East Birmingham: the beast was fed

Tony Delamothe

"We fed the beast. We turned the money around. What difference has it made? Not a lot." Few people I spoke to would have dissented from this verdict on the reforms' first year, delivered by Dr Anne McConville, East Birmingham's director of public health. Despite predictions made six and 12 months ago that "something" would have happened by now (and the possibilities ranged from the dire to the paradisical)[1,2] the real action was once again being deferred until some time in the future.

The general election—two weeks away—overshadowed my visit. If the findings of local opinion polls had predicted the outcome of the election then Labour would have won, and trusts and fundholding practices would have disappeared overnight. East Birmingham Hospital's acute unit, due to become a trust from 1 April, would have enjoyed its new status for less than a fortnight.

Instead of concentrating minds wonderfully this threat of execution distracted them. Purchasing, providing, and fundholding had required prodigious effort. If they were to disappear without trace then never would so many people in the health service have worked so hard for so little.

Supporters and detractors of the reforms were unanimous that one year was too soon to judge whether they were working. "It would take at least another three years to decide," said Dr Rowland Hopkinson, East Birmingham Hospital's clinical director of anaesthetics and a supporter of his hospital's application for trust status. "Ultimately, they will be judged by the balance sheet." What can we learn from an early peek?

Turning the money around

Howard Shaw, East Birmingham's district general manager, said that his district would break even in the first year of the reforms. If it hadn't bailed out the acute unit, which had overspent, then it would have been in surplus. The district had to do this because the acute unit couldn't start its first year as a trust in debt.

Why had the acute unit run up debts, and what did this say about its long term financial viability as a trust? Robert Naylor, East Birmingham Hospital's unit general manager, said his unit had incurred unforeseen costs of £1·3m in 1991-2. Some £0·5m of this had come from overspending on drugs, owing to changing clinical practice. Budgets had been based on the clinical practice of 18 months previously: "Would you want us to go back to those?" asked Mr Naylor.

Most of the rest of the overspend was due to activity in excess of contracted levels, and negotiations were under way with purchasers to claw back some extra money for these. Mr Naylor knew that his district purchasers had saved money on their contracts, and he took a dim view of it: hadn't they a responsibility to end the year in balance?

What did this mean for the acute unit's future as a trust? For example, drug costs might continue their inexorable rise: could a trust "cap" its pharmacy costs? Block contracts with their generous tolerance levels had lost the acute unit money in 1991-2: Naylor was looking forward to moving to cost and volume and

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Turn right for the trust

cost per case contracts. Last year his unit's contract information system had bugs and its hospital information support system (HISS), which would ultimately cost every patient's treatment, had not been installed. Asked about how contracts were priced for 1992-3, Mr Naylor implied that they had resulted as much from a "major competitor analysis" as from detailed costings.

Howard Shaw said that in the first year of the reforms the purchasers' policy towards providers had been along the lines of "Here is a load of money; do the best you can." In year two, providers had priced their services considerably higher than in year one. (East Birmingham's acute unit had raised its prices by about £800 000.) Purchasers' budgets, however, had not increased, meaning that they could afford to contract for less. "It's beginning to bite now," said Shaw. "The government wants us to increase activity but if services cost more then the same amount of money will buy less."

With higher prices purchasers were contracting for fewer cases, which was having a knock on effect on providers. With the same fixed costs providers were having to increase their unit prices to take account of the fall in the number of cases—which meant that purchasers were reducing even further the number of cases that they would be contracting for. This vicious circle had not been broken by late March. Originally, contracts were meant to have been finalised by 1 April, but the deadline has drifted into May.

Blood on the drawing boards

Howard Shaw was resigned to accepting providers' prices: "We can't negotiate special deals; providers have to charge the same price for all." His director of corporate management, Mrs Wai-Yin Hatton, wasn't so sure. Faced with a 25% increase in some providers' costs she was sending contracts "back to the drawing boards." Her reasons were as follows. Activity levels for 1991-2 looked like being down on the predictions made from the 1989-90 data. A fall in activity combined

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with an increase in prices suggested inefficiency to her: "We're being asked to carry their surplus capacity." By putting a foot down about price hikes purchasers could help management to make the painful but necessary decisions to minimise waste, she thought.

Presumably East Birmingham was intending to use up some of its surplus capacity by selling services at marginal cost. Its application for trust status had noted the "further opportunities for the Trust to agree additional contracts with other Birmingham health authorities at marginal costs." Mrs Hatton was likely to be even less happy about the price increases if she found out that some of them were due to her shouldering a higher proportion of East Birmingham's fixed costs.

Most contracts between district purchasers and providers in 1992-3 will be based on average cost per case for each specialty—as they had been in 1991-2. According to Howard Shaw, most providers still couldn't say on what mix of major, intermediate, and minor cases these average costs were based.

By contrast, fundholding general practices had been provided with much more detailed information: at Craig Croft Medical Centre Dr Ken Dawson had individual prices from each provider for 113 non-emergency procedures, outpatient appointments, diagnostic tests, and paramedical services. True, these were only interim prices, but Dr Dawson seemed unperturbed that he would be starting the new financial year before knowing the final costs of his contracts. The interim figures suggested a levelling out of the wide variations in providers' prices compared with 1991-2.

As it happened price hadn't been much of an issue in determining where his practice referred patients in its first year of fundholding. It hadn't shopped around for the cheapest price; its main priority had been to get waiting lists down. The practice had been successful in doing so, even using the private sector on two occasions when there was no other way of getting patients operated on quickly. (Dr Dawson said that it had been no more expensive than using an NHS hospital.) Their hospital budget for 1991-2 had been £698 000, and until the practice had been audited by the Audit Commission he wouldn't know how much of this they would have saved. (He didn't think it would be much.) There had been no change in activity levels over the previous year. For 1992-3 the region had increased his practice's budget for hospital services to £702 000; Dr Dawson seemed happy with this minimal increase.

The big change between 1991-2 and 1992-3 was in the practice's contract for pathology services. In 1991-2 they moved them from East Birmingham Hospital to Solihull. This year they were returning to East Birmingham, which had dropped its price from £42 000 a year to a staggering £14 000 for the same level of activity. The practice had decided to shop around and had even checked out private providers before coming to its decision. All providers had offered daily collection of specimens and equally quick turn around.

Craig Croft Medical Centre

Mission statement

To build on the experience of year one to improve the quantity and quality of care available to our patients.

Objectives

Primary care:

To implement all aspects of the patient's charter relevant to primary care

To increase the quantity of inhouse investigations, consultant clinics, and treatments available

To implement medical audit to monitor and improve the quality of care provided

To consider introducing a practice formulary

Secondary care:

To implement all aspects of the patient's charter relevant to general practice fundholding

To ensure that by 31 March 1993 no patient will have been on a hospital inpatient waiting list for more than one year

To increase the quantity of day case surgery where appropriate

To focus referrals away from block contracts to more flexible cost per case (or more accurately, zero volume cost and volume) contracts

Forecasts

Year three:

Closer links with district health authority (purchasing) regarding district standards

Scope of fund increased to include primary care nursing

Continued progress in shortening waiting lists

Year five:

All practices fundholding; smaller practices in consortia with outside management, either family health services authority or agency

District health authorities and family health services authorities merge

District health authority has overall control of strategic long term planning, to balance increasing influence of fundholders on short term service provision

Quality

For the Craig Croft practice the greatest achievement as fundholders had been to collaborate with Solihull's district purchasers in drawing up the quality specifications for their contracts. There was a "gentleman's agreement" that providers would offer the same quality specifications to fundholders as they did to district purchasers, and the practitioners were glad that their opinions were being taken into account. Quality standards include specifications about outpatients being seen by a consultant on their first appointment and how many days' supply of drugs inpatients should be sent home with.

For district purchasers, monitoring contracts for quality has taken a back seat as everyone has struggled to "turn the money around." "In terms of quality, providers are just hitting a minimum standard," said Mrs Hatton. Issues of quality would gradually attract more attention: by 1993-4 she expected much more information on outcome.

A spokeswoman for East Birmingham Community Health Council was sceptical about quality specifications. "I know East Birmingham has a wonderful discharge policy—we helped to draw it up. But there are horrendous problems of discharge from the acute unit, which relate to the inadequate support services in the community."

What it's all for anyway?

Turning the money around without serious mishap and maintaining rudimentary standards of quality are laudable achievements, but by themselves they hardly seem to justify the reforms. Dr Elwyn Elias, vice-chairman of the Birmingham Consultants for the Rescue of the NHS since its inception, views the reforms as an alien structure that an army of bureaucrats was superimposing on to what everyone was doing routinely. "We're stuck now with a system that wants to itemise and cost everything and play shop—a terrible waste of resources—while we carry on as before, responding to clinical need," said Dr Elias.

"A petty little example" crystallises Dr Elias's objections to a system "where money calls the shots." He was rung by a doctor from Cardiff about transferring a patient to his care. "Our management, however, refuses to accept a transfer unless we get prior agreement from the patient's health authority to pay. That means I can't take a patient until I've rung up the

guy with the cheque book. My heart sinks that we're moving to that: you can't treat someone until you can find someone to pay the bill. It will destroy the ethos of the NHS."

The market system was imposed to get rid of waste, yet the cost of imposing the market was likely to be several times greater than any supposed savings, he said. He agreed that doctors should be aware of the costs of what they do—"but we never objected to resource management—which was ensuring value for money—or medical audit—which was ensuring the best outcome: we were doing both of these before the reforms, anyway." Dr Rowland Hopkinson, a supporter of his hospital's bid for trust status, agreed: "All this might have been achieved by resource management—without the politicking."

In Dr Elias's opinion the NHS's problem was not waste but underfunding of its marginal costs. "The government had proved that this year with its waiting list initiative, which was funding for marginal costs by a different name."

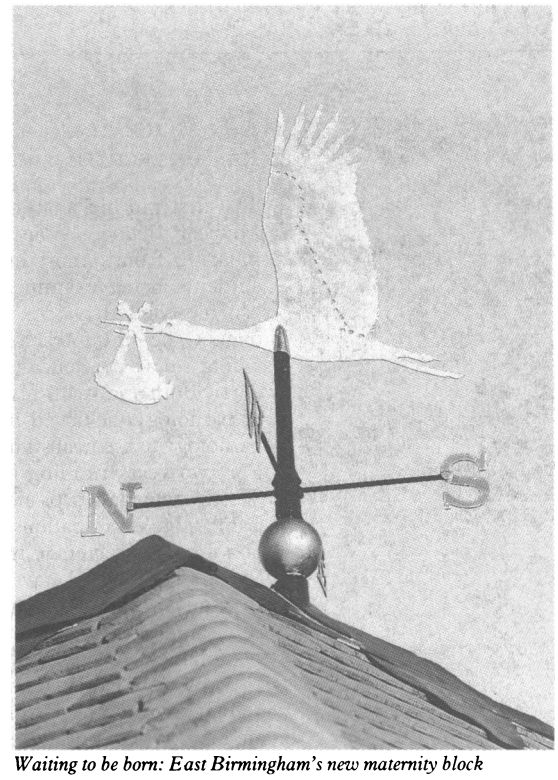
Birmingham had shown that you couldn't just let market forces rip: a certain amount of centralised planning was necessary. Predating the NHS reforms was the attempt to rationalise Birmingham's hospital services, "Building a Healthy Birmingham," which entailed the closure of many of Birmingham's hospitals. Self governing status looked like a lifeline for those hospitals threatened with closure, but the region had apparently decreed that none of them could apply to become trusts. (Its line seems to have softened recently with East Birmingham's application for trust status.) Commissioning Tomlinson to provide a strategic view of London's health care needs provided further proof that the market could not be left to itself to determine provision.

Competition, the engine that was meant to drive the reforms, requires surplus capacity and competing providers. Birmingham and London had these in abundance: if the rules of the game needed altering where they had the best chance of working then, Dr Elias wondered, why should they work unaltered elsewhere?

Futures

Even before the election results were known it was becoming increasingly difficult to think of the health service without the purchaser-provider split. In the year since I first talked to him Mr Alan Torbet, general manager of the Birmingham Family Health Services Authority, had been working on the consequences of this split for primary health care. West Midlands region and Birmingham City Council had jointly commissioned the authority to develop a primary health care strategy for the city. ("Building a Healthy Birmingham" had been limited mainly to secondary health care.) "We can't assume that four different purchasing plans [those of north, south, east, and west Birmingham district health authorities] are going to provide the best result for the city," said Mr Torbet. As well as representing the main providers of primary health care services the FHSA is the main purchaser of these services: it holds the purse strings. (Even fundholders remain contracted to the FHSA to provide primary health care services.)

In the past year his authority had pioneered two locality management sites. The plan was to appoint a primary care manager, accountable to primary care providers, for every 100 000 people. These managers could generate relatively robust information about the secondary care needs of their population. "Currently, there is no happy mechanism for translating information from the micro to the macro level," said Mr Torbet. Aggregated information on the pattern of general practitioner referrals could be used to draw up the district's purchasing plans; integrating the primary and secondary purchasing function would make sense, he said.



EAST BIRMINGHAM HOSPITAL NHS TRUST

Waiting to be born: East Birmingham's new maternity block

Coincidentally, the fundholding Craig Croft practice also envisaged the future amalgamation of the district health authority and the FHSA (box). But when last month I spoke to Dr Dawson, one of Craig Croft's partners, he was preoccupied with the likely demise of fundholding. He needn't have worried: the new government has said that it will continue.

Would it matter if fundholding had been abolished—as long as the split between purchasers and providers remained? The advantages of fundholding don't depend on its survival. The right to refer a patient wherever his or her general practitioner likes merely re-establishes the status quo before the reforms. And having general practitioners helping to draw up quality standards for secondary care doesn't require fundholding: Mr Torbet's locality managers, advised by general practitioners, could do the job. They could also advise purchasers of secondary services where to place contracts to reflect general practitioners' wishes.

For this to work, however, requires the continuing separation of purchasers from providers. The enduring legacy of the government's reforms may well be to make anything other than this separation unthinkable.

1 Delamothe T. East Birmingham: the great bureaucratic square dance begins. *BMJ* 1991;302:714-8.
2 Delamothe T. East Birmingham: running faster on the spot. *BMJ* 1991;303:842-4.

Correction

European research: back to pre-eminence?

An editorial error occurred in table I of this article by Richard Smith (4 April, pp 899-903). The totals at the bottom of the columns for France, Germany, Switzerland, and the United States should be 24, 61, 13, and 165 respectively.