Words from the source: an interview with Alain Enthoven

Richard Smith

Much of the thinking behind the government's review of the NHS originated with Professor Alain Enthoven, who is professor of public and private management at the Graduate School of Business, Stanford University, and one of America's leading experts on the economics of health care. In 1985 the Nuffield Provincial Hospitals Trust published a book he wrote on the NHS after visiting Britain and examining the service closely.¹ His main proposal was for an experimental internal market. We sent him copies of the NHS review and the working papers, and last week Richard Smith spoke to him in California.

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RS: What was your initial reaction on reading the white paper and the accompanying working papers?

AE: Generally very positive. I see several good ideas, but I also find it hard to understand just how the government's proposals would work in practice. I felt the need for diagrams and more explanation of how they would work. The details can be very important.

RS: And you didn't find that you got that in the working papers?

AE: No I was very surprised by the lack of detail. I would have expected definite and specific information on how this would work in practice.

RS: One of your reactions must have been that this is your own ideas being taken up?

AE: Yes, although I would have been pleased to see them worked out in more detail. I thought that I was throwing out a general idea that needed to be developed.

RS: Some people have suggested that it isn't for the government to provide detailed proposals. Rather it should set a direction and people in the health service could then work out the details for themselves. Do you agree?

AE: The government is asking a non-accountable industry to become accountable. It is attempting to introduce some competition into a non-competitive service. I think that it is asking too much for the government to expect the health service to do this itself without a good deal of direction from the government. Many important questions will have to be asked and answered in detail before such a scheme can be put into practice. For example, who decides, and on what criteria, whether a hospital can become a self governing trust? What happens if such a hospital and a health authority that depends on it cannot agree on prices? Perhaps the people in the health service can work out the details for themselves. But I would expect some of the questions to raise fundamental policy issues that the government will have to decide.

RS: And you think that must come from the government?

AE: Yes.

Strong and weak points

RS: What did you think were the strong points of the proposals?

AE: At the broadest level I thought that the NHS needs to separate the demand and the supply side: by that I mean that institutions independent of the production of the services have to be setting standards and priorities, measuring achievement, and seeking value for money. In my 1985 report I recommended that the district health authorities be recast as purchasers of services on behalf of the populations they serve, with choice of where and from whom they buy the services, rather than being cast as monopoly suppliers of services to the people in their districts. The NHS is allowed to set its own standards and measure its own achievement. How does anybody know whether it is performing as well as it should? Until now the NHS has been a monopoly—as if we at Stanford said to students, "You can set your own exams and grade them."

I see several important steps towards separating the demand and supply sides in the government's review. One is self governing hospitals. Another is the idea of a

mixed economy with private hospitals able to compete for NHS patients, as they do to a limited extent today. Another idea is that regions would all receive their main budget allocations on the basis of population, adjusted for age, morbidity, and the like with adjustments for cross boundary flows replaced by direct payments among regions. Thus their budgets would be based on estimated need, not on the services they produce.

Another very strong idea is that money follows patients. Today a hospital that does a great job of producing high quality care efficiently is likely to get more patients without correspondingly more money—not a very good incentive.

Greater delegation to the local level is a good idea.

Some experimentation with budget holding by general practitioners is an idea well worth exploring, though I have reservations about how the government proposes to do it.

Involving consultants in management responsibility is an important idea. Increasing the authority of district general managers over the appointment and rewarding of consultants in order to reward those who contribute most to maintaining and improving local services is an excellent idea.

The proposed scheme to charge districts for using capital assets—therefore rewarding those that use capital most efficiently—represents a major step in the direction of economic efficiency. The proposals to strengthen medical audit are also important and valuable.

If I were British I would certainly applaud “appointment systems which give people individual appointment times that they can rely on” and “clear and sensitive explanations of what is happening.”

In short the review sets forth many good ideas that definitely ought to be part of a reformed NHS.

RS: So you see lots of strong points. What about weak points?

AE: The main weak point must be the lack of specificity about how the good ideas will be put together in a working system.

RS: Were there no specific points that made you think “My goodness!”?

AE: The only thing like that was the proposal of tax relief for private health insurance. My reaction to that is “watch out.” That has been a disaster for us in the United States.

RS: Why?

AE: Because it costs the federal budget a great deal of money—about \$40 billion a year—and works to encourage the choice of a more costly rather than a less costly health scheme. And most of the money goes to people with high incomes, who don’t need an incentive to buy enough health insurance, rather than to people on lower incomes who do.

Self governing hospitals and general practitioner budgets

RS: Two central proposals in the review are that hospitals should become self governing and that large general practices should hold budgets. How do you react to these?

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AE: It is part of the separation of the demand and supply ideas. In my 1984 visit I saw Guy’s Hospital, a magnificent institution, being ground down by application of the RAWP (Resource Allocation Working Party) formula because there wasn’t enough demand for services in its own district. Meanwhile, patients in other districts not far away could have been well served by Guy’s. My feeling is “let Guy’s compete to serve them.” As a self governing NHS trust it will be free to do so.

“Society has legitimate concerns about the quality, economy, and efficiency of care, and if you don’t like the way the government is going about it then you should come up with better ideas.”

Letting hospitals negotiate their own pay scales will be a step forward. One district general manager told me that one of his main problems was keeping surgeons supplied with good secretaries. It can be a terrible waste of time for a surgeon to have to spend lots of time correcting and editing notes because he or she doesn’t have a good secretary. But the district included the headquarters of a great corporation that kept hiring the best secretaries for more money. The manager said he would have to obtain the personal approval of a minister in London to match the pay of the private sector. The process would doubtless have been matched by arguments about fairness: why should secretaries be paid more just because the private sector is offering them more money? The NHS pays a big price for overcentralisation.

I’m concerned, however, by the possibility of monopoly pricing—by which I mean that a hospital may feel that it can get away with charging much more than it may need to if it’s the only hospital within a convenient distance.

RS: How could that problem be overcome?

AE: One option would be to pay hospitals prospectively by diagnosis related groups as our Medicare programme does. That option should be looked at.

RS: What about budgets to general practitioners?

AE: It is an interesting idea, but I have reservations about the government’s proposals. Firstly, a practice with 11 000 patients is too small to support the management expertise that is needed to do a good job of purchasing hospital services. General practitioners haven’t been trained for that complex task. It would have been better to coalesce five or six such practices—to reach over 50 000 patients. I think, too, that it will be necessary to develop capitation fees that relate to the health risks of the patients. And 11 000 is too small for risk spreading.

General practitioner budgets would have been a good subject for a pilot project.

Objections from general practitioners

RS: General practitioners in Britain are one of the groups most unhappy with the government’s proposals. They worry that they will be pressurised to take on more patients, that they may have to work within cash limits, and that patients will be shunted around the country, making continuity of care very difficult. Do you sympathise with these worries?

AE: This makes me think of the worries of American doctors. I say to them that society has legitimate

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concerns about the quality, economy, and efficiency of care, and if you don't like the way that the government is going about it then you should come up with better ideas.

RS: That's a general response. What about the specific worries I've mentioned?

AE: I trust general practitioners to take sensible decisions and not take on more patients than they can handle. But there should be rewards for those who work harder and satisfy their patients. The problem of exceeding budgets is a complex management issue. I would presume that health authorities would not stop payment but rather encourage the overspending general practitioners to look at their practices and find ways to reduce cost.

RS: What about the problem of patients being shunted around from one end of the country to another?

AE: I think it's too easy to exaggerate the extent of being shunted around the country. For most people it would not mean going very far, and if it means having your operation done promptly by very skilled people then it may be a small price to pay to have to travel. People already travel for specialised services.

A two tier system?

RS: Some people in Britain are worried that these proposals might lead to a two tier system. Do you think that may happen?

AE: I think that Britain already has a system with various tiers in terms of quality of care and service, though they are not measured and documented. The reforms will not make it worse. Indeed, they might make it better. The main two tiers at the moment are the public and private services, and under the new proposals poorer people will have access to private hospitals. If the government's objectives are met service in the lower tier will improve.

RS: Another worry is that the proposals may be the prelude to full privatisation. Do you think that's likely?

AE: I don't think so at all. That is using extreme rhetoric to try and cloud some important issues of how to get more efficiency, innovation, and quality out of the system.

Information

RS: Let's talk about the problem of information. Much information that is not currently available will be needed to operate the new service. Do you think that generating the information will present serious problems of timing and expense?

AE: Management information is important, and the NHS must get on with producing it. My impression in 1985 was that there was a remarkable lack of information in the NHS. For instance, the NHS does not know the cost per case of a coronary artery bypass in one hospital compared with another or the risk adjusted mortality in one hospital versus another. Such information is important because there are wide variations in costing and mortality. One hospital may cost two or three times as much as another. Similarly mortality rates may vary widely. Here in California, for instance, risk adjusted mortality from open heart surgery varies

from 1% in the best hospitals to almost 18% in the worst.

RS: But such figures are hard to interpret.

AE: They are, but it's important to get on with it. Do the research that's needed to improve the systems. Quantified measures of outcome are definitely the way to go.

RS: But isn't this expensive. Will the information pay its way?

AE: If I thought I was going to need a bypass graft operation in California information on risk adjusted mortality at different hospitals would be worth a lot to me.

One cannot prove that systematic collection and analysis of data on quality and cost is worth the money. But I notice that every successful company in a competitive service or manufacturing business finds it worthwhile. There isn't one that doesn't do it. Why should the health service be different?

Florence Nightingale called for such information over 100 years ago. Modern information technology is making it practical to collect it.

Pilot studies, timing, and outcome

RS: You made great play in your book of the importance of pilot studies, but the government has decided against such studies. How do you react to that?

AE: I think it's a mistake. Demonstration projects are a very good idea. Proposed innovations should be developed locally with people who are keen to try them. The bugs can be ironed out, and then others can be brought in and shown how well the system works and encouraged to participate. I cannot understand why the government did not choose to test these very promising ideas in a series of pilot projects. Health care is an institution that is very difficult to change. There is much uncertainty, and so much is at stake. So people are reluctant to change. That reluctance may be broken down by successful pilot projects.

RS: The government plans to have this system up and running by 1991. Does that seem to you a realistic timetable?

AE: Considering the large changes that will have to be made—in information systems and culture—that's an amazing speed. Health care just doesn't change that fast.

RS: Finally, the government said in its white paper that it had two main aims—to give patients better health care and greater choice of services, and to achieve greater satisfaction for those working in the NHS who successfully respond to local needs and preferences. Do you think that it will achieve those aims?

AE: A more decentralised flexible model with more consumer choice and accountability could lead to these goals. Somewhere in the government's territory defined by the proposals there is room to achieve those goals, but I don't understand fully how the scheme is going to work and I think progress will take time, development of systems and expertise, and cultural change in the health service. Don't look for some big improvement overnight.

1 Enthoven A. *Reflections on management of the National Health Service*. London: Nuffield Provincial Hospitals Trust, 1985.

The *BMJ* has collected together this interview and the other commissioned articles on the NHS Review and will publish them in book form on 8 May. *The NHS Review—What it Means* will be sent to all representatives attending the BMA's special representative meeting on 17 May. It is available to others from the Publishing Department, British Medical Journal, BMA House, Tavistock Square, London WC1H 9JR (price £4.50 (£4 to BMA members)).