EFFECTIVE COMMISSIONING

Lessons from purchasing in American managed care

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June 1998

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Telephone: 0171 930 9203
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Price £7.50

ISBN 1 899040 55 2

Printed by BSC Print Ltd., London

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The Office of Health Economics is supported by an annual grant from the Association of the British Pharmaceutical Industry and by sales of publications, and welcomes financial support from other bodies interested in its work.

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A greeting

It may seem odd that someone from the most overpriced, wasteful and inequitable health care system in the industrialised world should pen a report on how to make the UK National Health Service (NHS) more cost-effective. Yet from the very deregulated nature of US markets have emerged useful lessons, as the leading buyers (that's American for 'commissioners') face up to all the ways that they did not save money during the 1980s when they thought they had. My aim is to employ familiarity with both systems in order to extract 'adaptable policy lessons' that could be used in the UK.[1] While based on a good deal of experience in the NHS over the past eight years, this report attempts to provide new ideas and fresh perspectives in an informal manner designed to stimulate discussion of fundamental issues.

Discussing fundamentals, however, raises a problem about language. I do not mean the problem of figuring out how one can not only put a boot in a trunk but a trunk in a boot. Rather, I mean the highly politicised language of British health policy and how much control seems to be exercised over what people say, think and even perceive.

For example, soon after the landslide victory of the Labour party in 1997, a prominent figure in health policy corrected my talking about fundholding by instructing me that 'Fundholding no longer exists.' For a moment I thought, 'My, things really have changed rapidly since I was last here four months ago.' Then I realised that there were just as many fundholders as before and that they covered half the nation. My colleague was coaching me in political correctness, but what degree of denial or mental muzzling was built into the coaching?

Experiences like this make me wonder if there is a Minister of Acceptable Language who issues such edicts, to which everyone seems eager to conform, even if they know the edict makes no sense. Such practices are dangerous, even crippling, because one can no longer talk or think about something, at least in official circles where critical thought might make a difference. Fortunately, I found in subsequent weeks quite a number of policy experts talking and thinking about the f– word without getting arrested for Unacceptable Language.

But the word 'commissioning' in our title is another matter. I had originally proposed that this report be titled Effective Purchasing. But when next I returned in October 1997, I was told that 'Purchasing is out.' Indeed, everyone had fallen into line with the mythical Minister of Acceptable Language by dropping the p— word and replacing it with 'commissioning.' This replacement may do the NHS, the Labour Party, and the nation a disservice; for commissioning is a fudge word that obscures accountability, and lack of accountability is a serious problem in the NHS.

If I *buy* and you *sell*, everyone knows who is doing what and who is accountable.* 'Commissioning', however, raises real worries. When it was first coined after the NHS reforms, I believe by Ian Carruthers about 1991, commissioning meant the same as 'commissioning a building.' You think through what will work best, from the ground up, and then you find the right people and 'commission' them to do it. The term captured the essence of 'needs-based purchasing,' the challenge still with us today to think through what configurations of health services will best meet the needs of the people served.

But by the mid 1990s, 'commissioning' had become fuzzy, as in the term 'GP commissioning'.[2] This meant advising the purchaser, certainly a potentially instructive role, but a kind of non-accountable, vicarious form of purchasing. This is a far cry from Carruthers, as the Chief Executive of the Dorset Health Authority, acting as an enlightened commissioner of new service configurations, with the authority and funds to back up his decision. The current plans to form Primary Care Groups and have them 'commission' services to one degree or another, in one relation or another to their health authority, invites problems of who will be responsible to whom and for what? The answer will vary greatly, and the fogginess of 'commissioning' will obscure what needs to be clarified. Beware. We are talking about spending more than £45 billion of the people's hard-earned money annually.

So off we go with a torch, into the commissioning fog, and I want to thank the many doctors, managers and policy analysts who generously answered questions, sent materials and gave time to be interviewed, many of them anonymously. In addition, a number of people took time to provide thoughtful reviews of drafts, including Christopher Bulpitt, Harry Burns, Martin Buxton, Tony Culyer, Robert Dingwall, Rob Flynn, Steve Harrison, David Hughes, Geoffrey Hulme, Roy Lilley, Carol Propper, Robert Royce, Ian Trimble, Nicholas Wells and Peter Zweifel. I am particularly grateful to Adrian Towse for his imaginative yet incisive guidance of the project from the start and throughout, and to Jon Sussex for his excellent, detailed commentaries and suggestions. Parts of this report were presented at a 'masterclass' in October 1997, generously sponsored by Glaxo Wellcome and the Health Service Journal, and research was in part supported by Glaxo Wellcome while I was its visiting professor at Manchester. I want to express my appreciation to Michael Bailey, John Cooke and Garreth Hayes for all their help, as well as to Peter Davies for his extraordinary editorial skills. The report builds on an article that appeared in the 17 January 1998 issue of the BMJ, greatly assisted by the insightful comments of Professors David Wilkin and Martin Roland at the National Primary Care Research and Development Centre. None is responsible for the contents.

*In fact the first meaning of 'to buy' had value-for-money built into it. In AD 1000 it meant 'to get posession of *by giving an equivalent.*'

1. Effective commissioning – no substitute for increased funding

This report is based on my conclusion that weak or ineffective commissioning has been and remains a central problem for maximising value-for-money.[1] Granting that the market reforms of the 1990s raised costs, created new inefficiencies and inequities, and caused a good deal of dislocation, the new Labour Government's era of 'partnership' and 'collaboration' will not get far unless commissioning is made strong and effective. I will outline what needs to be done and what lessons can be learned from the experiences of others. But to think that effective commissioning will solve the problem of underfunding is an illusion that needs to be cleared up at the beginning.

The NHS is doubly underfunded

Although some leading policy figures maintain that the NHS has enough money and only needs to reduce its inefficiencies[3], I have come to conclude that the NHS is doubly underfunded.[4] That is, if tomorrow enough funds were provided to treat everyone who has been waiting more than three months for a problem that a specialist has certified as needing attention, there would be thousands more patients with similar needs added to the so-called waiting lists who were being kept off them because their GPs thought the lists were too large or the waits too long.* Because British policy makers debate whether the NHS is [singly] underfunded, and because critics can point to examples where extra funding only led to waiting lists filling up with still more patients, they conclude that need is a 'bottomless pit', when actually the problem is double underfunding – both of those not served in a timely fashion now and of those behind them waiting to get on the waiting lists.

The myth of the bottomless pit of need

A good case can be made that demand is bottomless, but need – once defined responsibly – certainly is not. I call this excuse for underfunding 'the myth of the bottomless pit.' The argument goes like this: since patient need (or demand) is bottomless, there's no point in pouring more funds into the NHS. Note that this argument could lead one to conclude that 'Since patient need (or demand) is bottomless, the money we now spend on the NHS represents a futile pursuit; so we might as well reduce the NHS budget by £5 billion and spend it on

*See the section on conquering the so-called waiting list, below.

industrial infrastructure, where it will generate new revenues.' No one is saying this, but the bottomless pit argument leads to this conclusion as easily as it leads to no increase in funds.

The pit or well of patient needs, in fact, does have a bottom, and I have noticed that no ordinary British citizen ever talks to me about health care being a bottomless pit. They tell me about a friend or relative who had a serious medical problem and received wonderful care, or terrible care. Apparently one needs the luxury of a university degree and reasonably good health to entertain the bottomless pit argument.

The bottom of the pit can be measured epidemiologically in terms of incidence and prevalence and course of illness. Even the bottom of patient demand can be measured. Just take a health care system where there have been almost no barriers to service and see how many visits, tests, and operations are done. Push the case even harder by choosing upper-middle class people who live in towns and do not work, that is, people with high standards and expectations who can go down the street to the doctor whenever they like. How often do they go? Every day? For this is the fantasy behind the myth of the bottomless pit. In fact, people have better things to do, and indeed most of them probably do not like going to the doctor and fear going to the hospital or going under the knife. Their rates of utilisation are higher than British rates, but far from bottomless. In short, the claim that health needs are bottomless is an empirical question, not a foregone conclusion, and the NHS *could* be adequately funded.

The mirage of efficient healthcare

The other prevalent reason given for not providing more funds for needed health care is the alleged gross inefficiency of the NHS. The health group at the Treasury are said to believe the NHS should not get a pound more until its inefficiencies are eliminated, that is, until there is effective commissioning.

While effective commissioning can reduce inefficiencies, health care is inherently 'inefficient' when compared to manufacturing computer chips or running a hotel. Clinical medicine is *emergent, contingent* on what happens, highly *variable,* and rife with *uncertainties.* Talking about 'inefficiency' in health care may be a misapplied metaphor. Focusing on waste and value-for-money make more sense. To envision health care as efficient the way that a hotel or airline can be efficient is a mirage.

But there is a deeper point about the forms of waste or poor value that do exist in the NHS.[5,6] Most of them involve someone's interests being promoted or protected. They are highly political. In fact, a

principal requirement for strong and effective commissioning is the political will to withstand the pressures of those whose entrenched interests are challenged in the pursuit of better value. Perhaps the issue can be made clearest by formulating a test:

The 'are you serious about efficiency?' test

(for Treasury and other government officials)

1. **Specify which 'inefficiencies' you want reduced.** Vague talk won't do.
2. **Outline the major steps to be taken to reduce them.** That is, identify whose budget, or services, or incomes will be affected. For example, the lengthening waiting list and waiting times could be re-engineered into a performance management tool, and waiting times could be greatly reduced; but it would mean taking on the waste and vested interests of the current arrangements.[7]
3. **Publish your proposal, sign it, and include your personal phone number.**

My guess is that ministers and officials of the Treasury who resist additional funding for needed services until the NHS gets efficient would not pass this test for being serious about reducing entrenched inefficiencies. Only a handful of governmental officials could carry out Steps 1 and 2, and I wager that none has the courage to carry out Step 3. Yet as Harry S. Truman said when President, 'If you can't take the heat, get out of the kitchen.'

Not to fund services needed by patients because of inefficiencies that the government finds too 'hot' to address, however, is to make sick patients the victims of political cowardice. Ethically, this is indefensible. When I noted once that NHS payments are constructed so that no one loses much money if they are more inefficient, an astute GP replied, 'You're right, but in the NHS it's the patients who lose.' The inefficiencies of each nation's health care system reflect the history and politics of its entrenched interests. One must live with them or deal with them, but not make patients their victims.

The Private Finance Initiative: more costs for fewer services?

One false way to increase current funds is to save on capital repairs and projects by borrowing so that in years to come there will be less money to pay for services. In years past, the Conservative government kept depleting the capital budget for the NHS in order to come up with more money for current health care services. By the middle of the 1990s, the word went out that the government could 'no longer afford' to pay for upgrading or building hospitals and other facilities, when in fact it had created this situation by siphoning funds from the capital budget. What 'no longer afford' means is that politicians do not think they can afford to raise taxes.

The Conservatives then invented the Private Finance Initiative (PFI) as a way to borrow from private investors to pay for capital improvements. But borrowing, as every citizen knows, costs more than paying when you buy. How much more? Figure 1 tells the story. It shows how much it costs to pay back £1 billion if it is borrowed at 8, 10 or 12 percent, for 20, 40, or 60 years. For example, it will cost £4.1 billion to pay back every billion pounds that PFI projects cost now, if the terms are 10 percent for 40 years. This needs to be compared to the public cost of borrowing and to the interest on other uses of the money. My guess is that unless a PFI package is ingeniously designed, private borrowing will cost 50-100 percent more, and without new funds, services will have to be cut.

Figure 1 **The total cost of borrowing £1 billion**

	at 8%	*10%*	*12% return*
for 20 years	£2.0bn	£2.3bn	£2.6bn
40 years	£3.3bn	£4.1bn	£4.8bn
60 years	£4.8bn	£6.0bn	£7.2bn

Is PFI a Faustian bargain for giving the people 'free' new hospitals and clinics now, at the price of cutting their services when they get older? For if politicians believe that raising taxes for capital improvements is impossible, they won't be willing to raise taxes in the future. Do young and middle-aged adults know that paying the bond-holders may take precedence over giving them the medicines and

surgery they will need as they get older? Do doctors and nurses and other health professionals know? Do hospital managers and drug manufacturers know? Everyone could lose with the PFI except private investors.

An obvious reply is to assure the public that Parliament will raise more funds as more health services are needed. But if they can do that later, why not do it now and save a billion or more in future costs? The PFI just does not add up. When an article asks, 'Tony Blair: can PFI give him a winning formula of improved public services without tax rises?'[8] the answer may be 'Yes, by cutting medical services over the next 20 years.'

Back-door privatisation?

There are other serious worries and dangers built into PFI that Britain's most astute experts have noted.[9,10] Depending on the terms, the PFI can easily turn into a back-door privatisation of NHS hospitals and other facilities. As Ham puts it, 'It is likely that the private sector interests will wish to take a close interest in the management of services, including having a seat on the board and a say in the appointment of senior managers and doctors.'[11] In addition, the PFI is supposed to transfer risk to private investors, but in fact the terms of the PFI transfer most of the future risk from the investors to the NHS and to taxpayers.[10] For if the facility or the private investor incurs serious debts, the government apparently must pay for them.

The PFI is also supposed to benefit from the efficiencies of the private sector, but there is no evidence that the private sector is more efficient at running hospitals. In the United States, evidence keeps appearing that the public sector runs health care most efficiently, non-profit private facilities come in second, and for-profit corporations spend the most on executive salaries, administration, marketing and return to investors, and the least on clinical services.[12]

Primary care PFI

To the extent that any of these worries pertain, attention needs to be given to the widespread forms of private financing initiatives already going on in primary care. They are below the radar-screen of PFI watchers, but are increasingly widespread as health authorities address the need for larger facilities for GPs and community health services. A secondary industry of estate development companies and investors has sprung up to package, build and operate facilities for health authorities with little attention to or regulation of the deals they strike and the implications for back-door privatising of front-line health care.[13]

What puzzles me is that before the election, the PFI was widely

regarded by many top policy people as the most pernicious of Conservative strategies to privatise the NHS, and now Labour are pushing it forward even harder. Is Labour continuing to deplete the remaining capital budget for the NHS? Ministers are so intent on making the PFI succeed that even the chairman of a major health authority told me last summer about a large project with unfavourable terms that ministers insisted on approving anyway. And when £1.3 billion worth of PFI projects were chosen last summer, ministers said that 'they were unable to say how much this would cost the service in future...' until *after* terms were finalised.[14] The secret character of the negotiations and the lack of public debate run contrary to Mr. Blair's emphasis on public accountability and open consultation with taxpayers on how their money is being spent.

Conclusion

Ministers emphasise that these projects will constitute 'the biggest hospital building programme in the history of the NHS,' but does the public realise that the way they are being financed may mean billions less for clinical care in the future? The PFI needs a full airing and independent review, even though it is not 'politically correct' to do so. At the same time, each project should involve public meetings and include the present and future costs of alternatives, with a full analysis of which parties will bear what risks. The lack of oversight, regulation and accountability that the government apparently thinks is part of having private partners or private providers poses a grave danger.[9] Lack of accountability and oversight compromise effective commissioning, particularly as PFI projects are commissioned by providers, not purchasers. There is no reason why a public payer should not require full accountability and oversight of every private partner. After all, the private parties are getting the most risk-free deal in the world – a partner who will never fail to pay up regardless of how bad the economy or business gets.

The dangers and high costs of the PFI do not preclude other kinds of public-private partnerships under more cost-effective terms. In fact, it makes a great deal of sense to combine health centres and hospitals with pharmacies, opticians, offices, shops, hotels and even residential space that generate revenues for the NHS, not for private investors. But the capital costs should be paid out of public funds now, not borrowed, so that revenues from rents help pay for current services. It may be cheaper to mount a campaign for a one-time, 'Rebuild the NHS' surtax, than to borrow the money.

Fewer services no substitute for adequate funding

Besides the long-standing low level of funds for the NHS, the Conservative government declassified* long-term institutional health services for the seriously mentally ill and old and moved them over to local authorities as social services. Thus a million pounds after 1992 appeared to buy more health care than an equivalent million pounds in 1982, not because the transformation to commissioning had achieved greater value for money, but because a portion of it no longer had to be spent on these long-term services. As a result, 'In 1970, 28 percent of all elderly people receiving long-term care outside their homes received free NHS care; by 1992 this figure had fallen to 12 percent. Around 40,000 couples had to sell their homes to pay for nursing home care last year alone.'[15]

Declassifying sets a dangerous and tempting precedent found in other countries as well. Other wholly or partially declassified services have included optical and dental services, but declassifying long-term services for the seriously impaired is a much more frightening matter. Many (but not all) kinds of co-payments or user charges are forms of partial declassification, and in all cases they discriminate powerfully against those with modest incomes unless special provisions are made.

*Although the NHS has no list of covered services, 'declassify' refers to policy changes that partially or wholly drop NHS payment for services that have customarily been provided.

2. Pre-requisites of effective commissioning

While the new Labour government is abolishing the Conservatives' internal market, it has decided to retain the idea of purchasing or commissioning services through a purchaser/provider split. By definition, of course, this is an internal market within the NHS, only one characterised by contestability rather than competition. Since contestability is the basic dynamic underlying competition, this distinction means that the basic dynamic of the abolished internal market remains, only muffled.

In the United States, of course, competitive purchasing has the ironic status of a state religion – there is no other way. Yet it has real dangers for containing costs in health care. First, competition since Adam Smith has been an engine of economic *growth*. Adam Smith's famous book was not titled *The Cost Containment of Nations*. While competition rewards the efficient producer in the short run, it rewards innovative producers who create new needs and markets in the long run, and health care technology is very good at creating such needs. Second, purchasing or commissioning in health care is highly vulnerable to provider capture. After all, they control the technology, make the diagnoses, control what is ordered and control the information that the buyers need. Thus, it has been a long struggle for American commissioning groups of employers to learn how to do it effectively. From their efforts I think one can extrapolate five pre-requisites for effective commissioning:

Clear goals

The will to pursue commissioning goals

The ability to contract selectively

Integrated budgets in order to commission effectively

Clear measures of benefits and quality as well as costs

Let us look at each of these in turn.

Clear goals

The Secretary of State for Health has defined seven principles for the NHS:

fairness	integration
efficiency	flexibility
effectiveness	accountability
responsiveness	

These are worthy principles but they do not provide the basic goals or vision of what a health care system should aim to achieve in the 21st century. The first four are principles of process, and the last three are means to the first four. Some of them could add cost, depending on how they are defined. 'Flexibility' along with 'responsiveness' could easily lead to increased variations and inequalities. One needs to be careful.

'Responsiveness' usually implies responding to demands, while a cost-effective service firmly but nicely puts unnecessary demands in their place. There is a deeper point as well: demand-based equity leads to needs-based inequity.[17] Does the new Labour government understand the implications of this choice for how it commissions?

Another process goal featured at the opening of the new government's English White Paper, *The new NHS,*[18] is 'prompt high quality treatment and care when and where they need it.' This phrase contains a vision of a health care system that by itself it will invite more and more cost.

The goals or ends of health care should be:

- to minimise illness and disability. This implies an emphasis on the lower and working classes, making public health an integral part of 'health care', and emphasising secondary as well as primary prevention;
- to maximise functioning and productivity. This implies performance-based contracts and having measures of health functioning like those described below that can be used for performance management and training, not just political surveys of consumer opinion;
- to realise the minister's seven principles, as above;
- to develop participatory health care. This one calls for discussion.

Participatory health care

Health care systems in advanced societies face a growing number of chronic conditions, disabilities and aging patients. Prompt, high-quality treatment when needed will get very expensive. A new approach is needed if health care is to be affordable and effective, an approach that mobilises people to do all they can to manage their health problems or risks and help others do the same. Leading American commissioning groups believe that 70 percent of health problems can be postponed or prevented.[19] The NHS is well designed to maximise this potential because of its area-wide commissioning authorities and stable funding. Fortunately, the White Paper also mentions improving health.

An important goal for the NHS in the 21st century is to maximise people's self-sufficiency and productivity by mobilising their ability to manage their health risks and problems and to help others.[20] We could call this *participatory health care*.[21,22,23] Behind it is Giddens' idea of positive welfare in which programmes 'provide people with the resources they require to be active investors...' in their health. At the same time, 'we must provide security mechanisms which protect them.'[22]

Beyond participating in one's health is Gordon Brown's emphasis on fairness as maximising people's ability to grasp the opportunities of life and to make the most of them.[24] One of America's leading moral philosophers has developed just such a concept of fairness in health care.[25] Thus, participatory health care as a means to assure fair access to social and economic opportunities is the driving political philosophy of New Labour.

Besides primary prevention aimed at substance and alcohol abuse, accidents, crime, tobacco, and infectious diseases, a steadily increasing percentage of people experience discomforts, pain, dysfunctions and disabilities. Through education and clinical assistance, they can learn how to manage, on their own or with significant others, many of these problems and prevent costly relapses into acute problems. Once a problem goes beyond self-management, then the prompt high quality treatment can begin, and its goal would be to restore patients as quickly as possible to the highest level of functioning they can manage.

This basic goal means that effective commissioning does not start with purchasing services but ends with it. The starting point, which can be quite inexpensive, would involve community-based health programmes, educational resources, cross-sectoral initiatives in Health Action Zones and elsewhere, websites, self-help groups, and the invaluable network of charitable organisations that have become skilled at responding to the needs of their constituents. Many are doing splendidly on their own, but others need a boost here, technical advice there, help developing in a new region, some office space or equipment, or earmarked grants to get them over a hump or into a new phase of effectiveness.

Employers are a vital untapped resource in achieving this basic goal. They need to learn how they can increase productivity and decrease sick or disability days through empowering employee programmes. Many excellent ones have been developed in the employer-based American health care system on which they can draw.

The will to pursue commissioning goals

There is so much that a purchaser could do to increase productivity, integration and quality. But after seven years, the government as commissioner does not even know what it is getting for its money. Wide

variations in quality, from primary care on through surgery and intensive care, are perceived but not measured. Old inequalities get locked into current budgets. Two-tier waiting lists between fundholders and non-fundholders were possibly the least – and the least well documented – inequality in the NHS. So when the government makes eliminating that inequality the showcase of its commitment to equality and fairness, one has to worry that the commitment is not very serious. Much larger inequalities exist between patient access to some specialties compared to others, between GP practices, and in some inner cities and rural areas. These matters will be taken up more fully later, but here I wish to focus on the obvious but missing point that Parliament and the Treasury are, as the Sioux might say, the 'Great Commissioner in the Sky'. They are the agents of taxpayers, who give over hard-earned pounds in order to have an equitable, cost-effective health service.

The problem is that the government also sees itself as the provider of services as well. A major obstacle to effective purchasing is that the Secretary of State for Health is legally responsible for everything that happens in the NHS, even a bedpan dropping in some distant ward. Such a mandate and mythic vision completely hog-ties him or her as a purchaser. If accountability for every bedpan is the vision, then effective commissioning is doomed from the start. For if the purchaser is also the provider, then from whom is it buying? And if as provider the government feels obliged to defend the quality or equity of inferior or inequitable services, then how can it play the key role of a purchaser who is pushing its providers to do better? Getting these issues straight took years in the United States, but it has been fundamental to do so.

NHS Executive – managing vs commissioning?

The next obvious question is, what is the NHS Executive? Logically, it should be a team of experts at commissioning and contracting and performance management that help the Great Commissioner in the Sky increase fairness, effectiveness, integration, equity and other important goals. But empirically it seems more involved in running services than in commissioning those services. For example, the NHS Executive is the 'head office' for the provider trusts. The Chief Executive is the CEO of the NHS. By definition the senior management on the provider side of the table has a limited ability to give ministers, Parliament or the Treasury good advice about how to commission for better value or how to reduce inefficiencies, because such advice would challenge the way they are running the service. If one replies by invoking the model of long-term partnerships between Marks & Spencer or Toyota and their suppliers, one must be clear that those

partnerships are driven by the *buyer* and the buyer's unflagging search for good quality at lower cost.

In a thought-provoking study, Patricia Day and Rudolf Klein describe how the NHS Executive arose as the core part of the internal market concept of public management and grew from being an internal agency within the Department of Health to dominating it.[26] Central control has increased under the guise and rhetoric of devolving responsibility.[27] Moreover, many of the NHS Executive's 2000 staff come from operational management. Its culture is provider-centred rather than commissioner-centred. Its very organisational structure works against giving good advice about integrated care. How, then, can one abolish the internal market without also abolishing the NHS Executive in its present form and reconstituting it as a commissioning agency?

A corollary to making the NHS Executive into the technical arm of the Great Commissioner in the Sky is getting the elected representatives of the people in Parliament to clarify what they want. If Parliament wants the force and advantages of a commissioning model, and if it wants to have the political will to commission effectively, then to be accountable for, or hold ministers accountable for, every local crisis and shroud-waving over services in the NHS makes no sense.

Creating arm's-length commissioning relations with providers

Getting straight the government's role as commissioner and strengthening its will to commission effectively also requires arm's-length management of the health care services. At present, the national commissioning body (the government) owns the hospitals and employs the consultants, nurses and other personnel. One might be led to think that commissioning under these circumstances constitutes an internal market, perhaps even an incestuous market. Then again, one might not want to think such thoughts.

Health authorities are the delegated agents of the Great Commissioner in the Sky, led by hand-picked appointees, closely monitored and kept weak as commissioning agents through under-resourced staff hemmed in by over regulation. GP fundholders have been much more independent agents and indeed have performed in quite uneven and controversial ways, increasing inequality and running up managerial costs. The central aim of the English White Paper is to eliminate these problems and bring fundholders into Primary Care Groups that will commission everything, but within clinical, performance, and financial parameters set by central government. The problem still remains that the present contradictions between the government being the manager of services and the government being the commissioner of services will lead it to set parameters that lock in

and protect consultants, hospitals and other parts of the provider structure.

These observations should not be construed to imply that hospitals need to be privatised or employees spun off into firms, though Day and Klein note that constant political interference into managing the NHS 'has led successive Secretaries of State of Health to conclude... that the ideal arrangement would be an independent corporation.' If we drop the provocative term 'corporation', we are still left with the fact that Secretaries of State from both parties have concluded that providers and services need to be at arm's length. There are a number of public-sector options.

Hospitals and other trusts could have local boards like British schools, for example, which would put them at arm's length from the central government as commissioner and also make them more locally accountable. Specifically, instead of trust boards being appointed by and accountable to the central government, a school-like board would have some members chosen by local government, some by the staff, and the majority elected by people who have been users in, say, the past two years. If the new NHS is going to be patient-oriented, why not give patients a direct say in setting trust policy? Greater local accountability of providers and services is not only more real and accessible to patients, but it liberates the centre to commission more effectively. As strong commissioning pressures inefficient or duplicate hospital facilities into closure, local boards would have to struggle with what to do. This would certainly create local political heat and interference, but if the Great Commissioner is open, fair and sympathetic to alternatives, it can continue to be firm about its core goals of greater productivity and value for money.

It is not clear to me that the entire NHS as a provider organisation, or the trusts, need a national chief executive and central administration, especially when everyone emphasises how diverse operational practices are, and when successive governments have emphasised devolved decision-making of provision. The Great Commissioner in the Sky needs to do long-range planning and sign long-term contracts, but a more arm's-length management structure could start at the regional level and emphasise local boards for trusts. As the contractees, those boards would be especially keen to find competent teams to run their services. Those management teams could (and I think should) include doctors; a new career for senior registrars and consultants with a bent towards management. One can see how this argument and model differ significantly from the English White Paper. It clarifies and strengthens the commissioning role at the same time as it gives users a much greater say in how services are provided.

Such provider teams could be doctor-led, and indeed the leading edge of managed care in the US seems to be doctor-led systems of multi-specialty services,[28] but more on that later.

Professional vs commissioning priorities

The will to commission effectively centres on the will to address the large portion of the budget tied up in hospitals and reconfigure it. A hard lesson of the 1980s for US payers (employers) has been to disentangle themselves from being on hospital boards and identifying with hospitals in order to get their commissioning priorities straight. This raises a final indication that the will to commission effectively is not there – the word 'partnership'. American purchasers spent 15 years in partner-like, 'let's hold hands and do good' efforts to get hospitals and specialists to be more cost-effective. Time and again providers found ways to direct these partnerships to their own ends.[28,30] This led to what I call the Buyers' Revolt and a radical clarification that buyers and providers have very different priorities that profoundly affect costs, efficiency and productivity.

Likewise, my guess is that many British doctors do not want evidence-based guidelines or outcomes measures interfering with what they 'know' is the good medicine they practice. The systematic, rational pursuit of effective services that meet uniformly high standards, American purchasers have concluded, is a *commissioning* issue and has to be led by commissioners. Thus an American observer is not surprised to learn that British clinical audit has been relatively weak[31] because it has been run by the doctors themselves. The new Labour government's plans to take over the establishment of national clinical standards and guidelines will work, so long as the government leads this work as the Great Commissioner in the Sky.

Figure 2 outlines the basic differences in values between the state as commissioner and the medical professions.[32] The state aims to foster a vigorous, healthy population and workforce by minimising illness, maximising self-care and minimising the cost of medical services. The professions are focused on honing their skills, protecting their autonomy and enhancing their prestige and wealth. Their ideal health care system would provide the best clinical care to every sick patient and would advance scientific medicine to its highest level. These goals are not 'wrong', but they lead to a very costly health care system and to little interest in prevention or chronic care. Prevention is not 'real medicine,' and chronically ill patients are a testimony to the limits or failure of curative medicine. The profession fiercely defends autonomy and clinical control, but the problem is that autonomy and clinical control have led to large variations in quality and expenditure that cannot be explained by clinical variables. The state as commissioner

Figure 2 **State vs professional visions of health care**

State/sponsor	*Professional*
Key values and goals	
To strengthen the state or sponsor by a healthy, vigorous population.	To provide the best possible clinical care to every sick patient (who can pay and who lives near a doctor's practice).
To minimize illness and maximize self-care.	To develop scientific medicine to its highest level.
To minimize the cost of medical services to the state.	To protect the autonomy of physicians and services.
To provide good, accessible care to all sectors of the population.	To increase the power and wealth of the profession.
To instill loyalty, gratitude.	To increase the prestige of the profession.
Image of the individual	
A member, and thus the responsibility of the sponsor.	A private person who chooses how to live and when to use the medical system.
Power	
Either democratic or autocratic or a cross-mixture.	Centres on the medical profession, and uses state powers to enhance its own.
Secondary power to medical associations.	
Key institutions	
The ministry or department of health and its delegated system of authorities.	Professional associations.
	Autonomous physicians and hospitals.
Organization	
An integrated system, administratively centralized, or decentralized.	Centred on doctors' preferences for specialty, location and clinical cases. Emphasis on acute, hi-tech interventions.
Organized around the epidemiological patterns of illness.	A loose federation of private practices and hospitals.
Organized around primary care. Relatively egalitarian services and recruitment patterns.	Weak ties with other social institutions peripheral to medicine.
Strong ties with health programmes in other social institutions.	
Division of labour	
Bureaucratic, physician controlled.	Hierarchical, doctor controlled. Specialty oriented.
More health care teams.	
More delegation, substitution.	
Strong primary care base.	

Source: Ref 32: D W Light, 1997

wants accountability, not autonomy. The NHS is a complex mixture of these two paradigms or ideal types in Figure 2, and it is worth considering their underlying differences.

The ability to contract selectively

Effective commissioning is difficult to achieve if the commissioner has to contract with everyone, or if there is only one hospital or specialist to choose from in an area. Even if the commissioner is determined, lack of choice neutralises the power of commissioning and raises doubts as to whether a purchaser-provider approach is a smart strategy in the first place. Ministers and health authorities have been greatly hobbled by this problem. Certainly this pre-requisite implies that the most effective commissioning can be done in urban areas where choice exists, so that pressure can be put on providers to be accountable and demonstrate cost-effective, good care. This pre-requisite also implies that one should not be too quick to close down beds or hospitals; for in the surplus lies the commissioning power to break up professional fiefdoms, change entrench habits and leverage real, cost-effective change.

Integrated budgets in order to commission effectively

A central problem of commissioning in the NHS since its inception has been its split and segmented budgets.[27,33] For example, at the beginning of the reforms in 1990, health-related services were paid through three quite different budgets: the GP contract, the main health authority budget, and through the budgets of local authorities. Each had very different terms, structures and traditions. The NHS reforms led to a painful further separation of sub-budgets for hospital and community health services. Through GP fundholding, the reforms partly integrated at the practice level the GP budget with some of the hospital and community health services budgets; but fundholding itself created another budgetary split between the health authorities and the fundholders. These arrangements and re-arrangements seem tortured from an American perspective and certainly create large barriers to effective commissioning for integrated services.

During the 1990s, some progress has been made towards budgetary integration. The new commissioning role for District Health Authorities and Family Health Services Authorities led senior managers towards commissioning together,[34] and the creation of unified health authorities was an important step forward. But how unified or integrated their commissioning is less certain. Good information seems to be lacking on how integrated their budgets and commissioning really are, though such as assessment is vital.

Figure 3 **Integrated budgets vs segregated contracts**

On the whole, contracts are still written in the old way for each segment of the NHS, as illustrated in Figure 3. Underlying the unified health authorities, fundholding and various current forms of commissioning are relatively set amounts that go to hospitals, to community health care, to community care through local authorities and to primary care. This leads to all kinds of cost shifting and patient shunting, with a variety of distortions taking place at the crossover points. For example, when patients who have been started on an

expensive drug in the hospital go back to the care of their GP, the cost of the drug shifts over from the hospital to the GP. But hospital drugs are bought at a much deeper discount than their price to GPs so that the burden is proportionately much greater on the GP (and the taxpayer) for continuing the patient on that drug. Of course, pharmaceutical costs may be one factor in consultants' decisions about when to shift care of patients back to their GPs. GPs, on the other hand, may do quite a bit of cost shifting of their own. Any referral to a consultant saves them time and money. Sending patients to the local Accident and Emergency (A&E) department or using emergency admissions to hospital can be shortcuts to specialty care on someone else's budget.

Who needs these and other games? Certainly not effective commissioners. American purchasers believe that the major savings that could increase value-for-money lie in performance-based contracts for all services related to costly clinical groups. Otherwise, savings from fewer hospital admissions or quicker discharge to good follow-up services in the community and at home are not captured and reallocated. Two major obstacles to effective commissioning in the NHS, then, are:

- protective contracts for NHS hospitals;
- 'more work for no more pay' contracts for GPs and their teams.

As Dawson[35] and others have detailed, the rules for hospital contracts require that purchasers pay for all current fixed costs, which include just about everything. Moreover, the rules make it difficult for purchasers to bargain for prices that might cause an inefficient hospital to lose money, and hospitals have their hands tied by still other rules from using surpluses in one area to pay for multi-year projects to reduce waste in other areas.

The situation is apparently even worse. According to conversations with experts at programme budgeting, they find that hospitals use all sorts of ways to calculate their 'average' and 'marginal' prices, which have little to do with systematic budgeting methods.[36] In general, their marginal prices are set much higher than the actual cost of additional work. That is a principal reason why more elective surgery is not bought and waiting times are so long. Further, if a purchaser were to force a hospital or specialty to accept payments below their alleged costs, other purchasers would be forced to make up the difference. From an American point of view this might be called the 'No Risk, Preserve Waste Contract System.' Will the new Labour government change it enough to put inefficient hospitals and specialties at risk? The answer will depend on the degree to which the government acts as the head of commissioning or of providing.

As for the second obstacle, if British hospitals discharge more quickly, it simply adds to the burdens of GPs and community health care services without the money saved being transferred to them. This is one reason why American primary-care doctors are much happier than British GPs. Both are assuming wider and wider responsibilities for greater ranges of services to sick patients; but under integrated budgets, American primary-care practices receive more and more of the whole healthcare budget. If we want effective commissioning centred on primary-care and community services, then we need integrated budgets and contracts for integrated clinical teams.

Trust status obstructs commissioning integrated services

What else does the argument for integrated budgets mean? One implication that I have emphasised from the start[37,38] is that 'trusts' made no sense and got in the way of effective and integrated commissioning. Trust status walled off a budgetary fortress of services and put executive teams in charge of defending the fortresses from all comers. Even worse, executive positions in trusts, as walled-off sellers, have been made more attractive than executive positions in commissioning. Guess who has more power? Yet within the fortress walls, trust executives seem to manage everything except the consultants (see Figure 3). To top it off, trusts appear to be protected by a central government ambivalent between the need to purchase more effectively by dehospitising services and the need to protect trust hospitals, in which most of the NHS inefficiencies are embedded.[39] NHS trusts have helped to keep commissioning weak throughout the 1990s by embodying the worst of two worlds: greater independence and less accountability while being protected and facing little risk.

But if trusts were made really independent and given truly local boards, they would be public bodies at risk for proving their value or being forced to reconfigure. Reintegrating hospital and community health services would not be an unreasonable outcome, so long as value-driven commissioning rewarded community health services whenever they could figure out how to do hospital-based services more cost-effectively.

Reward providers for cost-effective integrated care

Another implication is that the GP contract, the consultants' lifetime sinecure contracts and the contracts for the salaries of other clinical professionals not only segment critical parts of the budget for effective commissioning but insulate the key spenders of money from efforts to commission more cost-effective reconfigurations of services. Before this statement incites a riot to kill the messenger, consider that the implication is obvious and that one does not have to carry it to

extremes. But wouldn't cost-effective care for patients with cancer, or heart disease, or serious mental health problems mean contracts for teams that involve community nurses, primary care teams, consultants and hospital services, when needed? If so, would it not be reasonable to set goals for performance and reward teams that meet those goals? Are performance management and performance-based pay too radical for the Great Commissioner in the Sky to consider?

Clear measures of benefits and quality as well as costs

Not measuring benefits means that no one knows what effective commissioning is, except cutting costs or more activity per million pounds, regardless of whether the activity is doing any good. Clinical activity has been going up recently in many parts of the NHS, but why? The British are not getting sicker. The glacial changes of aging and rising expectations, measured in decades, do not explain these recent increases. Are they provider-driven then? No one really knows, because there are no systematic data on changes in health status and health services utilisation, even though commissioning has been going on for seven years.

In the absence of outcomes measures, everything provided in the NHS (and most other health care systems) is seen as a cost, even though the point of health care is to provide very substantial benefits. The effects are seriously distorting. Did that drug relieve your pain or keep you from getting another heart attack? All that the Treasury and NHS commissioners know is that the drug was a cost. The solution is easy and always just under the surface of holding down costs: pinch the drug budget and leave patients with more pain and heart attacks. Did carefully designed therapy enable conduct-disordered children to control their impulses and anger so that they could be successful in school and work?[40] Sorry, it's a cost. Cut it.

Or consider new drugs that significantly decrease the need for certain kinds of surgery, like operations for peptic ulcers. Were cost savings and released theatre time and beds credited to H_2-antagonists? Of course not, and the new medicines were simply counted as an added cost. If effective commissioning is the chief goal, we need to have a calculus of benefits against costs across specialties and alternative treatment procedures.

By contrast, purchasing or commissioning in the UK has not so far given top priority to data and measuring health gains. In the early years, trusts and authorities were allowed to develop their own information systems, which led to incompatible systems and a Tower of Data Babel. Even now, the NHS's Information Management Group is reported as 'likely to be much smaller than today,'[41] when it is clear

that without good data there cannot be effective commissioning. Forerunners of primary care or locality commissioning, the total purchasing pilots and other similar groups, are exasperated by the lack of coherent, co-ordinated data on which to base contracts and measure performance.[42]

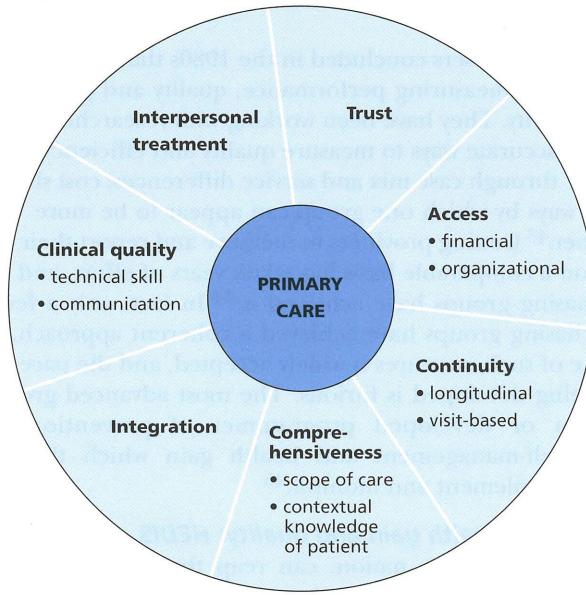
American purchasers concluded in the 1980s that establishing good data systems for measuring performance, quality and price had to be their first priority. They have been working with researchers to develop increasingly accurate ways to measure quality and efficiency, as distinct from 'gains' through case mix and service differences, cost shifting and other easy ways by which one group can appear to be more 'efficient' than another.[43] Getting providers to measure and report their activities and costs on a comparable basis has taken years of effort, and only the best purchasing groups have achieved it.[44] In fact, only a few of the large purchasing groups have achieved a coherent approach, but the importance of such measures is widely accepted, and the pace at which they are being developed is furious. The most advanced groups have also chosen or developed programmes of prevention, patient education, self-management and health gain which they require providers to implement and monitor.[45]

US measures of health gain and quality: HEDIS and PCAS

The UK, and any other nation, can reap the fruits of the massive research effort in the US to develop and test instruments measuring health gain and clinical performance. For example, the Health Plan Employer Data and Information Set, HEDIS 3.0 (fast on the heels of HEDIS 1 and 2, and probably soon to be revised again) provides an interesting mixture of population-wide measures of health status and how well providers do both prevention and clinical care.[46] HEDIS 3.0 includes measures of effectiveness of care, access to care, patient satisfaction, patterns of use, and costs. The measures 'are precisely defined, validated, and have been successfully used by more than 330 managed care organizations to date.'[46] A number of the measures would be irrelevant to the NHS, and others would have to be adapted; but given all the time, expense, and technical refinement that has gone into HEDIS 3.0, why not build on it?

Another promising instrument that is ready to help improve quality at lower cost is the Primary Care Assessment Survey, or PCAS, which provides a well developed system for measuring quality and service in primary care.[47,48] Developed by Dana Gelb Safran and a team at Harvard and the New England Medical Center, the PCAS takes the seven elements of 'primary care' as defined by the Institute of Medicine, measures each of them with carefully tested items and indices, and allows comparisons of either whole areas, whole practices,

Figure 4 **Essential attributes of primary care measured by the Primary Care Assessment Survey (PCAS)**



or individual doctors. (See Figure 4). Moreover, the PCAS is inexpensive and patient-based.

If the NHS wants to deliver on its promise of high quality, responsive primary care, what more could it want? PCAS can provide much more systematic information and be used much more effectively for pinpointing which practices need improvement than the patient survey recommended by the White Paper. That survey is fine, so long as a more scientific, evidence-based tool like PCAS is used as well. Fortunately, Professor Roland and the National Primary Care Research and Development Centre are developing a British version of PCAS for use in the NHS.

Because the US has so many well-funded teams working on solutions to similar problems to those which face the NHS, it has produced a number of excellent instruments and protocols that have no equivalent in the UK. For example, some excellent systems for turning back the flood of patients who inappropriately pour into A&E departments have been developed. There are a number of schemes in place for managing patient demand in primary care, another problem both countries

share. In prevention and health promotion, a number of systems have been well tested and seem to be effective. There is a lot that does not work in the US, but there is a lot that does.

British measures of health gain and cost-effectiveness: health related groups

But aside from such American products, Britain's own National Casemix Office has progressed in developing an integrated set of measures that should warm the cockles of the Treasury's heart in their ability to maximise 'efficiency' and value for money. First, the Office has developed Healthcare Resource Groups (HRGs) which are statistically more coherent, clinically more relevant, and structurally simpler than American diagnostic related groups (DRGs). Moreover, as 'health care is increasingly focused on moving care out of the hospital and delivering integrated care by different providers,' HRGs have the special potential to go beyond hospital care and 'to monitor integrated care across providers.'[49] They have a number of notable features:

- HRGs have been developed by teams of clinical specialists, an important feature for getting clinicians to accept and use them;
- HRGs already enable providers (and in theory commissioners if they want to be effective), to compare the cost and length of treatment by different specialty teams and different hospitals for treating the same kinds of clinical problems;[50]
- HRGs are a valuable tool for education and training to get costly teams and hospitals to learn how to treat cases more cost-effectively. Isn't this what the Treasury means by achieving clinical efficiency?
- HRGs can be used for writing performance-based commissioning contracts. Already, some hospitals like Northampton General Hospital have used HRGs internally as a high level tool for clinical audit and bringing everyone up to high standards of clinical practice.[51] Others like Southampton University Hospitals Trust have used HRGs to get their contracts with purchasers to realistically reflect significant casemix differences;[52]
- HRGs make budgets for both sides more realistic and accurate. For example, St. George's Hospital Trust (London) has used HRGs to demonstrate that their casemix has changed substantially and that therefore their contracts should reflect these changes.[53]

Figure 5 summarises the uses and benefits of HRGs.[54] They are exactly what commissioning agencies need. They are a vital management and commissioning tool for minimising 'inefficiencies' in a clinically responsible way. Yet they have been modestly funded and

Figure 5 **Objectives and benefits of Healthcare Resource Groups (HRGs)**

Objective	*Benefit*
To reflect casemix in contracts	Promoting cultural change
To promote a better understanding of workload	Providing 'common language'
	Contributing to quality of care
To use clinically acceptable, meaningful groups	Assessing service planning
To use a national standard	Internal resource management
	Improved monitoring and analysis of casemix
	Executive-level reporting
	Demonstrating value for money to purchasers
	Improved costing and pricing
	Improved data quality and coding
	Reducing area of data search
	Benchmarking against other providers
	Allowing casemix adjustment to annual contracts
	HRG-based 'variable' contracts
	Successful incorporation into existing handings
	Informing departmental/specialty budgeting process

Source: Ref 54: The National Casemix Office, 1996

timidly brought into commissioning. The handful of successful and leading-edge American commissioning groups *insist* that providers who contract with them adopt their chosen system for measuring clinical performance and report the data to them.[40,42] No data, no contract.

Why are the Treasury and ministers not equally insistent? In a survey about a year ago, only about half of the health authorities as the principal commissioners reported using HRGs to 'some' degree, though how much this subjective choice represents is unknown, and far fewer reported using them significantly. GP fundholders as commissioners were much worse.[55] Only 3-5 percent reported using HRGs in contracting for secondary services, and about 15 percent thought they would get around to using them in 1997-98.

These low uptake rates support the broader conclusion that primary care commissioning has largely focused on easy targets like obtaining discounted prices and getting better service rather than reducing forms of waste embedded within specialty and hospital practices. There are exceptions, like the South West London Total Purchasing Pilot that has used HRGs to minimise unnecessary hospital services by developing less costly, integrated, community-based services,[56] or the ways in which the Berkshire Integrated Purchasing Pilot has used HRGs to make their contracts much more precise and to restructure clinical services at the main local hospital trust.[57]

Getting HRGs into use as a management and contracting tool should receive the highest priority and substantially more funding. Otherwise, commissioning is working largely in the dark and tends to roll forward past practices. This should be coupled with an equally insistent stance that every advance in evidence-based medicine should be used. The Casemix Office has already developed inexpensive software and even packages to help users prepare HRG data and generate reports on casemix and costs. It has self-instructional software training packages as well as training workshops and a variety of services.

Health Benefit Groups

But what about benefits and health gain? Fortunately, the Casemix Office has addressed this fundamental need as well and has developed Health Benefit Groups (HBGs). HBGs group people by health condition and level of need, from being at risk to being in a permanently chronic or terminal condition.[58] These can then be combined with HRGs to form a commissioning and management matrix. (See Figure 6). If repeated over time, this matrix will document the changing proportion of patients who are at risk, get ill, get better, or stay chronically ill. Time series can also show the relative gains or losses from different allocations of resources.

Figure 6 **A matrix for maximising health benefits from interventions**

	Healthcare interventions (HRGs)				
Health condition (HBGs)	*Prevalence*	*Promotion primary prevention*	*Diagnosis, investi-gation*	*Initial care*	*Continuing care*
At risk					
Presentation					
Confirmed disease					
Continuing disease state					

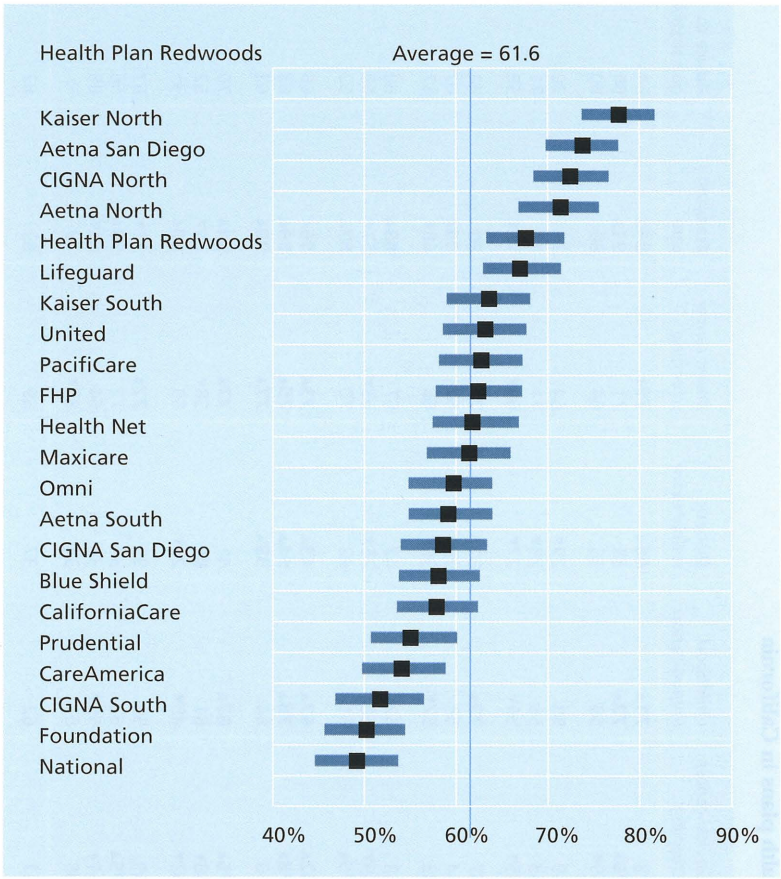
Source: Ref 58: The National Casemix Office, 1997

HBGs can do much more. They can document the changing health needs of the population for which one is commissioning, identify which healthcare services best meet those needs, and track health gains over time. They can also be used to establish accurate weightings for allocating resources fairly and understanding the service/cost implications of shifting care to community and home. HBGs will be joined soon by a set of outcomes measures. Yet HBGs are being used even less than HRGs in commissioning, much less, and they are getting the priority of a technical add-on rather than as the key to effective commissioning.

Empowering patients – going public

Although the British have excellent performance measures and can draw on selected American ones, there needs to be a new attitude of sharing the results with the public and journalists in easily readable forms.[20] Look at Figure 7,[59] one of a set published by the California Cooperative Healthcare Reporting Initiative, a collaborative of purchasers and providers analogous to the NHS Confederation. It shows the percentage of children who receive their immunization series for each of 22 health plans in California. The bars show the range of scores and the squares the average score for each plan. One thing you learn from Figure 7 is that American managed care plans have a long way to go to catch up with the childhood immunisation rates of the NHS, because the average rate for the entire state is only 61.6 percent. But imagine for a moment that the health plans listed are GP practices in, let us suppose, greater Leeds. Then public reports like this

Figure 7 **Child immunization rates of health plans in California**



Source: Ref 59: California Cooperative Healthcare Reporting Initiative, 1997

would allow patients and commissioners to see that children are much less likely to be immunised in 'CIGNA South' (51 percent) than in 'Kaiser North' (77 percent). Publishing these results, of course, puts pressure on less well performing practices. Other figures in the set provide a similar text and a bar graph on breast cancer screening, cervical cancer screening, early prenatal care and the other measures summarised in Figure 8.[59] It provides a comparative overview of performance, showing not only which plans were high and low, but also which plans have not yet collected data. Providers that score

Figure 8 **Published performance of health plans in California**

California health plans	*Cervical cancer screening*	*Childhood immunization*	*Diabetic retinal exam*	*Breast cancer screening*	*Prenatal care*	*Advice to quit smoking*[+]
Aetna North	73	**71▲**	**48▲**	**75▲**	**94▲**	64
Aetna San Diego	**76▲**	**73▲**	38	71	**91▲**	64
Aetna South	59▼	59	36	64	80	60
Blue Cross/CaliforniaCare	69	58	29▼	64	78	70
Blue Shield	63	58	29▼	71	77	71
CareAmerica	55▼	54▼	27▼	60▼	70▼	58
CIGNA HealthCare Northern	67	**72▲**	31▼	71	80	64
CIGNA HealthCare San Diego	64	58	29▼	67	**94▲**	67
CIGNA HealthCare Southern	63	52▼	30▼	65	68▼	57
FHP/TakeCare	63	62	42	67	**88▲**	60
Foundation Health	59▼	50▼	26▼	63▼	57▼	59
Health Net	**75▲**	61	42	70	**87▲**	52
Health Plan of the Redwoods	**82▲**	**67▲**	**43▲**	**73▲**	**96▲**	66
Kaiser Permanente Northern	**78▲**	**78▲**	**54▲**	**75▲**	**89▲**	63
Kaiser Permanente Southern	70	64	**58▲**	**77▲**	**90▲**	62
Lifeguard	**75▲**	**67▲**	41	**77▲**	**94▲**	70
Maxicare	58▼	61	■	58▼	74▼	52
National Health Plan	62▼	49▼	27▼	69	**88▲**	★
Omni Healthcare	69	59	33	**77▲**	72▼	67
PacifiCare	**75▲**	63	34	72	**90▲**	56
Prudential HealthCare HMO	61▼	55▼	38	64	68▼	65
United HealthCare	66	63	34	62▼	79	☆
Average of all plans surveyed	67	62	37	69	82	62

Figure 8 **Published performance of health plans in California** *(continued)*

Results for five clinical measures are based on HEDIS 3.0 Effectiveness of Care measurement and reporting definitions developed by the National Committee on Quality Assurance (NCQA).
Data were collected by the California Cooperative Healthcare Reporting Initiative and audited by an independent third party.
Data for Advice to Quit Smoking measure were collected as part of the NCQA Annual Member Health Care Survey.
Results cannot be compared with CCHRI reports of prior years because of differences in NCQA's data collection and reporting rules.

CCHRI used a statistical test to identify plans that scored significantly above or below average. That test indicates that differences as large as those found are expected to be true differences, not chance differences, at least 95 percent of the time.
Please compare each plan to the average and not to other plans. Many performance scores are based on small samples of health plan members. As a result, small differences between plans may not be statistically significant or meaningful

Key to performance strata

00▲ = above average
00 = average
00▼ = below average

+ Performance strata (above average, average and below average) could not be determined for this measure because of small sample sizes.

■ Plan was unable to collect data for this measure.

☆ Response rate for this plan did not meet minimum reporting threshold (25 percent).

★ Plan did not participate in NCQA Member Survey.

Source: Ref 59: California Cooperative Healthcare Reporting Initiative, 1997

Figure 9 **Published patient satisfaction with health plans in California**

California health plans	*Overall satisfaction*			*Interaction with physician*			*Access to care*		*Referral process*			*Member services*	
	Satisfaction with health plan	*Quality of care & services*	*Recommend to friend or family*	*Attention to what you say*	*Time with doctors & staff*	*Explanation of tests and procedures*	*Ease of choosing physician*	*Time b/w scheduling and visit*	*Authorizations have not delayed care*	*No difficulty receiving needed care*	*Ease of referrals*	*No recent complaints*	*Staff able to answer questions*
Aetna North	77	**85▲**	81	**85▲**	**76▲**	**77▲**	**76▲**	**69▲**	69	70▼	59	82	79
Aetna San Diego	**81▲**	83	**84▲**	81	74	76	76	**70▲**	71	**81▲**	58	86	**88▲**
Aetna South	76	77	77	74▼	66▼	71	67▼	60▼	61▼	71▼	52▼	83	84
Blue Cross/CaliforniaCare	78	80	80	79	70	75	70	59▼	66▼	77	57	85	79
Blue Shield	72▼	79	73▼	80	72	70	68▼	67	62▼	70▼	52	74▼	74▼
CareAmerica	73▼	73▼	76▼	72▼	64▼	68▼	66▼	60▼	64▼	73▼	51▼	84	**87▲**
CIGNA HealthCare Northern	78	83	83	**84▲**	75	73	71	**69▲**	74	78	**62▲**	79▼	79
CIGNA HealthCare San Diego	77	**85▲**	82	**86▲**	**79▲**	74	**80▲**	**70▲**	71	75	56	80▼	**86▲**
CIGNA HealthCare Southern	67▼	70▼	65▼	73▼	61▼	65▼	62▼	57▼	63▼	68▼	46▼	77▼	75▼
FHP/TakeCare	**81▲**	81	79	79	70	73	72	57▼	74	78	58	**88▲**	73▼
Foundation Health	69▼	79	70▼	80	74	72	66▼	**71▲**	61▼	69▼	56	80▼	67▼
Health Net	75	77▼	80	78	70	72	69	60▼	68	75	54	86	80
Health Plan of the Redwoods	79	**90▲**	**83▲**	**89▲**	**84▲**	**81▲**	**87▲**	**79▲**	**76▲**	**80▲**	**60▲**	**87▲**	**89▲**
Kaiser Permanente Northern	**85▲**	81	**87▲**	80	68▼	74	69	57▼	**90▲**	**87▲**	60	**92▲**	83
Kaiser Permanente Southern	**84▲**	80	**90▲**	79	71	75	72	58▼	**88▲**	**87▲**	**62▲**	**92▲**	**89▲**
Lifeguard	**84▲**	**88▲**	**88▲**	**88▲**	**80▲**	**79▲**	**81▲**	**77▲**	**75▲**	78	**62▲**	85	**86▲**
Maxicare	79	76▼	80	78	68▼	71	70	57▼	70	78	56	**87▲**	79
National Health Plan	★	★	★	★	★	★	★	★	★	★	★	★	★
Omni Healthcare	74▼	81	78	82	75	74	75	68	69	77	58	81	82
PacifiCare	80	78	**85▲**	77▼	67▼	72	71	55▼	71	78	56	**87▲**	**86▲**
Prudential HealthCare HMO	74	76▼	76▼	76▼	70▼	69	69	64	66▼	78	58	84	79
United HealthCare	☆	☆	☆	☆	☆	☆	☆	☆	☆	☆	☆	☆	☆
Average of all plans surveyed	77	80	80	80	72	73	72	65	71	77	57	84	81

Figure 9 **Published patient satisfaction with health plans in California** ***(continued)***

The survey of health plan members was developed by the National Committee for Quality Assurance (NCQA) and administered by the California Cooperative Healthcare Reporting Initiative (CCHRI). The results cannot be compared with prior years' Health Plan Value Check Surveys administered by the Pacific Business Group on Health because different questions and methods were used.
Results are based on statewide random samples of participating health plan members (average sample size per plan = 1860).
For questions with three favourable categories in the response options, the score reported here often reflects the total percent of responses that fall in the top three categories (i.e. extremely satisfied/ very satisfied/somewhat satisfied or excellent/very good/good), which is a departure from NCQA reporting guidelines recommending aggregation of the top two satisfaction categories.
CCHRI used a statistical test to identify plans that scored significantly above or below average. That test indicates that differences as large as those found are expected to be true differences, not chance differences, at least 95 percent of the time.
It is possible that those sampled health plan members who returned the questionnaire are more satisfied or less satisfied than sampled members who did not return the questionnaire.

Key to performance strata

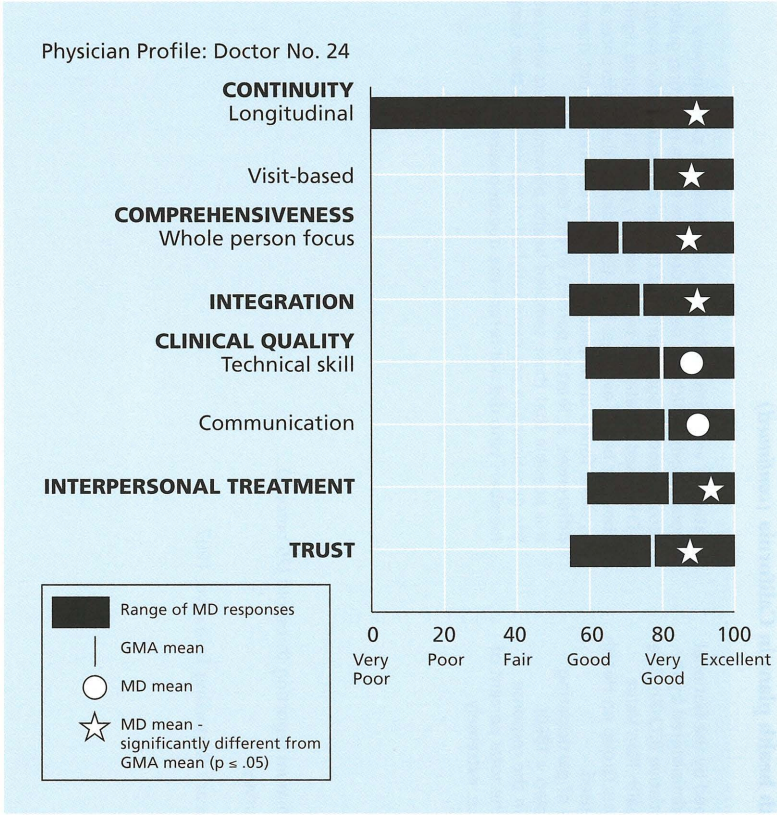
00▲ = above average
00 = average
00▼ = below average

☆ Response rate for this plan did not meet minimum reporting threshold (25 percent).

★ Plan did not participate in NCQA Member Survey..

Source: Ref 59: California Cooperative Healthcare Reporting Initiative, 1997

Figure 10 **Clinical performance of a GP using the Primary Care Assessment Survey (PCAS)**



Source: Ref 49: Safran et al., 1995

significantly higher are in bold type. This is complemented by results from measures of patient satisfaction, shown in Figure 9.[59] This shows that patients were very happy with Lifeguard and much less happy with CIGNA Southern. Going public with such data empowers patients and prompts a new world of discussions among providers about what scores mean and how they can attain higher scores. The measures are not perfect – no measures are – but they don't have to be. They only have to be fairly and reasonably constructed, because the real point is to get the results out there. The PCAS measures of primary care performance are even more precise, rigorous and specific. They get down to a profile of each doctor. In Figure 10,[47] for example, we can see that Doctor 24

is a star; he rates significantly above his practice average in six of eight measures and above average in the other two.

Summing up

The pre-requisites of effective commissioning call for the government (or any large payer) to:

- have a central goal and vision of health care in the service of health and functioning;
- clarify for itself the implications of being an effective commissioner;
- reconceptualise the NHS Executive, a creation of the old internal market, from the managerial head office of trusts to a central commissioning agency;
- change legal obstacles and obligations that impede or prevent effective commissioning;
- make trust hospitals, as the object of commissioning, more accountable, and rethink the functions of hospitals;
- develop integrated budgets and contract for integrated care;
- develop forms of performance-based team pay for the doctors and staff in specialty firms and GP practices;
- give top priority and extra funding to implementing data systems that measure health needs, the comparative quality and cost of different services and health benefits;
- empower patients with comparative data on the clinical performance of doctors and hospitals.

3. The White Papers: new management strategies

During the past seven years, a great deal of money was wasted and inequities created in trying to transform the NHS into a set of interlocking competitive markets, a strategy ill-suited to health care and the NHS.[1,60] Today, the new Labour government and the NHS have an unusual opportunity to reduce waste and inequalities, but to do so will require effective commissioning and strong management strategies. Labour's three White Papers, for England, Scotland and Wales, launch a set of shared new strategies, but with some significant differences between them in tone and tactics.[18,61,62]

A paradigm shift

New Labour emphasises working together, openness, partnering, reducing inequities in access and variations in health conditions, and sharing.[63] Appleby worries, "'Sharing' sounds nice of course; better than the spikiness of 'financial competition'. And it rhymes with caring. But what is going to be measured, and is sharing it really going to work?"[64] Despite his worry, the most profound part of the paradigm shift involves moving from a focus on measuring activity and its efficiency to a focus on effectiveness, outcomes and health gain. The government is catching up at last with the realisation that more activity for your money is not the point: health gain and effective services are.

Figure 11 **The Cochrane test for effective and efficient health care systems**

To what extent does a health care system:

1. Determine the relative effectiveness of interventions?
2. Make more effective interventions available to all and drop less effective ones?
3. Minimize ill-timed interventions?
4. Treat people at the most cost-effective time?
5. Treat people in the most cost-effective place?
6. Focus on preventions that are effective?
7. Focus on diagnostics that affect treatment?

Source: Ref 65: Light, 1991; revised

This was a central insight of Archie Cochrane, that making health services more 'efficient' starts with making them effective as shown in Figure 11.[65,66] Although public attention seems drawn to the development of locality commissioning in the English and Welsh papers, and indeed a word search by Roy Lilley showed that 'local' and 'commissioning' are the most frequently used words in *The new NHS*,[67] what strikes me as more important is the extensive national framework proposed for managing that process. Indeed, 'national' appears in the White Paper 101 times.

The paradigm shift goes beyond a refocus from clinical activity to clinical effectiveness or health gain; for new Labour proposes also to address basic causes of ill health through partnerships with local authorities and masterplans for health improvement that will guide all commissioning. Thus the new White Papers set up strong performance management of the NHS but also recognise that to address the health needs of the 21st century the government must reach beyond the NHS and mobilise people in their communities to attend to causes of ill health. In developing this wider agenda, partnering with the Healthier Communities movement in the US could be mutually beneficial.[68,69]

The national framework for performance management is extensive. The White Papers propose to establish evidence-based patterns and levels of service, clinical guidelines and clinical performance review, in order to assure patients of high and uniform quality throughout the system. These will also measure value for money in commissioning, and they will be backed by national research and development and related programmes. There will even be a new NHS charter emphasising outcomes and 'a new statutory duty for quality'.* Public reports and open data are to underscore public accountability and end the multiple forms of secrecy that supported favouritism and inequality under the Conservatives. Developing sophisticated computer and data systems are key to these measures as well as to plans for co-ordinating care, patient involvement, health promotion, and an appointment system that will replace waiting lists. Appleby worries that collecting such data will be very expensive, and he provides cogent examples of why it may be quite difficult to figure out what differences between areas or groups really mean.[64]

The central government also plans to develop a national schedule of reference costs for specialty treatments in trusts and a national formula for setting fair budgetary shares for Primary Care Groups. (Reference costs risk locking in wasteful practices.) A national performance review

*To American ears this sounds funny: 'Parliament declares that henceforth it is the duty of clinicians to do quality work.'

system is proposed around equal access, health improvement, the effective delivery of appropriate healthcare, and efficiency in order to create 'a one-nation NHS, with consistent standards and services, wherever they live'.[18] Backing this up will be nationally set sanctions against below-par performance (as yet undefined), and 'the NHS Executive will be able directly to intervene to rectify poor performance in any part of the NHS'.[18] 'For all the soothing assurances that the government does not wish to see a return to a top-down command and control system,' Hunter observes too, 'this is precisely what much of the white paper implies.'[70]

This paradigm shift has several historic implications. From the beginning, government officials have faced the dilemma of paying and being responsible for services over which officials have little control,[27] a dilemma faced by US employers, German sickness funds, Dutch insurance companies, and any other significant payer. For decades, the bargain struck in the UK and in many other countries has been that the government (or other large payer) will set the budget but then leave doctors alone to decide how best to treat patients. 'The doctrine of clinical autonomy continued to reign supreme.'[27] But physician autonomy has been dealt a fatal blow by research over the past quarter century showing both that doctors' clinical decisions vary widely (at considerable cost) when treating the same disorders, and that they often do not know which treatments are more effective. The resulting development of outcomes research evidence-based medicine, and clinical protocols represents a basic shift from provider-centred autonomy to purchaser-centred accountability. Physician profiling in the US now routinely tells a given doctor more than he himself knows about his own clinical work compared to peers or evidence-based standards.

Setting national clinical standards, protocols and service frameworks may be a response to government having given doctors considerable funds to do clinical audit and having witnessed only tepid results, just as the American government and other payers experienced in the 1970s when they let the profession lead various efforts to contain rising costs.[30,71] Professional associations find it understandably difficult to tell members with high costs and referral rates to re-examine how they practice medicine or flag members using ineffective treatments. Thus 'clinical governance' as a theme of the White Papers may not mean what doctors think. They may believe that at last they have a government that is going to restore their birthright to govern clinical work. Perhaps, but the term is ambiguous. Clinical governance may also mean governance by the centre of clinical work. Granted, clinicians will play key roles in developing evidence-based standards, and if the government is smart it will partner with the various royal

colleges to develop standards of quality and effectiveness. But the government as manager and payer will (or should) drive this agenda.

These developments also imply that the medical profession will increasingly move towards an elite of clinical managers and evidence-based medicine, issuing standards and guidelines and managing the rank-and-file clinicians. They also imply an extension of the 'new public management' approach of conservatives; for they embody five of its seven practices: greater accountability through hands-on management, explicit standards of performance, close management of resources through output controls, decentralisation and disciplined financial planning.[72]

Demand-oriented health care?

Accompanying the paradigm shift towards effectiveness and health gain, all three White Papers put great emphasis on being consumer-oriented and meeting consumer demand. Even without this encouragement, both patients and providers have natural interests in doing more.[73] This politically popular theme is a political trap: how will the government pay for the increased demand it creates?

Putting this question another way, consumerism is a basic part of the old internal market that the new government purports to abolish and is inappropriate to a national health service because 'the NHS consumer can only be sovereign at someone else's expense.'[74] Already, the past encouragement of greater demand has led to patients pushing against one another in primary care and emergency services. Politically, it creates more criticism and alienation. Inducing greater demand also fosters more privatisation and opting out by the classes one most needs to keep supporting a national service.

Demand-oriented services also increase inequality, because the middle and professional classes are quicker to demand and more skilled at getting what they want. Indeed, there is no recognition in the White Papers that a major cause of inequality in access to specialty and hospital services is demand-led variations in GP referrals, which then can get locked into primary care based funding.[17] Large Primary Care Groups could be an easy way to bring this inequality to an end through a risk-adjusted capitation formula for primary care, but the White Papers do not discuss the issue.

As Ron Singer points out, 'Historically, much of the NHS responded to immediate patient demands; there was little reflective planning.'[75] The move to commissioning and planning implies a shift towards defining a service based on need and "carries the implication of saying 'no' to some demands..." For reasons of equity and affordability, therefore, it would be better to emphasise the thesis suggested by the

concept of participatory health care and Giddens's idea of positive welfare. The message might look something like this:

A new social contract for health care

The nation cannot afford all the health services that people might *want*, but with your help it can possibly provide all the health services people *need*. If you learn how to stay healthy, manage minor problems and cope with chronic problems, thus minimising demand, we can focus on providing excellent, equitable services when you really need them.

Community-oriented primary care

Another major development shared by all three White Papers is the broadening of general practice to a comprehensive amalgam of community-oriented primary care services. Indeed, much of the chapter in *The new NHS* on Primary Care Groups focuses on this concept.[76] 'All of the local community should benefit from the best that primary and community health services have to offer'.[18] These will involve 'health visiting, school nursing, chiropody, speech and language therapy. Services such as district nursing, community psychiatric nursing and physiotherapy can enable people with short or long term illness or disability to be cared for in their own homes'.[18] Exactly. This is a natural and welcome extension of a trend that began many years ago, as GPs increasingly combined into group practices, then added other clinical staff, and then used fundholding to develop co-ordinated services across a much broader spectrum of community health and primary care. 'Primary care' then takes this line of development beyond 'primary health care' to include this range of providers, and especially social workers, with their uniquely important contributions to a wider health agenda. Such services should save money, be more responsive to patient needs, and keep patients from needing costly referrals. A major frustration up to now has been that as GPs took on a greater proportion of health care, they did not receive a proportionate increase of the NHS budget; but the White Papers imply that the new government will take care of that problem.

Comprehensive primary care also provides the institutional and financial basis for joint efforts with local authorities to address the wider agenda of public and community health. Unwittingly, these developments are reaching towards the pioneering work of Sidney

Kark in 'community-oriented primary care' (COPC) and the extensive literature that has grown from it.[77,78] Yet Kark is as unknown among British health policy experts as Archie Cochrane is unknown among American experts. Jo Ivy Bufford brought this work to the UK when she was at the King's Fund; it seems such a natural for the NHS. Yet although some work has been done on it,[79] COPC is largely unknown and untaught to managers, planners, or clinicians. Beyond joint efforts with local authorities lies the question of whether it would advance the broader agenda for better health and make health care services more democratic if local authorities assumed those responsiblities.[80]

This development towards COPC raises a further question: why not have local governments or health councils run community-oriented services? As Singer observers, 'The final step would be the inclusion of users and carers.'[75] The whole spirit and intention of the NHS seems so oriented towards local governance, yet the NHS has been highly professionalised from the beginning and remains so in these White Papers. Granted, there are the rhetorical sentences about consulting users and taking the local pulse. There are even more weighty sentences about the boards of trusts having more local representation; but such people would be appointed. Local authorities once played a critical role, and in Finland elected community health councils commission health care. This policy thrust would support the development of participatory health care and built up community involvement. Ham has outlined ways to develop democratic self-governance of local facilities and services. Ham rightly points out that such community-based programmes need to be combined with the 'continuing role for health authorities as strategic commissioning authorities' responsible for the wider health agenda and for doing performance review.[81] Another approach to consider is something like school boards, with users (in that case, parents of students) electing representatives for a majority of seats, and other portions of seats going to representatives of providers (teachers) and local government.

Creating large Primary Care Groups or trusts to provide a wide spectrum of community-oriented services will itself be a tall order, even short of having them become the purchasers of other services. At a Cavendish Seminar on the White Paper[82] and in related conversations, the following problems were identified:

- In fundholding and GP commissioning, GPs chose their partners. The new groups, however, have to be geographical so that GPs will have to partner with others, including GPs they do not particularly like or respect. Things might go more smoothly if rolling waves of volunteers were used.

- Fundholding was usually small-scale. Many GPs will resent being forced into large groups.
- Natural ties, alliances and link-ups with hospitals may make for strange geographical configurations. Conversely, geographically natural areas for Primary Care Groups may make for strained, unnatural groupings.
- GPs vary a lot in their clinical views. In multi-funds, it has taken months for them to work out their differences in just a few areas, and they have exhibited other weaknesses.[83]
- Developing partnerships and joint services with nurses and other staff from community health trusts will be even more difficult and involve professional differences in language, concepts of treatment, concepts of competencies and roles, and values.
- Community health trusts will not take kindly to being dissolved. They have spent years avoiding being co-opted by GPs, with exceptions.[84]
- Primary Care Groups for 100,000 patients will be in most cases too large for the professionals to feel like a group or to identify with a 'community', despite a few counter examples like the Nottingham commissioning group of non-fundholding GPs.

Despite these problems, creating broad community-based groups of primary care providers is worth the effort, because it would provide an organisational platform for making primary care services more equitable, less uneven in quality and more accountable. This argument implies that such groups should be commissioned by taking a contract for all primary care and community services so that they have the funds to organise integrated community services. The problems imply that it will not be easy and will take time. GPs do not have a good track record for working as team members or as managers of community staff.[75] As Singer concludes, 'There is a long way to go to realize a primary care-led NHS,' but to do so is essential.[75] It will take a firm but sympathetic hand, incentives, training, knowledgable coaches, patience and funds to help groups with what they need.

Integrated budgeting

Having described the paradigm shift that drives the three White Papers and the shared agenda to develop community-oriented primary care as much as possible, we can turn to the agenda of integrated budgets for integrated health care. While the English and Welsh aim to have these

large, broad Primary Care Groups hold the budget, the Scots do not. There is a question in either case about how integrated services can actually be. First, some but not all of the budgetary segments will be integrated, such as the budgets for hospital and specialty care, community care, and medicine. But an American purchaser would ask, 'What about the GP contract, or the funds that pay consultants' salaries, or the hospital contracts?' It appears that *de facto* they will be ring-fenced and protected.

There is another worry. All three White Papers talk about trusts as carrying on into the future, even as they talk about integrated commissioning. One wonders how many of their protective regulations which I discussed earlier will remain in place. For American purchasers have found that the major savings cannot be attained unless hospital services are re-engineered and hospitals are reconfigured. Multi-year contracts and new flexibilities may or may not drive out current forms of waste, but they alone are not enough.

Will the White Papers lead, then, to partially integrated budgets but segregated contracts? And if more than 500 new primary care trusts are created, will they shortly become a new entrenched interest (represented by a National Association of Primary Care Trusts) that will form a new institutional barrier to integrated service contracts?

Creating hundreds of new trusts is ironic, because ministers express such irritation in the English White Paper at the ways in which trust status has fostered a kind of independent non-cooperation. Waving a big stick, they growl, 'The Government will establish a new statutory duty for NHS Trusts to work in partnership with other NHS organisations', as if partnership can come from legal coercion. Rising to full height, they declare, 'The days of the NHS Trust acting alone without regard for others are over'.[18] (Selfish bullies. We'll show 'em.) In other passages they declare that 'Trusts will be expected to…' do this or that, a tone suggesting that otherwise the prefect will give them a caning. Trusts behave as they do because they were given strong incentives to do so, and as I have argued before, the way trust status was done did not bode well from the start.[38]

Primary care commissioning

Now let us turn to the major difference between the various White Papers: whether or not Primary Care Groups hold the entire budget and commission all other services. In *Designed to care* (the Scottish White Paper), 'commissioning' is hardly mentioned, much less having Primary Care Groups control the budgets for everything else. The Scottish structure is essentially a command, delegate and control model. Of the three, it has the cleanest design and clearest

management structure. Health Boards are to develop Health Improvement Programmes framed by national standards, but with strong community representation.[61] The Boards then implement the Programmes by in effect managing the hospital and newly formed primary care trusts. These latter will include mental health services, and there will be one per area overseen by a Health Board. While all three White Papers feature 'improving health and reducing health inequalities', the Scottish Paper makes these the priorities that drive their entire strategy. The question will be whether this clean design will be led by strong leadership.

The Scottish White Paper also features a cross-over mechanism, called Joint Investment Funds, that enables money saved from using hospitals less to be transferred to redesigned services in the community. In parallel, acute hospital trusts and primary care trusts are to 'set up joint planning and budgeting arrangements to cover the interfaces between primary, secondary, and tertiary care'.[61] Details are sparse, and perhaps this arrangement will be used timidly; but the Scottish priority of health improvement combined with budgetary flexibility to reconfigure services is the powerful combination needed for cost-effective integrated care.

Implicitly, the Scottish White Paper questions whether commissioning makes sense at all, when it takes place inside a national service where a purchaser/provider split is nearly impossible to achieve and purchasing is so politicised. It also takes a voluntary, more flexible approach to encouraging interprofessional and local cooperatives in primary care.

The English and Welsh White Papers propose to recreate the commissioning functions of health authorities by forming, training and staffing more than 500 primary care commissioning groups.* This strategy seems to stem from five implicit conclusions:

1. Health authorities are not effective commissioning bodies. This has become a self-fulfilling prophecy created by years of neglect of health authorities and the purchasing function, even after its importance was belatedly recognised.

2. GPs have proven themselves to be effective, informed commissioners. The evidence for this conclusion is mixed, weak or missing.

*The Welsh Paper has a similar design to the English but a more cautious tone of keeping a close rein on commissioning as it evolves and integrating more with local authorities.

3. The public would much rather have doctors purchasing (and rationing) than managers or health authorities. True.
4. If hospitals are going to be closed or reconfigured, and if the wasteful habits of some consultants are going to be addressed, it will be much more credible if doctors do it. True, if they do it.
5. GP fundholding and commissioning have gone too far to abolish; we have to mobilise it to serve our agenda of health gain, equity, and better value.

Yet effective commissioning will depend heavily on the new tools of performance management of the central government in this new form of an internal market, as Primary Care Groups use contestability to pursue better value from specialists and hospitals, on whom the bulk of the budget is spent. Professor Rob Flynn brilliantly summarised the White Paper the day after it came out: 'The internal market is dead. Long live the internal market.'

Primary care commissioning is to take place at four levels, with Primary Care Groups starting at whatever level is appropriate for them and progressing upward from there. Level 1 is like GP commissioning – advising the health authority as it commissions. Level 2 involves holding the budget for all health care jointly with the health authority. Level 3 appears distinct because the Primary Care Group holds the budget and commissions on its own ('freestanding'); yet it is accountable to the health authority for what it commissions. And Level 4 is Level 3 plus 'added responsibility for the provision of community health services for their population'.[18*]

The daunting task of bringing these primary care commissioning groups up to speed will be managed by the health authorities as they themselves undergo mergers, shrinkage and a possible exodus of talented executives. In fact, health authorities are the unexamined lynchpins to the English and Welsh management strategy, because they are not only responsible for developing the Health Improvement Programmes and for the complex task of bringing the new commissioning groups on line, but they will also *per force* do most of the commissioning while most of the primary care commissioning groups are at the first or second stage of development. Despite these multiple functions, health authorities seem as understaffed and overextended as ever, keeping them functionally weak.

*This seems odd, because Primary Care Groups are previously characterised as combining GP and community health care staff and functions, in paragraphs 5.1-9.

Figure 12 **Capacities for effective commissioning**
Health authorities are the most suitable and cheapest organizations for most commissioning

	Main types of services to be purchased		
8 key requirements for effective commissioning	*Common and elective*	*Less common and emergency*	*Rare or needing tertiary care*
Needs assessment	HA	HA	HA
Obtaining information about services	P, L	HA	HA
Influencing providers	P, L	P/HA	HA/R
Patient involvement and choice	?P, L	?HA	?HA
Setting appropriate priorities	P, L	HA	HA/R
Monitoring and maintaining equity	HA	HA	HA
Minimising transaction costs	HA	HA	HA
Managing financial risk	P, L	P, L, HA	HA

Key
R = purchasing at regional level
HA = purchasing at current health authority level
L = purchasing at locality or general practice group level
P = purchasing at individual practice level

Source: Adapted from Ref 83: Mays and Dixon, 1996, Table 3

Some GPs are already saying, 'Level one for me, and no more.' Even for those Primary Care Groups that reach Level 3 or 4 commissioning, health authorities are given vital roles, such as being accountable for what those groups commission. Meantime, as indicated in Figure 12, adapted from an excellent review of capacities needed for effective commissioning, health authorities are the most suitable and cheapest organisations for doing most levels of commissioning.[85] The problem has been that they have had few incentives to generate a surplus, limited ability to vire funds in order to develop more cost-effective configurations of services, strong pressures to keep everything stable as it is, and strong career incentives for managers not to pull anyone's chain.[35,86] These observations raise the question that if Primary Care

Groups mainly stay at Levels 1 and 2, and if health authorities are the lynchpins, does this mean that the English and Welsh reforms are the Scottish approach cloaked in primary care garb?

In addition to their concerns about Primary Care Groups, members of the Cavendish seminar raised some important questions about such groups taking up the central commissioning role:

1. With all the national clinical standards, performance standards, reference costs, budgetary formulae, outcomes measures, guidelines, and monitoring, how much 'commissioning' will be left for GPs and nurses to do?

2. Commissioning is complicated, hard work. What's in it for GPs (or nurses), and how many of them will want to bother?[87] Burn out is a major concern for commissioning groups.[85]

3. How will the managerial capacity and know-how of over 500 commissioning groups be built up? Mays and Dixon's excellent review of existing primary care commissioning arrangements identifies key management skills, some of which are in short supply even in the current 100 health authorities.[85] How long will it take and at what cost? Significant investment will be required.

4. Power and governance within these groups are vital, yet unclear. The confusion about who is responsible and accountable for what could be extensive, especially with the vague notion of 'commissioning'. How will GPs go from being individualists accountable to no one for anything, to being collective bodies accountable to health authorities for everything?

5. The resulting bureaucratic and managerial complexities could be extensive. Hunter quips that chaos theory may become the new management fad.[70]

6. Primary care commissioning eliminates the purchaser-provider split within primary care and creates serious conflicts of interest that in the US have undermined patients' trust in their doctor.

Thus, primary care commissioning solves a central dilemma of the NHS and most health care systems, between the state's need to hold costs down and the profession's inclination to do more investigations and treatments. The solution? Give doctors the budget. That's what an increasing number of American managed care companies have done. California primary-care led physicians' groups have successfully driven down unnecessary and inefficient utilisation, admissions and bed days,

but they have held the entire budget (including everyone's take-home pay) for specialty groups, hospitals, community care and home services. They have also been allowed to keep for themselves what they save. Even then, it has taken 10-15 years of unflagging effort for physician commissioning groups to extract better value from an overfunded, overpriced system with lots of excess utilisation and capacity. And one great liability has been a loss of trust by American patients of their own doctor. 'Is he recommending this because it's best for me or best for him?' Once professional trust is lost, limiting expenses and services loses credibility. Effective rationing depends on trust and fairness; otherwise those rationed will protest and rebel.

In sum, the White Papers represent a major advance in effective commissioning by meeting all four pre-requisites outlined in the previous section. Moreover, extending general practice to integrated models of community and primary care will take one of the great strengths of the NHS and make it twice as strong. But doing that well will take a decade and should precede having those groups hold budgets for hospital and specialty care. In the meantime, they can provide clinical realism to health authorities as advisors.

4. Challenges to effective commissioning

Thankfully, the three White Papers do not try to address all issues and thus avoid a 1,700 page tome like President Clinton's proposal for national health care reform.[88] Among the topics not addressed, four basic ones are highlighted here.

Conquering 'the waiting list'

The infamous NHS waiting list is a source of national frustration and political embarrassment. When it gets larger, political leaders have to go on television and apologise, or explain what they are going to do about it. But since the list seems largely out of politicians' control (or anybody else's), about the only thing they can do is blame the other party or pour more money into it, as Labour promised to do in response to the large rise in the list in late 1997. Meanwhile, nobody seems to know why or how the list grew so much in the first place. The waiting list gets only brief and inadequate treatment in the White Papers; yet political observers believe that the public will measure the government's new management strategies for health care on how effectively they address the waiting list.

This entire situation, of waiting lists making victims out of everyone from the Prime Minister to ordinary citizens with worrisome or painful medical conditions, is completely unnecessary. As I suggested years ago,[89] the infamous waiting list seems more like a tribal ritual by which the British affirm that life is full of uncontrollable suffering. But its latent function is to prevent effective performance management and commissioning of specialty services.

Effective commissioning would take control of waiting for elective procedures and restructure it into a tool for managing resource allocation through a district appointments centre. To take this challenge requires understanding the myths and realities of the waiting system:

1. Waiting lists aren't lists; they're pools. Anyone who thinks they are 57th or 357th on a 'waiting list' needs a bucket of cold reality splashed on his or her head. To call the waiting pools 'lists' misleads the public and plays on their sense of fair play, when in fact there is no queue nor any clear criteria used for deciding who gets treated sooner and who later. Moreover, the number waiting is not the point. Focusing on the number waiting will always make the NHS look bad. It's a form of institutional self-flagellation.

   For example, suppose the Secretary of Health for New York counted all the patients who are waiting to be seen by specialists and

called it 'the New York waiting list.' Some will see their specialist tomorrow, some next week, and others in five weeks. There is no problem here (so far as this example goes). Yet putting them on a 'waiting list' just because they are not being seen today implies there are not enough doctors, hospitals and funds in New York to treat patients adequately.

What matters is how many wait beyond a reasonable amount of time, say three months, and how many have no appointment. Those waiting less than three months shouldn't 'count' because they are being treated adequately by the system. The waiting pools should then be defined in terms of the number and percentage waiting 3-6 months, 6-9, 9-12, and over 12 months.

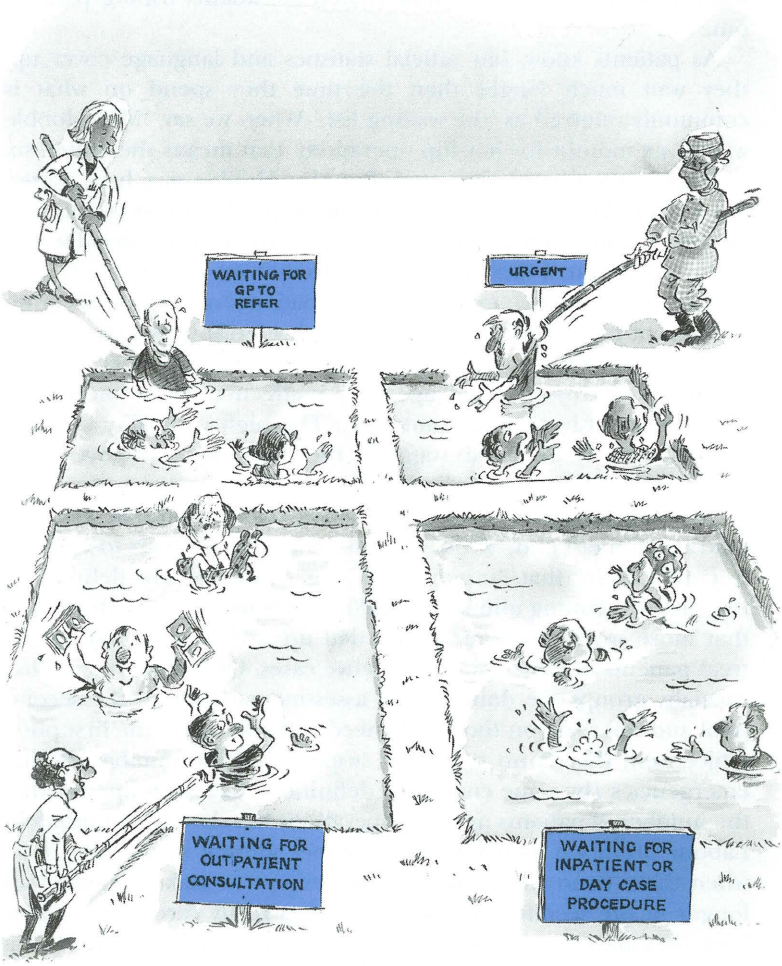
2. Consultants pluck patients out of the pool according to unmonitored and unaccountable criteria. These criteria may (or may not) include pain, severity, job loss or time waiting. Other criteria are professional 'taste' and the ability to make money by getting patients to 'go private'. As Labour has pointed out, 'There is a direct link between the number of people who buy private insurance and the length of NHS waiting lists in their area.'[90] The direct link is the part-time contract for consultants that offers handsome rewards for getting patients to go private, largely for surgery.[91,92]

   Will Labour address this direct connection between long waiting times and growth of private care? Until it does, it will be a victim twice over: politically embarrassing large pools and wasted resources. Moreover, managers will not be able to see how much of the waiting is unnecessary. A recent collaborative effort found that more than half of those waiting for surgery didn't have to, and waiting times dropped to less than eight weeks.[93]

3. There is not one waiting pool but four, each subdivided by specialty, by consultant or by hospital. They can be manipulated so that the main list gets longer or shorter without management having much control over what happens.

   The 'official' 1.2 million (in late 1997) waiting pool consists of those patients waiting for a specialty procedure as an inpatient or a day case, after having been judged as needed by at least two doctors: the patient's GP and a specialist. A second, poorly documented and monitored pool contains everyone waiting to be assessed by a specialist, who may then put them into the first pool. A third pool behind this one contains large numbers of patients not put into the second pool for assessment, because their GP either thinks that pool is impossibly large and the wait impossibly long, or thinks the

Figure 13 **The four waiting pools of the NHS**



patient's problem is too trivial or chronic. Finally, a fourth pool, which no one considers to be one, consists of those waiting for urgent care. It too can be enlarged or shrink. Researchers have found that the criteria for which cases are considered as 'urgent' are so highly variable and fluid that 'there is no prospect of a standard definition which could be rigorously applied'.[94] Thus how this rapidly growing pool is managed can significantly affect how many

patients are tossed into the first pool. Figure 13 portrays the NHS waiting pool system, with white-coated attendants fishing patients out.

As patients know, but official statistics and language cover up, they wait much longer than the time they spend on what is commonly referred as 'the waiting list.' When we say, 'Mrs. Hobble waited six months for her hip operation,' that means she waited six months in the first waiting pool. But Mrs. Hobble may have waited five months before that for an assessment (in the second pool) and two weeks after being 'taken off the list' to be scheduled for her actual operation, a total of $11\frac{1}{2}$ months, not six.

The government, managers and patients need an accurate account of *full* waiting times, from initial referral to final treatment or other outcome, so that poorly organised specialty services, poorly co-ordinated cross-pool management, ineffective interventions, and unnecessary visits can be eliminated. The high variability between consultants in medicine suggests the need for evidence-based criteria and guidelines to eliminate waste.

The interdynamics of the four waiting pools mean that when we read at summer's end, 'Broken promises as NHS list soars to 1.2m,'[95] it could mean that 'urgent' is being more loosely defined in response to growing numbers of GP referrals to A&E departments so that more specialty resources are tied up and are not available to treat patients in either pool of elective cases. Or it could mean that specialty groups are doing initial assessments faster in the second pool and referring on those who need treatment into the first pool. Objectively, there's no reason to suspect that the number of true emergencies (by some consistent definition) has gone up, nor that the number of patients needing operations has risen. Unfortunately, Labour promised to reduce the number waiting in the first pool, when there is no clear way to do so, except to make patients wait longer in the second pool. What patients really care about – how long they have to wait to get relief – seems to have receded as a priority. Yet this government has the opportunity to recast all four pools and manage TWT – Total Waiting Time – from the day a GP refers a patient onward.

4. The methods, criteria and sources used to gather data on these pools, if gathered at all, are highly variable, unreliable and not comparable. Nor are the pools co-ordinated or linked so that one can have an accurate picture of how long patients are waiting for what, *and with what consequences.*[96] Given that meaningful and reliable measures could be gathered, the current situation prevents effective commissioning and keeps patients in the dark. The new

government has a chance to make itself and the NHS look much better by recasting 'the waiting list' into those waiting over, say, three months for specialty referral and testing and for treatment if recommended. To do this requires tackling the data problem, but that should not be so difficult, given computerised systems.

Here are some initial suggestions on how to turn the waiting pools into a waiting stream:

Relocate and centralise scheduling

The management of waiting pools must be taken out of the hands of consultants and co-ordinated by the commissioning organisation across a city or district, as I recommended seven years ago.[89] Under the current arrangements, there are too many conflicts of interest and too much evidence of poorly managed waiting pools. Waiting times vary greatly, even within the same city. Such variations indicate that patients suffer unnecessarily and resources are used inefficiently.

Waiting times are a *management* issue, a critical measure of performance and service. One needs a system for tracking all patients referred beyond primary care in order to manage and coordinate specialty services. The commissioning organisation needs to set up a Scheduling Centre that would use computer systems linked with each consultant firm to schedule all visits and treatments. Of course, consultants would be involved with the Scheduling Centre every day, but patients and their GPs would gain a significant increase in choice among consultants and scheduled times. Indeed, this is exactly what patients and doctors experience in the Staffordshire 'Direct Access Service,' in which participating GPs make appointments directly to participating consultants.[97] It also saves time, reduces visits and reduces waste of theatre time. But only a small percentage of GPs and consultants are involved, and it needs to be developed into a full-scale management and commissioning tool.

Waiting is a kind of medical house arrest: you never know when you will get a note or call stating that you can get treated. Moreover, part of the inefficiency is the way in which patients are notified so as to maximise the chances they will not be able to show up. An appointment gives you freedom to get on with the rest of your life. That is why the emphasis on shifting to appointments in the Scottish White Paper is a smart move. It greatly helps patients, and it strengthens commissioning.

Identify and minimise bottlenecks

One bottleneck is having too few beds, so that urgent cases keep disrupting any effort to schedule elective procedures. This problem can be easily solved by not closing so many beds so fast. Keep more

slack in the system. A major lesson learned by American hospital chains in the 1980s was that spare bed capacity does not have to cost much if it's organised properly. Another relatively easy bottleneck in the flow of elective surgery is the inefficient use of operating theatres and doing minor work in major theatres. Other bottlenecks are more difficult, like a shortage of theatre nurses in a given hospital. One needs to examine practices in each hospital closely and then address the bottlenecks found, because each hospital has its own problems, often embedded in the professional culture and organisation of work.[39]

Put a team in charge of all relevant services

At the heart of the delays, cancellations and poorly coordinated services that make British waiting times for surgery much longer than they need to be are professional prerogatives and turf battles. One might call it 'Middle Eastern surgery', done in a territory rife with sheikhs, princes, buried history, old scars and armies of rules to protect professional borders from invasion. Cost effectiveness and accountability call for appointing a Supreme Commander, a respected consultant who controls all personnel, resources and services involved from work-up to final discharge. One needs this kind of financial and organisational power to clear away all the professional games that get in the way of treating more patients better. The team he or she commands should be allowed to keep a significant proportion of any money they save and reallocate it as they see fit. Such internal subcontracts within hospital trusts would increase productivity greatly.

Pay for elective procedures at marginal rates

Most hospital costs are fixed, making up perhaps 85 percent of the average costs that become hospital tariffs. These fixed costs should be in the contracts for urgent care, so they are sure to be covered. Doing this should then make the marginal costs for most elective surgery and other specialty procedures very cheap, about one-quarter the average costs in the main contracts.* Surgeons, for example, claim that they do so little elective surgery because health authorities don't pay for much, but the 'marginal' prices they pay are usually close to full average costs. No wonder so little elective surgery is bought.

Minimise pain, disability and loss of income

Reducing the large inequities in access to specialty services also requires a scoring system for prioritising those waiting. To the extent

*There are exceptions, such procedures that involve expensive prostheses or whole new levels of capacity.

that consultants fish out those patients treading water in a pool according to personal preference, professional taste or profit, these practices should be eliminated. The new government could adapt the priority index developed in New Zealand that balances evidence-based effectiveness with levels of dysfunction and need, including family needs like being a single parent, the carer of an elderly relative, or a breadwinner whose medical problem interferes with working.[98] Using such a system would allow commissioning groups to measure health gains as well.

Remove minor problems

Consultants tell me that GPs clog their waiting pools by referring patients with problems that the primary care team could handle, if only they were motivated and received a bit of extra training. This is a prime example of how integrated budgets and integrated contracting could result in better service to patients at less cost. Initial set-up and training costs would save money for years thereafter. This strategy could reduce those swimming around in some waiting pools by a third.

Mobilise senior registrars and registrars

A significant number of patients in waiting pools have problems that registrars and senior registrars could treat if they were required to get more practice training than they do now. By international standards, senior registrars have nearly the equivalent training of board-certified specialists. In an exercise done some years ago it was shown that a two-year waiting pool of 1,400 patients for a leading consultant firm could be eliminated in just 43 weeks by getting the registrars to treat the appropriate cases. Instead, the consultants were clamouring for another consultant post.

Let patients waiting over three months arrange their own specialty care and charge the commissioning authority

This is how the Swedish cut through their waiting list problems, and the results were amazingly quick.[99] One might call it the butt-head approach – blunt but effective. To conclude, my guess is that these eight strategies would leave few British patients waiting longer than three months.

Performance-based contracts for specialists

Effective commissioning is blocked at the heart of the NHS by an arrangement whereby NHS consultants are underpaid, but then given contracts with duties so vague and minimal that solicitors do not think one could tell when a 'breach of contract' has occurred. In addition, if

consultants earn more than 10 percent of their income from private work (self-reported and not monitored), they give up as little as nine percent of their salary for minimal duties in order to be allowed to do all the private work they want, even during regular NHS hours.

This situation produces several undesirable results. Most consultants work very hard but for inadequate pay, while a minority of consultants exploit the minimal, unmonitored duties of their contracts to earn much more by using their waiting pools to get patients to go private. Confidential information indicates that of the approximately 16,000 consultants about 2,000 bill a great deal. Very few are Scottish; almost all are English surgeons and anaesthetists. They are reported to bill up to £750,000 a year for private surgery. Essentially, they use the NHS as a recruitment base for their private practice and their NHS salary to pay part of their tax bill.

One might conclude, as these surgeons probably do, that the NHS is getting good value for whatever time they put in. But the private pricing, the charges that exceed even US levels, the lack of accountability and the ways in which they exploit the NHS make this look more like a government-approved racket than a bargain.* The exorbitant charges to private patients and insurers are in a market without published prices centred on patients who are usually in no position to shop.

Everybody loses except this small minority of consultants. Hard-working, full-time surgeons and the Royal College of Surgeons are tainted by their action. They make a mockery of the government's pledge to guarantee equal access regardless of ability to pay, and of the Royal College's motto, 'Skills for the benefit of all men [sic].'** Some surgeons are simply not available to the NHS or to patients for two whole days a week. Patients, employers and insurance companies are subjected to these consultants charging 30-50 times the hourly rate the NHS pays them.[91,100] The conflict of interest and perverse incentives have the predicted effect: whole-time surgeons operate less than a day a week on NHS patients.[101] As Figure 14 shows, their combined time in clinic and at the operating table amounts on average to two days a week of work. That means about half of them do even less. When these figures were challenged, the Audit Commission went out and gathered more extensive data that confirmed them.[102] The Audit Commission also found that a significant number of surgeons did not carry out their duty to supervise training surgeons, a disturbing issue of ethics and low quality.

*Strong buyers in the US have driven down surgeons' fees for cataracts to £400-600, while the prevailing charges in England appear to be £800-1200.

** Isn't it time to delete 'men'?

Figure 14 **Average number of hours per week for consultant surgeons**

Specialty	*Theatre*	*Clinic*	*Both*
General surgery	6.06	6.21	12.27
Urology	5.57	6.27	11.84
Trauma & orthopaedics	5.14	8.58	13.72
Ear, nose & throat	4.35	10.25	14.60
Ophthalmology	3.75	9.58	13.33

Source: Ref 101: Audit Commission Study of 581 consultants in 112 trusts in 1995

Equally predictable are the wasteful practices found in some hospitals. When I carried out a study of them, I found half-filled sessions, de facto cancellations that did not show up as such, methods of notifying patients that maximised the number who could not come in, use of major theatres for minor operations, and poor co-ordination of operations with recovery beds and nursing needs. All these 'inefficiencies' (actually, professional conveniences) get built into the prices for surgery so that health authorities buying many fewer operations than they could actually afford if they got their money's worth.

Let me make clear that I am not against private surgery or medicine. Nor am I against doctors supplementing their NHS incomes. But it should be after hours, and not by praying on the anxieties of NHS patients or manipulating 'a one-nation NHS, with consistent standards and services...'

The challenge to effective commissioning is to research and design multi-year contracts that provide clear incentives for surgical firms to prioritise operations by effectiveness and health gain and then maximise the number of operations they do, including all post-op care. My guess is that there is so much waste built into arrangements of convenience now that waiting times for elective surgery in productive units could drop to a month.

Patients who need multiple services

A very different challenge to commissioning is posed by the rapidly growing numbers of patients who need multiple services at home or in the community that involve different kinds of professionals. Each has

its own definition of the problem and sense of who is responsible for what. Behind these differences, community and specialty nurses, social workers, GPs, specialists, physiotherapists, nutritionists and other clinicians have different concepts of intervention and competence. Moreover, they are paid differently and answer to different hierarchies or professional standards.

These differences pose sizeable problems for commissioning community-based health services, and they indicate challenges to drawing up contracts within Primary Care Groups or other kinds of integrated primary care teams even before such teams take on the much larger task of commissioning other health care services. Detailed reports of contracting for community health services reinforce my earlier point that integrating such services is a large undertaking in itself and that commissioning them needs to be done by a larger body.[103,104] Field research by trained sociologists is an invaluable resource for learning how to make such integrated commissioning successful, because it takes one away from programmatic policy and economic models to the coal face, where it documents how the organisation of work, hierarchy, power and values affect actual negotiations.

Researchers found that the heterogeneity, local boundedness and indeterminacy of community-based health services 'presented fundamental problems for commissioning and contracting..., significantly influenced by their willingness to trust the other party in a whole range of circumstances.'[102] The variability and uncertainty of what services were needed made them difficult to assess and thus required 'substantial amounts of trust in the professional discretion of providers.' But the process of commissioning engendered distrust: how will we know that you do what you say you are going to do; what evidence is there that your service makes a difference? The more purchasers asked, researchers found, the more it undermined the coordination and networking that community health services by nature require.

Contracting embodies a focus on performance and evidence-based work, which irritates, if not offends, the professional's sense of inherent competence and autonomy. Defining 'outcomes', negotiating competencies, allocating responsibilities, and setting prices or financial terms are difficult and painful. Deep cultural changes need to take place across all the health professions before integrated contracts and commissioning can work effectively.

Contracting realities

While visions of integrated commissioning dance in the heads of ministers, the multi-year research project on contracting by the Economic and Social Research Council includes detailed studies of

contracting realities that paint quite a different picture. This invaluable work appears unread by ministers and members of the NHS Executive. Instead, the NHS Executive gathers data and carries out surveys that are inherently superficial. The official reports show, for example, that HRGs are used in a high percent of contracts with trust hospitals, but they do not show how they are used and with what bite to ferret out professional practices that waste resources.

Likewise, government rules are tough about meeting waiting list targets and imposing penalties on trust hospitals that go over target. Direct, sustained observation of actual contract negotiations by research sociologists, however, found that hospital executives and health authorities worked out ways to circumvent these rules.[105] Hospital executives know how little control they have over such matters without a politically bruising confrontation with the surgeons, which takes us back to the first challenge to effective commissioning. They know that while ministers seem fiercely intent on holding down waiting times and reducing inefficiencies, they will back the consultants if the executives get tough with the consultants and the consultants retaliate with a vote of 'no confidence.' Researchers found that in a number of cases, hospital executives told the contracting health authority that they will sign the official version of the contract with the penalty clause only if a letter were written on the side assuring them that in reality no penalties will be imposed for exceeding waiting time targets.

Such contract realities appear to undermine government policy, but in fact do not. For the government (so far) has not been serious about effective commissioning. It has wanted shorter waiting times, but not if it means a face-down with consultants, disruption, or bad press. Yet that, American purchasers have learned, is what it takes. These NHS hospital executives, then, were doing just what the government has wanted, creating the appearance of being tough about waiting pool times while avoiding confrontation or the financial losses of the penalties. Likewise, researchers found that lists of excluded treatments were drawn up, but then the data gathered on treatments done lacked the breakdown to know whether consultants had done them or not. 'The significance of exclusion lists appeared to lie more in their presentational value as a public statement of DHA priorities than in the economic savings achieved.' In support of this conclusion, the researchers of contracting realities documented a health authority that 'went by the book' and firmly carried out the rules, sanctions, and penalties laid down by the NHSE and ministers. Nothing but trouble ensued. By the third year, the penalties had mounted, acrimony prevailed, and senior government officials intervened. By the fourth year, 'none of the former executive directors remained in post.'[105]

Sociologically speaking, all contracts are a negotiated reality, in which the parties project their values, expectations, fears, self-images and relationships within an organisational and political context. From a policy perspective, this implies the need to understand these factors and work realistically with them to achieve policy goals. The illusion that policy pronouncements become realities soon after is just that: an illusion.

5. Seven lessons for effective commissioning

Based on the struggles and failures of American purchasers to control costs throughout the 1980s, the five pre-requisites for effective commissioning imply seven lessons:*

- **Commissioning organisations need to be large and strong**
- **Commissioning teams need to be smart, well trained and technically supported**
- **Everyone is accountable; autonomy is a false pretence**
- **Providers must bear some risk for cost shifts**
- **Re-engineering clinical care for cost-effectiveness takes time and money**
- **Commissioning through primary care has serious drawbacks**
- **Primary care is critical and needs to be commissioned like everything else**

Let us look at these seven lessons more closely one at a time.

Commissioning organisations need to be large and strong

As mentioned before, American employers and Congress spent many years developing extensive programmes in cooperation with the medical professions to control rapidly escalating costs, only to have them subverted in a number of ways. This led to the Buyers' Revolt and aggressive efforts to review the work of clinicians. Prospective review consisted of asking, 'Does this patient need to be hospitalised? Does this procedure need to be done?' Concurrent review had nurse specialists questioning each morning how much longer hospitalised patients had to stay. Retrospective review analysed months of computerised records to see how different hospitals and specialty teams compared in the costs of treating comparable cases.

These efforts met with a great deal of resistance, especially from hospitals. Specialists did not want to provide the data and found the

*These seven differ somewhat from the nine lessons featured in my 1998 *BMJ* article (316:217-220) because some of those have already been addressed.

entire undertaking highly offensive. Nevertheless, buyers confirmed research that revealed large variations in tests, procedures, surgical rates and hospital use by doctors, even after controlling for diagnosis and other clinically relevant variables.[106,107,108] When buyers asked specialists questions like, 'Are the high-end doctors doing too much, or the low-end ones doing too little,' they got no clear answers. Or, when they asked, 'Which procedures are the most cost-effective for lower back pain,' there seemed to be as many answers as consultants in the room. Meantime, despite concerted efforts at utilisation review, costs kept rising in real terms as much in the 1980s as in the 1970s, because doctors and hospitals found numerous ways to shift patients and costs to budgets or areas where costs were not being controlled so well. These experiences are a major reason why Alain Enthoven, the father of managed competition, was so impressed with providers' abilities to exploit or circumvent partial efforts to manage costs, that his model calls for not only extensive rules but also for a watchdog team to manage the market.[109]

For these reasons, the most sophisticated and successful US employers have concluded that they need to form large commissioning (as we shall call them here) groups. There are at least six reasons why:[28,43,44]

a) Effective commissioning requires marketplace clout to take on wasted money and inefficiencies in hospitals and their specialists, who have all the natural advantages of prestige, patient loyalty, control over what is clinically 'necessary', control over vital information, deep pockets and political power.

b) Effective commissioning requires a large population base and budget to reconfigure clinical services across institutional and specialty lines in more cost-effective ways.

c) Effective commissioning must be large enough to bear and manage considerable risk, especially for rare, costly cases.

d) Effective commissioning must be large enough to support a highly skilled team of clinical and financial managers that can contract and subcontract skillfully.

e) Effective commissioning must be large enough to spread such administrative and transaction costs over a large client base.

f) Effective commissioning must be large enough to avoid the increased inequalities and service fragmentation that come with devolved purchasing.[110] Devolving decisions about patient services works, but is quite different from devolving decisions about commissioning.

To these six should be added a seventh that is very pertinent to the UK and the Labour government's agenda: effective commissioning should take place on a large enough geographical and political base to advance a public health agenda of prevention and health gain aggressively. Only a few advanced US purchasing groups have developed programmes of prevention, patient education and self-management.[44] As with the monitoring systems they choose, they require any provider group contracting with them to implement these programmes and monitor their progress.

Ironically, while American businessmen struggle to form large and effective commissioning groups and Congress slowly gets its act together as the largest commissioning agent of all, the British already have large commissioning groups with the organisation and legal mandate to commission health care services for a defined population. They are called health authorities. Yet from the start of the reforms, the Conservatives neglected them. Purchasing was not even declared important until several years into the reforms, and even then health authorities struck me as treated like big sponges to sop up all the problems and leftovers of the political favourites, GP fundholders. Some health authorities managed remarkable achievements nevertheless, and some fundholders showed they could be streets ahead of their health authorities; but generally this characterisation holds. Now the new government wants to reinvent the functional equivalent of health authorities on a smaller scale, and that may be fine; but we should be clear what is being proposed. It seems to me a wholly practical matter. The government should figure out whether it would cost more and take more time to make health authorities smart, strong commissioners or to create new, primary care-based commissioning groups. In any case, it will take a while for the new commissioning groups to get going; so if there is to be effective commissioning in the next couple of years that will reduce inequalities or shorten waiting times, health authorities need to be strengthened and motivated to do effective commissioning.

Commissioning teams need to be smart, well trained and technically supported

The best American commissioning groups have concluded that health care is far more complicated to purchase than anything else – mainframe computers, aircraft, telecommunication systems – you name it. Their salary and bonus packages are designed to attract the best and the brightest. They require excellent data system analysts and programmers, clinical epidemiologists, clinical managers, organisational experts, financial specialists and legal advisers.

The NHS reforms, by contrast, led to an army of untrained staff being promoted to managerial rank, some unsympathetic to consultants and many uninformed about the complexities of clinical work. Health authorities could do little else but be price takers, not price makers, and hospitals still issue their tariffs. US purchasers realised after several years that hospital-issued prices were a shell game with the lights turned off. They had no idea exactly how hospitals were putting their prices together. Some of them had to hire major accounting firms to determine what fair prices should be, and the results were considerably lower than the prices that the hospitals had issued.

Small wonder that the Conservatives turned on their own creation by announcing a policy of cutting managerial staff, or that such policies are politically popular. Moreover, the army of middle managers was led largely by executives with old, strong ties to hospitals, some say by the executives that hospital boards passed over. Chief executives of commissioning are paid on average substantially less than chief executives of providing. But the American view, I believe, would be if you are going to commission at all, it requires a significant investment in management teams.[111] Regardless what kind of future NHS is envisioned, there is an immediate need for US-style management training programmes for nurses and doctors so that a skilled cadre of clinician-managers are in place as soon as possible.

Everyone is accountable; autonomy is a false pretence

Aside from serious errors, no one seems accountable in the NHS. GPs and consultants make their clinical judgements, which have substantial monetary consequences, with little accountability. Surgeons and other consultants fish patients from the so-called waiting list according to entirely unaccountable criteria. Clinical audit has received low grades for being a toothless exercise by those being audited. Health authority executives are evaluated by performance measures even they call 'arcane' and 'perverse.' The Treasury's 'efficiency index', by which it measures the performance of hospital executives and determines their bonuses, has been widely criticised as perverse. Little or nothing has been done by the Great Commissioner in the Sky about executive purchasing teams that perform poorly.[113] Executives who are widely known to have botched up a trust or authority reappear within a year in some other senior post. What do these patterns imply? Doing damage control and making performance look good seem to be the main preoccupations. This takes us back to whether the government is primarily a provider trying to make its performance look good, or a commissioner who stands back and evaluates the performance of providers and managers.

A great deal could be written about kinds of accountability and positive forms of quality improvement. But one basic point worth mentioning is that autonomy is an indefensible basis for professional work and in the US at least has been supplanted by accountability. To indulge in a bit of sociological theory,[114] the claim for professional autonomy has long rested on the fact that no one can observe or properly assess the subtle mixture of complex skills and fine judgement that goes into clinical work. Therefore, society must trust professionals and grant them autonomy, in return for their assurances that they will apply expert judgement to the needs and interests of the client or patient. What else can society, or a commissioner, do given that clinical work takes place in a black box?

A moment's thought makes one realise that this argument makes autonomy a second-best basis for professional work. First best is accountability, to get inside the black box, to evaluate clinical performance. In fact, that is exactly what faculty do when they train clinicians; so the autonomy after graduation is actually a convention that once doctors are licensed, no one should review their clinical performance as was done just before getting licensed! Autonomy might be fine if the profession actually assessed the relative effectiveness of different procedures and if professionals' work reflected best professional judgement. But the research documenting large variations in doctors' practices and the research documenting large numbers of unnecessary or ineffective procedures exploded the 'autonomy-for-quality' argument of the profession.[106,107,108] The recent history by Jane Lewis documents the posturing and pretence used by organised medicine in its insistence on autonomy.[115] Most important, the development of clinical profiling and medical informatics now means that experts outside the clinical black box can tell doctors more about their comparative performance than they can themselves. Evidence-based clinical protocols and computer-assisted systems are also more consistently accurate than are fully trained specialists. Finally, the true basis of professionalism – professionally based accountability – is possible. Effective commissioning requires the full utilisation of these tools.

Providers must bear some risk for cost shifts

If no one seems accountable in the NHS, no one seems at risk either. Take GP fundholding, for example. Up to now, at least, if fundholders went over budget, they were bailed out. If hospital trusts went over budget, they were in effect bailed out too. In fact, the rules of commissioning have been set up so that trusts cannot lose in the end.[35] For a while I had the impression this was not so. I would hear that one

hospital or another had 'run out of money' or was seriously in debt. But when I asked, 'Is the heating bill paid? Are the staff still getting their paychecks,' I learned that they were. They had 'run out of money' on paper, in accounting books; but by American standards it was not real, and in all of this, the take-home pay of doctors, nurses and managers was largely protected.

American commissioning has gone to the other extreme, of passing all risk on to the providers. Doctors are also being paid in ways that put their take-home pay at substantial risk. Such extremes are dangerous and ill-advised; they can lead to either desperate measures or greed that jeopardise good patient care. But American purchasers may be correct in concluding that contractees must bear some of the risk for the decisions they make. This is best done at the team and group level, because it provides a graphic incentive for clinical and managerial teams to get together and review together how they can reduce ineffective or unnecessary tests and procedures, or how they can reorganise care in more cost-effective ways. Thus, commissioning for integrated care goes hand in hand with the risk-reward corridors I discussed in my review of fundholding.[2] These corridors consist of a financial corridor (for example six percent of a risk-adjusted capitated contract with a primary care group) that will go to secondary care providers if more referrals are made, or to the primary care group if fewer referrals are made. Similar risk-reward corridors can be constructed for expenditures on drugs or other parts of overall care, and they must be adjusted for the health profile of the patients served. Royce discusses a number of other contractual arrangements developed by US managed care that could be used in the NHS.[116]

The obvious dangers are that patients' primary care providers will underserve or inappropriately take on tasks they cannot handle and should refer. Thus, good monitoring systems like PCAS, and good grievance procedures, need to accompany risk-bearing contracts; but they need to be put in place anyway for the reasons already stated in the pre-requisites. But if risk-reward terms are judiciously set in three to five year contracts, they reward teams for monitoring themselves, reviewing how they do their work and finding more cost-effective ways to carry it out. In American terms, by the way, we are talking about risks and rewards that affect one's take-home pay. Given how modestly most providers and managers are paid in the NHS, I would recommend instead performance-based bonuses and minimise downside risk. The bonuses will add to costs, but the savings from more cost-effective care can pay for them, and morale will rise sharply. Imagine an NHS where the nurses and doctors who work hard to come up with a better way to provide services received bonuses! It would transform the culture and get the NHS out of the doldrums.

Re-engineering clinical care for cost-effectiveness takes time and money

Besides it seeming as if no one is accountable and no one is at risk in the NHS, it seems as if the current government, like its predecessor, thinks that significant innovation and improvement come free. In business terms, this is entirely unrealistic. Granted, the previous government and this one end up pouring extra funds into the NHS, but this happens as a rearguard action, in part because insufficient investment has been made in addressing effectively the inefficiencies of the NHS. Except for GP fundholding, where substantial extra funds were offered up front, projects like the total purchasing pilots, or GP commissioning, or the Primary Care Act Pilots (PCAPS), are launched with little or no funds for the considerable time and technical challenges that these initiatives require. Yet they are the prototypes of the 'new NHS.' The results, if one looks realistically, are predictable: dedicated, hard-working enthusiasts struggling to put something new together without the equipment, technical skills, or staff to make it happen very well, and with little or no valid evaluation. Then, a year later, another initiative is announced and launched, without knowing much about how the previous one worked out. Primary Care Group commissioning, for example, is a national initiative based on demonstration projects that have not yet finished their course and have not been adequately assessed. The string of initiatives over the past seven years seem more like diversionary tactics, to distract not only the public from the real problems of the NHS but also to keep government leaders from facing up to the real issues that effective commissioning needs to address.

The lack of sufficient funds and rewards for innovation lies at the root, I believe, of an NHS paradox: considerable local innovation and initiative but low morale and poor diffusion of the best ideas. Alan Milburn and Frank Dobson are said to be puzzled by seeing an excellent programme for reducing costs and improving care in one place they visit, but nothing like it at other stops they make. On the other hand, another one of those places will have a showcase programme in another clinical area that the others do not have.

What this pattern shows is that effective commissioning cannot live by spontaneous invention alone. If the efficiencies and savings of showcase improvements are to be realised throughout the system, programmes must be developed by the centre for their diffusion and incentives provided for others to take them on board. Spontaneous invention may be possible but not spontaneous diffusion.

Programmes like GP commissioning and the PCAPS pilots attempt to get a free ride out of spontaneous invention by inviting all the

innovators to come forth and be blessed. This can work up to a point. The level of dedication in the NHS is stunning. If the US government announced a programme like the PCAPS pilots with no funding, American doctors and managers would say, 'Forget it! What do they expect? A lot of extra work for nothing?' But that is exactly what the British government expects, and that is often what they get. Over 570 primary care groups applied, eager to have the chance to carry out challenging and complicated innovations for nothing, except the satisfaction of doing them and serving patients better! I went on site visits to review some of the best applicants. They were irrepressible in their enthusiasm and desire to be given the chance to work evenings and weekends for the next several years in order to realise their vision of better clinical care. But if one looks closely a year or two later, the lack of people and resources to realise the best-designed innovations (not to mention the more usual ones that need changes and revisions) leave dedicated innovators at the leading edge of the NHS frazzled, demoralised, even angry. Moreover, insufficient funds have usually been provided to assess what has been accomplished and what needs to be done to make the innovations work. And behind the innovators are ranks of more ordinary, conscientious workers demoralised as well. This whole approach to innovation and improvement is penny-wise and pound-foolish. Its ineffectiveness is a self-fulfilling prophecy.

Commissioning through primary care has serious drawbacks

From the experiences of American purchasing groups, GP fundholding and other forms of primary care commissioning make little sense. American purchasers regard primary care as terribly important, and they are working constantly to make this front line of service and cost management as strong as possible. But having small primary care practices take on the job of commissioning secondary care services requires several qualities such practices do not usually have:

- sufficient clout to take on powerful specialty groups and hospitals;
- the technical skills and infrastructure to challenge ineffective or inefficient practices;
- the time and training to carry out this complex task; and
- the ability to address inequities and wasteful practices in primary care itself.

This American perspective is supported by reports that most GP

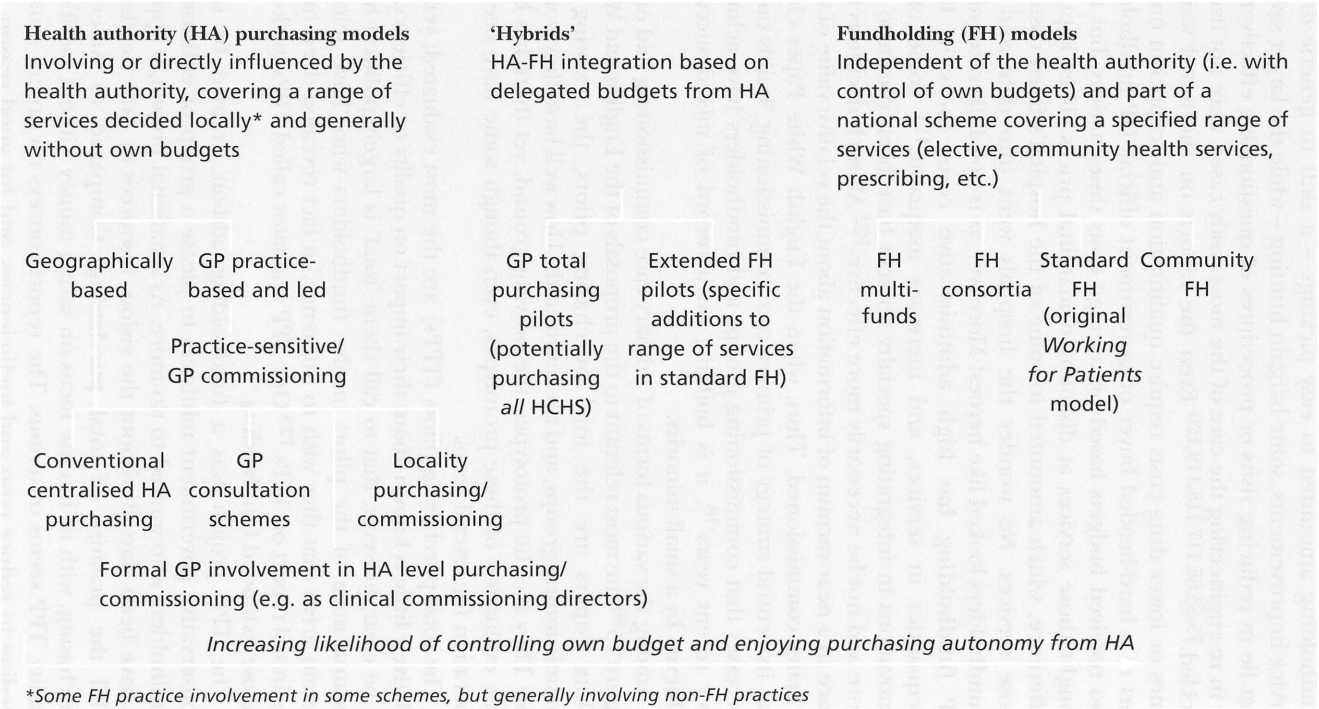
fundholding amounted to easy pickings – a shift to generic drugs, service improvements, some bargain hunting – while the larger savings that lie in reducing visits or procedures of questionable effectiveness, or in re-engineering the care of the most costly cases, were not usually tackled.[75,83,86,117,118,119,120] Even the reports on shortened waiting times or lower drug costs require qualification and scepticism on the part of a hard-headed buyer or government official. GP fundholding also received budgets based on average costs times activity, but then bought those services at discounted marginal prices. They kept the difference, which amounted to some of the hospital's fixed costs for those services. No wonder the hospitals went into debt and the foundholders looked like heroes! Moreover, as is now fully recognised, GP fundholding has high administrative costs, locks in large inequalities in services, and increases inequality.[121] Some of its innovations in integrating specialty services have been shown to cost more and not be necessarily more effective.[122] All such decisions took place in a near vacuum of information about the relative value of what is being commissioned. Thus, when the English White Paper claims that its central strategy of primary care commissioning 'builds on the successes that commissioning groups and fundholders have achieved over recent years'[18], it is building on a record of mixed successes achieved by a small minority.

Among the various forms of primary care commissioning laid out in Figure 15[86] the most relevant to the proposals of the English and Welsh White Papers are the total purchasing pilots, the existing GP commissioning groups, and the multifunds. How well have they worked out? They are the prototypes, the proving ground, yet there has been little evaluation of these prototypes, even though some have been in operation for several years.

The total purchasing pilots (TPPs) are the most evaluated; yet still relatively little is known about their impact on quality or efficiency. Let us be clear, however, that to call them 'total' is largely political hype, because most of the pilots involve fundholders who 'have selected certain areas that they wish to influence,' a fact revealed deep inside the initial report on TPPs.[123] One TPP evaluator called TPPs 'pick-and-choose extended fundholding.'

The TPP project was a fundholding add-on, created by some Conservative government ministers to please a group of enthusiastic fundholders who wanted to do more. As a national project, it appears to have been started without the vision, resources or time needed to fulfil the promise of total purchasing. Compared to American purchasing, with its intense focus on saving money without sacrificing quality, TPP seems unserious. The report conveys no urgent sense of needing to reduce costs and inefficiencies, and for good reason. The

Figure 15 **A typology of current purchasing organisations in the NHS**



Source: Ref 86: Le Grand et al., 1997, Figure 1

wasted resources and inefficiencies that concern the Treasury and ministers so much are not real costs for GP commissioners, though they clearly care enough to devote hundreds of extra hours to securing better services for their patients.

TPP GPs have found themselves facing a thicket of challenges without the resources they need to do their job well and facing some inherent difficulties that will also frustrate effective commissioning by Primary Care Groups in future. The latest research finds them frustrated by the lack of coherent data by which to measure value for money, or even to know what utilisation patterns are so that they can form coherent purchasing plans.[42] TPP leaders are also finding that GPs differ significantly among themselves about how to treat similar classes of patients, about what they want to commission from other providers, about turf and divisions of labour, and about priorities. This has also been the experience of multifunds. It takes a long time for GPs to sort out their differences, beneficial as that exercise may be, and it will take even longer for cross-professional groups to do it. Although concerted discussions of this kind should put clinical care on a more solid, evidence-based foundation, a lot of commissioning decisions will have to be made in the meantime. This takes us back to the importance of strengthening health authorities if commissioning is going to reduce waste and inequalities in the next five years.

Like TPPs, GP commissioning groups come in a variety of forms, large and small, and on the whole they have not been evaluated. Their design, as organised advisory groups to their health authorities, however, is a way to combine their local knowledge, clinical savvy and professional legitimacy by getting people's GPs involved in commissioning with the technical advantages and clout of health authorities. GP commissioning is population-based, low-cost, collaborative and egalitarian. It uses the health authority as the commissioning group's fund manager and technical centre, and it leaves GPs conflict-free to advocate for their patients.

Indeed, the original plan of the Labour party called for such a reform, where primary care commissioning would not involve holding funds or buying services but would influence purchasing by health authorities.[125] Perhaps the Labour government should revisit this simpler, less costly and more pragmatic version of primary care commissioning. This suggestion is supported by an excellent review of commissioning models which found that GP commissioning groups were able to meet more of the eight requirements for effective commissioning and four organisational requirements than any other approach, as listed in Figure 17.[126]

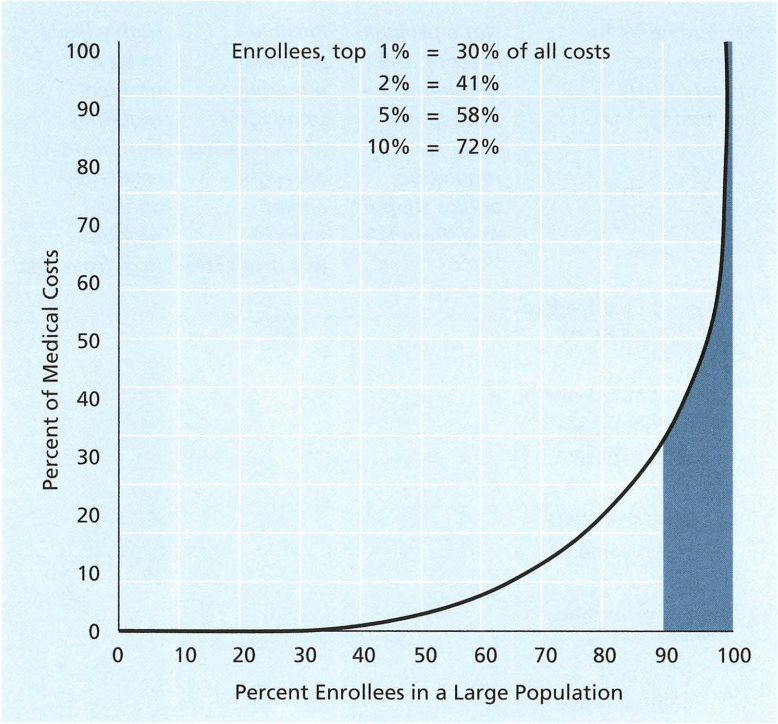
BOX 1 **A secondary care led NHS?**

As a mind-stretcher, how good a case could one make for turning primary-care commissioning on its head and arguing that secondary-care consultants should commission health care services? The arguments are different from a primary care-led NHS but quite compelling:

- Most of the budget and most of the savings lie in re-engineering the care of people sick enough to be in the hands of consultants. Remember that the sickest 10 percent of a population consume 72 percent of all health care costs, as illustrated in Figure 16.[25,124] Consultants have the expertise and power to drive efficiencies for this group.
- Specialists diagnose and treat more accurately and effectively in their respective clinical domains than do GPs, especially when it comes to medicines and surgery. They can re-design referral protocols for GPs better than GPs can do for them.
- Multi-specialty firms can be put at risk with capitated contracts for a population, and they will develop programmes that maximize appropriate referrals and delegated follow-up services to primary care and nurse-based practices. They would commission primary and community care as a sub-contract.
- Multi-specialty consultant firms have the expertise and clout to make hospital services much more efficient. Consultants can take on hospitals; in fact, to a significant degree they (and nurses) are the hospital. If the Treasury or the Great Commissioner in the Sky want to get more services per million pounds in the short run, secondary care is where to do it.

Are you persuaded? Consultants of the World Unite! Of course, this is just a mental exercise, though it also happens to be a principal strategy for commissioning in the United States.[28,43,44] Multi-specialty groups of doctors hold the budget for all care and share the risk of meeting expense targets within performance and quality standards. They contract with hospitals for services they cannot do in their own clinics.

Figure 16 **The critical 10 percent**



Source: Ref 25: Daniels et al., 1995, Figure 4.1, revised. Based on Ref 124: Berk and Monheit, 1992

Primary care is critical and needs to be commissioned like everything else

A final implication of effective commissioning for integrated care is that primary care is not exempt. It too needs to be commissioned. Quality is uneven and unmonitored. Patterns of referrals and the expenses that GPs generate vary greatly, which means that a significant proportion of primary care practices is wasting taxpayers' money.[17,127]

Expanding general practice to community-based primary care services requires commissioning oversight, as ably argued by professors Wilkin and Roland at the National Primary Care Research and Development Centre.[128] Assuring quality, equity and value in primary care needs to be done by an anchor commissioning group, like health authorities, with regional offices backing them up. In terms of the

Figure 17 **GP commissioning**

Requirements for an adequate model of NHS purchasing	*Not a problem meeting this requirement – little or no need for regulation and/or support (e.g. from HA)*	*Possible problem requiring some form of monitoring/ oversight and/or support (e.g. from HA)*	*Highly likely to be a problem requiring significant regulation and/or support (e.g. from HA)*
Processes required to meet the goals of purchasing			
Assessing patient needs	✓		
Obtaining adequate information about services	✓		
Influencing providers			✓
Patient involvement and choice			✓
Setting appropriate priorities	? ←	✓	
Monitoring and maintaining equity	✓		
Minimising transaction costs	✓ →	?	
Managing financial risk	✓		
Required organisational qualities			
Accountability			✓
Minimising conflicts of interest		✓	
Sustainability	? ←	✓	
Appropriate mix of skills	✓		

Note: The ?←✓ and ✓→? indications mean that the characteristic may be moving from its current status to another. For example, transactions costs may be becoming more of a problem.

Source: Ref 83: Mays and Dixon, 1996, Table 7

White Paper proposals, what this lesson means is that developing equitable and high-quality comprehensive primary care teams need to be achieved first, before they begin to commission other services.

If primary care needs to be commissioned, especially if it is to embrace a comprehensive array of community-based services (a good idea), then from an American purchaser's point of view GPs have to be part of the system and part of integrated contracts. For the foundation of the NHS model to be 'outside the NHS' makes no sense. A stand-alone GP contract that does not make GPs responsible for their rates of referral or costs to the system, and that has few levers to assure integrated care of good quality, does not make sense. Indeed, a key goal of GP fundholding, GP commissioning groups, TPPs, multifunds, and now PCAPS pilots is to bring GPs into the rest of the NHS.

In many ways, the Nottingham commissioning group[129] is the prototype for Labour's master plan for England and Wales: large commissioning groups of GPs who successfully purchase all health care and save money. Granted, the Nottingham group (or other exemplars like mid-Devon or Bromsgrove) are not mandatory, do not have to include a host of other primary care providers in their decision-making as well, and do not hold a budget – three warning signs that the master plan may be asking for trouble. Even if the goal were merely to blanket the land with 500 Nottingham commissioning groups as they are, could it be done?

A cautionary tale comes from the United States, where we had our Rochester (New York) model of cooperative, cost-effective commissioning. Throughout the 1970s and 1980s, Rochester stood as a glowing example of how co-operation and volunteerism (America's answer to British 'socialized medicine') could hold costs down and harmoniously balance all the elements of insurance, speciality practice and hospitalisation. How did Rochester do it? The key was the way in which employers, insurers, hospital executives and providers sat down together over pancakes and 'regular' coffee (weak, with cream and sugar), and worked things out. Why not, then, replicate the Rochester formula elsewhere?

The US's largest foundation in health care joined forces with an outstanding panel of senior advisers and invested millions to replicate Rochester's success in other cities. They made success much easier than the White Paper does: they hand picked the most promising of all the municipalities that applied and claimed they too had the key ingredients to match Rochester's achievement. After several years of implementation, an independent evaluation team concluded that not a single 'Rochester' has been replicated.[130] One way or another, things fell apart at each site, largely over egos and politics. How can the same result be avoided for Primary Care Groups commissioning?

6. Conclusion: management strategies for the new NHS

This report contains a host of minor and major recommendations to improve the management and commissioning of health services. Of these, a few are pulled together and featured here:

1. **Get community-based primary care groups functioning well first, before giving them other tasks.** It will be a big job just to develop integrated primary and community health services. Make them a comfortable size for the members of the primary care team, often smaller than now contemplated.

2. **Reap the benefits of primary care commissioning without the organisational, financial and political liabilities, by making groups advisory to health authorities.** In terms of the English White Paper, this would mean being sure that Level 1 Primary Care Group commissioning is working as well as the mid-Devon or Nottingham commissioning groups before moving on to Level 2.

3. **Take control of all four waiting pools, transform waiting into a management tool, and get waiting times for elective surgery down to a few weeks.** The government no longer has to be victim to the 'waiting lists', the overpricing of elective surgery, or the small fraction of consultants (principally in England) who exploit their sweetheart contracts.

4. **Be sure that PFI schemes do not reduce clinical services as people get older, and consider other sources of capital, like a one-time surtax to raise £2 billion for capital improvements.** Gleaming improvements and new facilities will be popular. This is what 'modernising' really means to the public. Meantime, back-door privatisation and future reductions in service can be avoided.

5. **Realise the potential of health authorities (or health boards) to lead the commissioning and public health agendas.** There seems to be no choice in this matter. Even the English strategy for primary care commissioning depends on how well health authorities carry out several key tasks, and if there is going to be effective commissioning in the next 5-10 years, most of it will be done by health authorities. The goal should be to attract the best-trained executive teams, with the best support staff and team-based performance bonuses. Their technical capacity needs to be significantly enhanced.

6. **Carry out the excellent national programme in the White Papers for an integration of public health with health services, both driven by measures of outcomes and quality.**

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