution to the problem of legitimacy raised by decentralisation of purchasing, it seems unlikely that the Department of Health will be able to sustain 'light touch' regulation of the entire range of NHS purchasing in the long term. The course that seems most likely to be followed by the government is one of 'hands on' head office management of DHA/FHSA purchasers, in the sense of increasingly prescriptive guidance on priorities, together with encouragement of more GPs to join the GP fundholding scheme. Further expansion of the range of services covered by the fundholding scheme into the high-tech core of DHA purchased services is not practicable because of the need to match local monopoly providers with monopoly purchasers.

#### DECENTRALISATION OF PROVISION

In contrast, the uncoupling of the provider arm of the NHS from direct political influence appears to be essential to the logic of the internal market.

Direct line accountability of NHS Trusts (as public corporations) can be achieved through the minimal oversight required to ensure they balance their books while accountability for the services they provide can be achieved through their contractual relationships with purchasers, who in turn have a line accountability to the Secretary of State for Health.

It has been noted, above, that health services in Britain and elsewhere are undergoing a technology driven process of reconfiguration which will involve the closure of many acute wards and hospitals and the reprovision of services elsewhere. The internal market provides a mechanism for selecting efficient providers and eliminating the inefficient ones which is – arguably – superior to mechanisms of administrative planning. The process of reconfiguration, however, will inevitably be opposed by health professionals and other NHS employees working in facilities which are under threat and it can be expected that they will lobby politicians accordingly. Having created an internal market, it would then be, at the least, inconsistent for the government to allow market judgements to be negated by top-down political interference. There will inevitably be some occasions, notably the reorganisation of teaching hospitals in London, where the politics are so sensitive that a politically determined solution has to be engineered. But it seems logical for the administration of the NHS to be arranged in such a way that the bulk of ward and hospital closures and service changes flow from contracting decisions of DHAs and GP Fundholders charged with the responsibility of delivering the most cost effective healthcare service from their limited government funding.

If DHAs and GP Fundholders start to buy

substantial amounts of service from independent healthcare providers, that would modify the requirements of provider regulation still further. The British public probably still thinks of the NHS in terms of its physical presence – ‘our hospitals’ and the people who work in them. The more abstract idea of a purchasing system which guarantees the ideal of equal access to entitlement according to need may not evoke the same sentiments. Nevertheless, contracting out or outsourcing of even central functions within an organisation has become a familiar management concept in the private sector – to the point where the ‘virtual’ company – such as Reebok which owns neither factories nor distribution outlets and has no employed sales force – is held up as an exemplar. If the NHS does evolve in this direction then the essential function of provider regulation will change to that of hospital and healthcare services inspectorate, supported by an accreditation system, to provide a further assurance that DHA and GP Fundholders are purchasing healthcare services of an adequate standard.

The main management task of the NHS will be purchasing, accountable directly, or via Parliament, to the public. The key management challenge in healthcare, as opposed to in the NHS, may, however, remain that of the efficient provision of care.

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