Incentives to efficiency in NHS management

An American view

The Nuffield Provincial Hospitals Trust has just published *Reflections on the Management of the National Health Service. An American looks at incentives to efficiency in health services management* (Occasional Papers 5, price £4·25 including postage). Written by Professor Alain Enthoven from Stanford University, former Rhodes Scholar and one of America's leading experts on the economics of health care, the monograph is based on a prolonged study of the NHS carried out while he was a fellow at St Catherine's College, Oxford. His visit was founded by the Nuffield Provincial Hospitals Trust.

Professor Enthoven's summary of his essay is published in full here. A leading article is at p 992.

This essay is meant to be a sympathetic review of some problems of organisation and management in the National Health Service, with particular focus on incentives for efficiency and innovation.

The NHS enjoys widespread support in Britain, and it produces a great deal of care for the money spent. But given the tight limits under which it must operate, the NHS will find it increasingly difficult to meet the demands placed upon it. The NHS will need to find ways to produce even more value for money if it is to make effective new medical technology available to all who can benefit from it at the standards enjoyed in other industrialised democracies.

Gridlock of forces

The NHS is caught in a "gridlock" of forces that make change exceedingly difficult to bring about. Public policy should seek to create an environment for the NHS that is hospitable to quality improving and efficiency improving change. Opportunities for constructive change should be nurtured, not politicised or otherwise abused.

The NHS runs on the ability and dedication of the many people who work in it. But its structure contains no serious incentives to guide the NHS in the direction of better quality care and service at reduced cost. In fact, the structure of the NHS contains perverse incentives.

The Griffiths NHS Management Inquiry recommended establishment of a Health Services Supervisory Board to set policy and a full time management board to supervise implementation and control performance. It also recommended that general managers be identified at authority and unit levels. Both seem to me to be very sensible ideas. But if the structure and incentives in the NHS are not changed more fundamentally these changes are likely to be little more than cosmetic.

A decree requiring all authorities to implement general managers is an unlikely way to bring about real change. The idea of general managers would have had a greater likelihood of success if it had first been developed and tested in a few interested pilot districts. National uniformity should not be a requirement in such organisational matters.

Competitive tendering from commercial contractors for catering, cleaning, and laundry services could yield significant financial savings. Competitive tendering can be the entering wedge for a great deal of management improvement.

Again, a circular directing all districts to submit programmes is not the best way to go about implementing this good idea. Better to begin with a dozen pilot districts whose managements are enthusiastic about the idea, develop and test it with the benefit of expert advice, then push it to the maximum in the pilot districts, and display the benefits for all to see.

NHS purchasing of acute care services from the private sector now appears to be a matter of "targets of opportunity." The NHS doesn't know its own costs so it isn't able to recognise a good deal when it sees one. Cost finding systems ought to be developed. The NHS ought to be willing to buy acute care services from the private sector when it can get them at a lower price than the internal cost of providing the services. The NHS could become more of a discerning purchaser of services from competing private suppliers and thereby realise some of the benefits of efficiency and innovation that competition in the private sector offers.

The NHS could benefit from making much greater use of demonstration projects. As described to me, the "clinical budgeting" experiments are too narrow in scope and not likely to change things significantly. We do many demonstration projects in the United States, and we learn a great deal from them.

Regional and district medical officers are drawn from community medicine. They are not trained for management and their background is not the best for persons expected to give leadership to the consultants. Medical leadership might be strengthened by giving postgraduate management training to selected consultants and by finding ways to make careers in top level management attractive to them.

Despite the efforts to implement the recommendations of the Resource Allocation Working Party (RAWP), many inequalities of access and spending persist. Moves toward equalisation are inhibited by the difficulty of closing facilities in the better-served areas. RAWP has been interpreted in a way that implicitly equates spending in a district with spending for services for the people in a district. As a consequence, the only way to equalise the latter is to attempt to equalise the former. But that is hard to do because of all the difficulties in shutting down hospitals. I suggest dropping the implicit assumption that people must get all their services in their own district, equalising the need-adjusted per capita spending on the people in each district by appropriating the funds to the district health authority, and letting districts buy services from other districts as needed. Among other things, this might let the London teaching hospitals compete for referrals from other districts rather than face being ground down by the relentless application of the RAWP formula.

Internal market model

This line of thinking could lead to an "internal market model" for the NHS. Each district would receive a RAWP based per capita revenue and capital allowance. It would continue to be responsible to provide and pay for comprehensive care for its own resident population, but not for care for other people without current compensation at negotiated prices. Each district would resemble a nationalised company. It would buy and sell services from and to other districts and trade with the private sector. In such a scheme, district managers would be freed to use all their resources most efficiently. Some perverse incentives would be eliminated. But the main defect in this model is a lack of powerful incentives for NHS personnel to serve patients as efficiently as possible.

In the appendix, I discuss health maintenance organisations and the evolving consumer choice model in the United States of America.

The dominant system of health care organisation and finance in the USA is still solo practice, fee for service payment to doctors, fee for service or cost-reimbursement for hospitals, and insured

(continued at p 1068)

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administrative and clerical staff employed in the NHS. Most of this increase has been among medical secretaries and ward clerks who work in patient related areas—such staff constitute half the total administrative and clerical workforce—and who release doctors, nurses, and other professional staff from routine administrative duties, thus enabling them to devote more time to patient care.

1 National Association of Health Authorities in England and Wales. *Too much bureaucracy in the NHS? NAHA's response to the critics*. Birmingham: National Association of Health Authorities in England and Wales, 1985.

Hospital accommodation: BMA seeks meeting with ministers

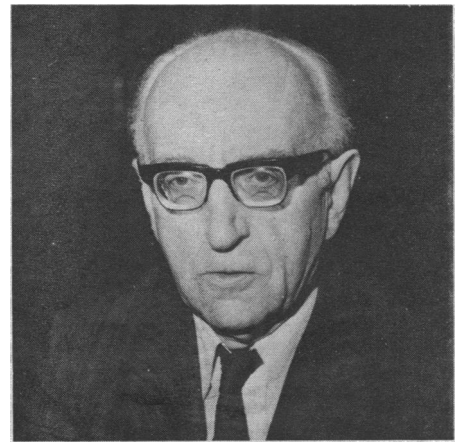
The secretary of the BMA has written to the Secretary of State for Social Services about the standards of hospital accommodation for junior staff and the fact that the NHS Management Board had refused to issue central guidance to authorities on the subject. Dr John Havard's letter is set out here.

"Earlier this week the council of this association debated the issue of standards of accommodation at the urgent request of the Hospital Junior Staff Committee. The HJSC was dismayed by your letter of 5 August refusing to intervene with the management board over the issue of guidance to authorities on standards of accommodation. The juniors were further angered by the apparent refusal of Mr Victor Paige to recognise a small amendment to this guidance, which we believed had been agreed earlier in these proceedings.

"The junior doctors are convinced that the matter of accommodation is a contractual one and is a proper subject for central guidance. They are required as part of their contract to live in hospital when on call and therefore the standards of 'hotel' accommodation provided for them is part of their contract. The need for central guidance on standards is illustrated by the specific case, which gave rise to the debate: the accommodation in the hospital concerned had leaking windows, damp, dangerous wiring, was not cleaned properly, and 20 doctors shared a single bathroom. When the cleaning contract was put out to tender the specification did not mention provision for laundry with the result that the juniors on call were instructed that they could collect bed linen only between 9 30 and 10 30 am on a single day each week. In this case I understand that the authority has been persuaded partially to ameliorate these conditions but only after eight weeks of pressure from the junior doctors' representative in the hospital who has had to devote herself virtually full time to this problem at the expense of her commitment to patients. I cite this case merely as an illustration of the need for central guidance.

"At its meeting on Wednesday council accepted in principle that authorities in breach of the accommodation standards, which the BMA deems to be acceptable, should be included in the Important Notice section of the *BMJ*. I have no doubt that we shall soon be asked to include a number of authorities in this category. If the number becomes great I am sure that council will be asked to reconsider the situation and to authorise junior doctors to refuse to live in hospital when on call.

"In view of all this we ask you once again to reverse your decision not to issue agreed guidance. May I also ask you to meet a small deputation from the HJSC so that we can put to you the frustration and anger of their constituents. Please let me have your response as soon as possible."



Sir Douglas Black, former president of the BMA, has accepted an invitation to chair the board of science and education. At its meeting on 2 October the council paid a warm tribute to his predecessor, Professor Peter Quilliam, who has been chairman since 1982.

NHS Management Board completed

Mr Len Peach has been appointed director of personnel on the NHS Management Board from 4 November. Mr Peach is being seconded for three years from his present post as director of personnel and corporate affairs with IBM (UK) to take up his new appointment at deputy secretary level in the Department of Health.

Advertising: CHCs' comments

The Association of Community Health Councils for England and Wales has responded to the request from the General Medical Council for comments on the guidance that is offered to the medical profession on advertising. An extract from the association's comments is set out here.

"We fully recognise and support the limitations placed on advertising, as it is generally understood in the council's guidance to the medical profession. However, there is a clear distinction between advertising for gain or professional advantage and providing information about medical practices, which would be helpful to the public and patients in choosing and using the practice most able to deal with particular needs. Widely available, regularly updated, information is needed on the conditions and procedures in practices, including appointments systems, ancillary facilities and staff, deputising arrangements, etc; specialisms; the background and experience, sex and age of the practitioner; prescribing facilities either within the practice or among local chemists; policies and preferences in relation to special needs (women, elderly people, ablebodied and handicapped children, homeless people, mentally ill people, etc); availability of contraceptive advice and methods; whether registered for antenatal and on the list for home deliveries; availability of advice on drugs and alcohol problems; attitudes towards and facilities for health promotion, education, and prevention (including screening and health checks); access for disabled people and links with other agencies.

"Members of the public should have enough information to choose the practice with which they wish to register, subject to geographical proximity. They also need information if, for some reason, they should wish to make a change. Information on attitudes to visitors or temporary registration would also be useful.

"A major consideration would be how such information could be made properly available without stepping over the boundary between objective communication and the advertising referred to in your present guidance. The information could be made available in a published form."

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patients with a cost unconscious free choice of doctor. This system is the most important contributor to the rapid rate of increase in spending on health services that has now reached crisis proportions.

The main alternative to this system of organisation and finance are hospital maintenance organisations whose enrolled membership reached nearly 17 million Americans by the end of 1984, up 22% from a year earlier. A health maintenance organisation accepts responsibility for providing comprehensive health care services to a voluntarily enrolled population for a fixed periodic "capitation" payment set in advance. Comparative studies show that hospital maintenance organisations cut cost roughly 25% compared to fee for service. Even if Britain were never to adopt the hospital maintenance organisations idea, I believe the hospital maintenance organisations experience offers useful insights and examples for the NHS.

For example, when it is in the doctors' interests, they can do effective audit and control of quality and economy of care. Economic interest can even motivate doctors to expel poor performers from their group. In competition, doctors impose on themselves controls they would never dream of accepting if the government tried to impose them. Thus, "clinical freedom" is giving way to effective control of quality and cost-effectiveness.

I do not sense any serious demand for radical change in the structure of the NHS. However, if British policy makers were to seriously wish to examine a radically different scheme for health care, I would recommend the competing hospital maintenance organisation model as the most promising candidate.

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