NHS Review

New health care market

Ray Robinson

The belief that a competitive environment stimulates efficiency and enhances consumer choice has been a central component of the government's economic strategy for the past 10 years. With the publication of the white paper *Working For Patients* its plans for extending this approach to the NHS have finally been unwrapped.¹ A key component of this strategy will be competition between short stay hospitals for service contracts from district health authorities acting as purchasing agents, from general practitioner budget holders, and from private patients and insurance plans.

The origin of these ideas lies in the work of the American health economist, Alain Enthoven.² During a visit to Britain in 1985 he noted that the NHS commanded widespread support but that it provided few incentives for efficiency. As a result wide variations in performance exist between hospitals and districts. These include differences in operating theatre utilisation, levels of bed use, and the extent to which clinical staff make productive use of their time. His suggested remedy was to retain those features that make the NHS such a popular institution—especially universal access within a tax financed, free at point of use system—but to improve efficiency through trade in clinical services between district health authorities. This arrangement has become known as an internal market.

The white paper builds on this model but goes a good deal further. The rudiments of its proposal for a new health care market in hospital services are shown in the figure.

The government's plans envisage separation of responsibility for the purchase of services from their delivery. Three main types of budget holders will be included in the purchasing arrangements. Existing district health authorities will act as purchasing agents for most of the inpatient care received by their resident population. Where these services are provided will be determined by district managers in consultation with referring general practitioners. In addition, however, general practitioners with list sizes of over 11 000 patients will be given the opportunity to become direct budget holders for selected hospital services. Services they will be able to purchase directly on behalf of their patients include diagnostic tests, outpatient services, and a defined group of inpatient and day cases, such as hip replacements and cataract removals. As with districts, general practices which opt to be budget holders will be free to purchase these services from hospitals of their choosing. Finally, private patients and insurance plans may be expected to figure increasingly as purchasers of services.

On the supply side services will be provided by hospitals that continue to be managed directly by the district health authority, by private hospitals, and by a new category of self governing hospitals acting as

independent trusts within the public sector. Self governing hospitals play a key part in the government's plans for the future. Initially, major short stay hospitals with more than 250 beds have been identified as suitable candidates for self governing status, but eventually other hospitals may be eligible.

The rationale underlying the new health care market is that competition provides both an incentive structure for improving efficiency and a transmission mechanism for spreading it throughout the service. Hospitals which can provide high quality, cost effective services will be able to obtain funds for expanding workloads and this will act as a spur to less efficient ones. This contrasts with existing financial arrangements in which cash limits often penalise efficiency by restricting a hospital's ability to use its capacity to the full.

Whether or not these expected advantages materialise will depend crucially on the way in which the proposals are implemented. The white paper provides a blueprint not a working model. It leaves many questions unanswered, particularly about competition.

- How far will competition be allowed to develop?
- Will competition increase consumer choice?
- Will it be possible to link management's objectives with the activities of clinicians?
- Will competition jeopardise the aim of universal access to health care?

New health care markets for hospital services

Competition, prices, and regulation

For competition to produce an efficient allocation of resources certain conditions have to be met. At the most fundamental level prices need to reflect the real cost of providing services. Otherwise market "signals" will be distorted. This requirement makes the government's decision to introduce a system of capital charges into the NHS a sensible one. As the white paper points out capital assets are at present often treated as a costless "free good." There is little incentive to ensure that they are employed to the full. From April 1991, however, health authorities will be charged for their existing capital assets and new investments.

But if hospitals begin to charge for capital assets, including rental payments that reflect the current value of their sites, it might lead to some unexpected developments. Most notably, it would provide a powerful incentive for the relocation of some services away from high value, inner city sites, especially in London. Herein lies a tension. The need to ensure that certain core services are always made available locally will mean that the government will be unwilling to allow market processes totally to determine location decisions. The new resource allocation formula addresses this problem by taking account of the relative costs of providing services in different areas. The Thames regions, for example, will receive larger capitation payments than elsewhere. While it is quite proper for the government to modify economic forces to pursue social objectives, such intervention does raise the question of the size of the efficiency loss that it is prepared to incur to meet this aim.

Limits placed on the size of capital programmes may also be a source of inefficiency: borrowing restraints will continue to limit managers' freedom to determine the optimal size of their investment programmes. District managed hospitals will still have their investment funds allocated by regions within an overall programme total. Self governing hospitals will face an annual financing limit set each year by the Secretary of State as part of the public expenditure planning process. The fear must be that an undercapitalised service will still be restricted by a public expenditure policy which owes more to macroeconomic objectives than to the needs of the health service. Private hospitals, of course, will not be similarly constrained.

An important feature of a competitive market is that firms should be free to expand and contract. New firms appear and successful firms expand, while unsuccessful firms contract and sometimes go out of business. But this could be an expensive process for the NHS. New investment would be required in those hospitals gaining patients while excess capacity existed elsewhere. Unlike the successful private firm, which does not have to bear the costs of its rivals' unused capacity, it would clearly be wasteful for the NHS to add to capacity at some hospitals while it was left idle elsewhere.

Consumer choice

More patient choice is a theme that runs throughout the white paper. Markets are an established mechanism for providing choice. How far will the new health care market meet this aim? There should be more diversity in the supply of services, with general practitioners acting as budget holders. The removal of obstacles to changing a general practitioner will also enhance the patients' choice. General practitioner budget holders who purchase hospital services directly on behalf of their patients will have more choice. Better information systems should enable general practitioners to select hospitals where waiting times are shorter. All these changes offer genuine scope for greater responsiveness to patients' preferences. For

core hospital services, however, the impact of the white paper's proposals is less clear.

Districts as purchasing agencies will be responsible for determining where service contracts are placed. The white paper states that they will need to "take account of" general practitioners' existing referral patterns and "discuss... the possibility of changing those patterns." Without knowledge of existing referral patterns it is impossible to say how much change will be necessary. But the need to ensure that referrals are consistent with district service contracts is clearly a potential source of restriction on general practitioners' existing freedom of referral. At the very least this will require some extremely delicate negotiations.

Managing clinical activity

In a free market managers set their firm's objectives in terms of profitability, sales revenue, growth targets, and other financial variables. It is competition between rival firms pursuing similar objectives that produces an efficient allocation of resources. The division of responsibilities within a hospital makes it far less easy to ensure that everyone works towards a common objective.³ The link between the management's financial objectives and the activities of clinicians is particularly problematic.

The white paper is a tantalising document. It offers the prospect for major improvements in the way that health finances are used and services delivered. It specifies the broad strategies of decentralisation and competition that the government believes will bring about these improvements. But there are many pitfalls. Much will depend on the way that the strategy is implemented. In particular, potential conflicts among the pursuit of cost efficiency, equity, and the quality of care will require careful attention.

The white paper proposes the delegation of more authority to hospital managers. They will be responsible for gaining service contracts from purchasers by offering cost effective services that patients actually want. Their funding will depend on their success in attracting business. But while managers will have overall responsibility for financial performance consultants will continue to make clinical decisions that determine the way money is actually spent. They will also have the ultimate responsibility for meeting any changes in workloads—upwards or downwards—resulting from service contracts.

It has, of course, been the recognition of the clinician's pivotal role in committing expenditure that has led to successive attempts to persuade them to participate formally in decisions about the use of resources. The resource management initiative is the latest attempt to encourage further participation of doctors and nurses in management. The government intends to extend the resource management initiative to 20 short stay hospital sites by the end of 1989, with the aim of building up to 260 units by the end of 1991-2. Is this ambitious timetable feasible?

Despite the considerable enthusiasm displayed by some of the participants at the resource management sites, one recent research study concluded that general experience of including clinicians in budgetary decisions was disappointing: neither managers nor doctors have shown much enthusiasm.⁴ This does not augur well for plans to extend the initiative nationwide over such a short period, especially as the additional complication of workload funding will be added to the existing difficulties with which the initiative is having

to grapple. Moreover, it is also of concern that the decision to extend the initiative has been taken before the Department of Health's evaluation of it—by a team at Brunel University—has been completed. The final report is not due until towards the end of 1989.

Access to health care

While competition may yield efficiency gains there is always a danger that without safeguards these will be achieved at the expense of a loss of equity.

Services offering clear revenue earning potential will become more attractive. Many health promotion and screening services—primarily aimed at the affluent, worried well—are likely to fall into this category. Similarly, it will be easy to draw up service contracts for well defined, short stay, minor elective surgery. Providing long term care for the mentally ill and handicapped, the chronically sick, or for elderly people suffering from dementia may hold less attraction as a source of revenue.

Access to services will also be influenced by the location of services resulting from the competitive process. If competition leads to greater specialisation and the concentration of services at fewer sites there will be greater need for some patients to travel further for treatment. This might penalise less mobile people and their families. Continuity of care after hospital discharge for those patients treated outside their home districts may also be a problem. Liaison between hospitals and local general practitioners, social service departments, and community services is already a cause of concern. Treatment at a distance might exacerbate these difficulties.

- 1 Secretaries of State for Health, Wales, Northern Ireland, and Scotland. *Working for patients*. London: HMSO, 1989. (Cmd 555.)
- 2 Enthoven AC. *Reflections on the management of the National Health Service*. London: Nuffield Provincial Hospitals Trust, 1985.
- 3 McGuire A, Henderson J, Mooney G. *The economics of health care*. London: Routledge and Kegan Paul, 1988.
- 4 Pollitt C, Harrison S, Hunter D, Marnoch G. The reluctant managers: clinicians and budgets in the NHS. *Finance Accountability and Management* 1988;213:33.

The illnesses of Elizabeth Barrett Browning

D A B Young

Although Elizabeth Barrett Browning, 1806-61, was famous in her own day as a poet, she is now remembered almost exclusively for her romance with Robert Browning. Their love story became known throughout the world in the 1930s in the celebrated film of Rudolph Besier's play *The Barretts of Wimpole Street*. In this Elizabeth, a fragile, chronic invalid, confined to her bedroom for eight years with a respiratory illness, defied both her condition and her father's tyrannical selfishness to elope with and marry a little known poet of limited means.

The romance of the elopement, however, depended entirely on the invalidism, for Miss Barrett was 40 years of age, had a private fortune, albeit a modest one, and was a successful writer. That in the remaining 15 years of her life she bore a child, had four miscarriages, travelled widely, and led a much more active and adventurous existence than she had done before, must lead to grave doubts about the genuineness of her illness. The traditional diagnosis of tuberculosis, which was not countenanced by her doctors, has little to support it.¹ Consequently many biographers have suggested one or more of the following as the explanation of her invalidism: hypochondria, frank malingering, opium addiction, and mental illness.

Before her marriage Elizabeth Barrett had two major periods of illness—1821-2 and 1837-46. Interestingly, all her biographers have linked the two illnesses, even if only to suggest that the second exploited the techniques of hysterical self deception perfected in the first. As the illnesses were quite different and lacked any exact diagnoses such linkage without justification is unwarranted. But the real difficulty about Miss Barrett's second illness is that for a non-tubercular respiratory condition to have so dominated a young person's life for eight years there must have been an additional disablement. I believe that the first illness holds the key to the problem.

Our information regarding the first illness has two different components, which have been difficult to reconcile—namely, information about an accident and about a sickness. The former concerns an accident that Elizabeth had while saddling her pony. According to

her son Pen Browning, the spinal injury, not suspected at first, was caused by a strain while tightening the pony's girths. This was essentially corroborated by her friend Lady Ritchie.²

The second component is two letters from doctors regarding a sickness rather than an injury.³ One letter from a Dr Carden, dated 8 May 1821, states that the symptoms of the "harassing malady" were considerably mitigated, and he recommended cold showers, more quinine, and as much exercise in the open air as possible ("and if the rides could be varied the advantage would be greater"). His letter also indicates that at least one other of the Barrett children was also affected ("a little more to the eldest and rather less to the youngest, of the volatile tincture of valerian"). A second and much more detailed letter from a Dr Coker, dated 24 June 1821, describes the "history and present symptoms" of the case:

It began with pain in the head, which continued at intervals for seven weeks—the pain then attacked various parts of the body, for a considerable period, and for the last month it has permanently seated itself on the right side, that is about the centre of the angle formed by the greatest projection of the ribs, the umbilicus and the anterior superior spinous process of the ischium [? ilium]. The pain commences here, is carried to the corresponding region of the back, up the side to the point of the right shoulder and down the arm. The suffering is agony—the paroxysms continue from a quarter of an hour upwards—accompanied by convulsive twitches of the muscles, in which the diaphragm is particularly concerned.

Three attacks a day

Although Miss Barrett remained conscious throughout, at the close of each attack, of which there were generally three a day (none at night), she was confused. The pain and weakness in the back prevented her sitting up without support. She was unable to lie on her right side, had the sensation of her side being swollen, and complained in the mornings that it felt as if a cord had been tied around her stomach. It seems that though opium had at first relieved the spasms it soon ceased to be effective.

Dr Coker could detect nothing obviously wrong

Downham Market, Norfolk
PE38 9ND
D A B Young, DPHIL,
formerly principal scientist,
Wellcome Foundation

Correspondence to: 23
Hillcrest, Downham
Market, Norfolk PE38
9ND.

Br Med J 1989;298:439-43