HOUSE OF COMMONS LIBRARY

THE NHS REFORMS - THE DEVELOPING AGENDA

Research Paper 93/109 29 November 1993

C O N T E N T S

Keith Cuninghame

Health services & medicine

Background Paper

289	Breast cancer: treatment & screening	03.06.92

Research Note

92/108	Selected list prescribing	15.12.92
92/81	Health of the Nation	Oct 1992
92/67	Dentists pay - The current dispute	29.06.92
92/51	Animal experiments	04.06.92
92/43	Europe - The next phase: Health moves up the agenda	14.05.92

Research Paper

93/69	Euthanasia	21.06.93
93/66	Gene therapy	14.06.93
93/53	Community pharmacists remuneration in England & Wales: Background to current dispute	26.04.93
93/49	Prioritising health: The debate about health care rationing	16.04.93
93/1	The Osteopaths Bill 1992/93	01.01.93

INTRODUCTION

The NHS Reforms which separated the `purchasers' of healthcare from the `providers' and created an internal market were introduced in April 1991 and continue to be highly controversial. In recent months, however, the agenda has evolved with new issues developing. This Research Paper begins by summarising the key elements of the reforms in a largely descriptive way before going on to examine the key issues in the evolving debate about them. It largely replaces Research Note 92/17 *The NHS Reforms: An Interim Report* but for those seeking more information on the arguments about the reforms around and immediately after the time of their introduction that paper would still be relevant. Specific examples quoted relate to England but similar arguments apply throughout the UK.

THE KEY ELEMENTS OF THE REFORMS

The current reforms of the NHS were set in train by the White Paper *Working for Patients*[1] published in January 1989. That White Paper was itself the result of the Government's review of the NHS instituted a year earlier at a time of great concern about NHS funding. The detail of the policies evolved in numerous subsequent documents and the necessary legislative provisions were contained in the National Health Service and Community Care Act 1990. Box 1 sets out the main elements of the reforms.

Box 1	The NHS Reforms: A Headline Summary
●	"Purchasers" and "providers" of health care are separated. Purchasers (mainly DHAs, but also FHSAs and fundholding GPs) use the funding they are allocated to buy health care from providers who are now mainly NHS Trusts but some "directly managed units" remain. They can also purchase from the Private Sector.
●	DHAs are allocated funds on the basis of a "weighted capitation" formula.
●	DHAs have the role of assessing the health needs of their local population and taking action to improve their health status.
●	The link between purchaser and provider is mainly through the contracting process or the "internal market", although some patients are treated as "extra-contractual referrals" (ECRs) either because they are emergency cases or because the DHA has agreed to a one off referral.
●	Providers are now mostly NHS Trusts, directly answerable to the Department of Health with no management accountability to DHAs or RHAs, but accountable for fulfilling the details of their contract specifications. Over 90% of provision are likely to be Trusts from April 1994, compared to about two-thirds currently.
●	FHSAs have a more proactive role in relation to GPs and other family practitioners especially under the terms of the new GP contract, introduced in April 1990.
●	Larger GP practices can become "fundholders" and given a budget to cover some of the hospital services their patients need together with community nursing services. 25% of the population are currently covered by fundholding practices.
●	GPs have indicative drug budgets.
●	The **Health of the Nation** initiative and the **Patients' Charter** place additional responsibilities on the NHS.

[1] HEALTH Dept of. Working for Patients. Cm 555 Jan 1989.

The Purchaser/Provider split

Central to the changes is the separation of the assessment of health need from the delivery of health care. The principle of this aspect of the reforms has gained quite widespread acceptance. Both the Labour Party and the Liberal-Democrats supported it at the last election, though they did not support the method of achieving it through the internal market. There are seen to be advantages in having the assessment of the health needs of the local population done at one remove from pressures from the providers of healthcare who may have their own agendas to push. They are in a position to take a wider view of health policy and are encouraged to form "healthy alliances" with other organisations. They can also monitor the work of providers from a detached point of view. As David Hunter of the Nuffield Institute for Health Service Studies at the University of Leeds puts it: "Though they may be loath to admit it, there is the potential for much common ground on large tracts of health policy that is being fashioned" and that "With a new found commitment to the purchasing role and to the opportunities it allows to think about health in holistic terms, this part of the change agenda is rapidly becoming the centrepiece of the reforms"[2]. This aspect of the reforms also needs to be seen in the context of the *Health of the Nation* White Paper[3] which sets out targets to be achieved in a number of `key areas' and generally seeks a reorientation of health policy more in the direction of disease prevention and health lifestyles.

NHS Contracts and the Internal Market

If separating the commissioning of health care from its operational provision has won broad acceptance the same is not true of the Government's means of operating that separation, through the contracting system of "internal market", which has remained one of the most controversial aspects of the reforms.

Having assessed the health needs of their local population DHAs (and, for the services covered by their budgets, GP fundholders) place contracts to meet those needs, or alternatively make one off "extra-contractual referrals".

Contracts can be of various types. At their simplest, block contracts define a level of service and facilities to be provided. More sophisticated contracts can build in more specific service levels and contracts can also be used as a vehicle for setting out quality standards and getting the best value for money. Critics, though see the process as being at the heart of the "commercialisation" of the NHS and fear that cheapness rather than quality will become the determining factors in letting contracts.

---

[2] HUNTER David. Time for Action, Health Service Journal 27.6.91

[3] HEALTH Dept of. The Health of the Nation. Cm 1986, July 1992

National Health Service Trusts

NHS Trusts (originally known as `self governing hospitals' and often called `opted out hospitals' by their critics) are rapidly becoming the normal managerial arrangement for the delivery of health care. Virginia Bottomley recently said that from April 1994 "90 per cent of acute and community health services will be provided by NHS Trusts". The current figure is about two-thirds[4].

Like any other NHS provider, Trusts depend for their survival on contracts placed with them by District Health Authorities and fundholding GPs. They are run by Boards of Directors comprising a Chairman appointed by the Secretary of State, five non-executive directors of whom two are appointed by RHAs and three by the Secretary of State and five executive directors. They have the freedom to:

- acquire, own and dispose of assets;
- bid for capital directly to the NHSME;
- borrow money within limits set annually;
- create their own management structure;
- employ their own staff and set their own terms and conditions of employment.

Trusts have been one of the most controversial aspects of the reforms. Despite assurances from ministers that they remain fully in the NHS fears have been expressed that their lack of local accountability make them at least part of the way towards being in the private sector. As Trusts have become the norm for health care provision the arguments of principal over their establishment have become less fierce. The principle of developing decision making to hospital level is widely accepted and indeed it has been part of the rhetoric of NHS reforms for at least two decades.

In one sense it is relatively unimportant whether a unit becomes a Trust since all units, Trusts or not, depend on successfully attracting contracts in order to survive. Some doubt has also been cast on how able Trusts are in practice to exercise their freedoms. They may be tied down by the nature of their contracts with District health Authorities and limited in their freedom of action by their managerial accountability to the NHSME. Most opponents of Trusts, however, support the principle of greater devolution of decision making to individual hospitals and units.

Role of Family Health Service Authorities (FHSAs)

The old Family Practitioner Committees which were transformed into Family Health Service Authorities by the NHS and Community Care Act 1990 were often dismissed as bodies which

---

[4] BOTTOMLEY Virginia. Virginia Bottomley announces 99 new NHS Trusts. DOH press notice H93/985

had limited functions other than to provide "pay and rations" for general practitioners and the other family practitioners under contract to them.

The 1990 Act sought to give them a wider role by:

- integrating them more into the NHS management structure, involving
- giving them oversight of GP prescribing budgets;
- giving them greater control over ancillary staff employed by GPs;
- giving them responsibility for decisions on rural dispensing previously made by the Rural Dispensing Committee;
- giving them oversight of GP fundholders.

FHSAs have been encouraged to work closely with DHAs and following the statement by Mrs Bottomley on NHS management on 21 October 1993[5] legislation will be introduced to allow mergers of FHSAs and DHAs, and it is Government policy that such mergers should be encouraged.

General Practice Fundholding

The system for GP fundholding allows larger GP practices to apply to become fundholders and so be given a budget to cover some of the secondary health care costs incurred by their patients and some other costs (see Box 2). The scheme now covers about a quarter of the population and that figure is expected to rise to one third from April 1994 [Dr Mawhinney, HC Deb 26.10.93 col 548W].

Box 2	What the budget for GP fundholders covers
●	Some hospital in-patient and day case treatment required by the practice's patients. These are mainly non urgent surgery and similar procedures. Urgent surgery is excluded and there is a cost ceiling of £5,000
●	All out-patient referrals for initial diagnostic investigation and tests
●	Diagnostic tests
●	Prescribing costs
●	Community nursing services
●	Dietetics and chiropody

[5] BOTTOMLEY Virginia. Statement on management arrangements in the NHS. HC Deb 21.10.93 col 398

The scheme was originally limited to practices with 9,000 or more patients but there is a provision for smaller practices to group together. From 1 April 1993 the limit was reduced to 7,000.

Fundholding has continued to be one of the most controversial parts of the NHS reforms. Supporters argue that fundholders have been spearheading improvements in services to patients which have later spread to all patients and that they can provide frontline knowledge of patients needs which DHAs are not in a position to do. Opponents are concerned about the development of a two tier service with only fundholders getting access to treatment in some cases. There are also worries that fragmentation of purchasing between fundholders and GPs makes the planning of a comprehensive service harder.

Indicative drug budgets

Indicative drug budgets seemed likely to prove highly controversial. There were widespread fears that the scheme would lead to elderly and chronically sick people being removed from GPs' lists and of people not being able to get the drugs they needed. However many of these fears were alleged as a result of discussions between the medical profession and the Department of Health. In a statement on 23 May 1990 [BMA press notice] Dr Michael Wilson, then chairman of the BMA's General Medical Services Committee said "As a result of discussions with the Secretary of State and NHS officials, we have achieved significant changes in the manner in which the Government is now seeking to introduce a system of drug budgets which remove a number of anxieties GPs hold".

For the future there are some fears on the part of GPs that cash limited budgets may be introduced at practice level - the present ones are only indicative. This is on the context of the Government's concern at the rising NHS drugs bill.

The Health of the Nation and the Patients' Charter

The NHS reforms need to be seen in the context of other Government policies affecting the service. In particular the *Health of the Nation* initiative and the *Patients' Charter.*

The *Health of the Nation* strategy was set out in the White Paper of that title[3] which followed an earlier Green Paper. The strategy selects five "key areas" for action and sets out objectives and targets in these areas. The key areas are:

- coronary heart disease and stroke
- cancers
- mental illness
- HIV/AIDS and sexual health
- accidents

The strategy is seen as one of the pursuit of "health" in its widest sense and implementation as the responsibility not only of the Department of Health and the NHS. Nonetheless the NHS has a key role to play and Virginia Bottomley argues in her introduction that "The reforms of the NHS have made this strategic approach possible. the need to focus on health as much as health care has long been the ambition. The reforms have enabled us to make it a reality"[6].

The Patient's Charter restates a number of existing patients' rights and creates some new ones. Health authorities must publish information about performance against the standards and can set their own Local Charter Standards. District Health Authority purchasing intentions need to reflect the obligations of the service to comply with the Charter.

THE DEVELOPING ISSUES

As implementation of the reforms has developed the policy emphasis has shifted in some areas and so has the nature of the arguments about them. The original White Paper, for example, hardly discussed the purchasing role of health authorities at all, but recent speeches by Ministers have brought it centre stage. This section of the paper sets out some of the issues now at the forefront of the health reforms debate. These issues are summarised in Box 3.

[6] For further background on the subject see The Health of the Nation Library Research Note 92/81, 12.10.92 by Keith Cuninghame

Box 3	**The developing issues**
●	**Performance of the NHS since the reforms**. Ministers regularly claim substantial increases in the numbers of patients treated and a reduction in average waiting times since the reforms were introduced. Others are sceptical, pointing to changes in the way numbers treated are measured and increasing numbers on waiting lists.
●	**The new focus on purchasing.** By common consent the role of the DHA as purchaser was neglected in early discussion of the reforms. This is now seen as of central importance to improving the health of the population and getting the best value for money out of the available funding.
●	**Rationing healthcare.** The reforms have opened up the debate on health care rationing or prioritisation in the UK since in deciding what to purchase DHAs must also decide what not to purchase.
●	**Privatisation.** DHAs and fundholders can purchase care from the private sector as well as the public sector and are being encouraged to use that power. This leads to the possibility that healthcare could become increasingly provided by the private and voluntary sectors even though remaining largely publicly funded.
●	**The London and other inner city problem.** The mismatch between the supply of hospitals which are numerous in many inner city areas, especially London and the limited local population base, together with the desire of health authorities outside these areas to place more local contracts, has led to sharp funding problems in many inner city areas.
●	**Structure and management.** There has been a trend towards larger health authorities as they have sought greater purchasing clout. The Government has announced the abolition of RHAs and the merger of DHAs and FHSAs, as well as reforms at the centre. There are concerns about management costs.
●	**Accountability.** With the removal of local authority representatives from health authorities there has been discussion about whether the NHS has sufficient local accountability and if not, what changes might be made.
●	**GP fundholders.** There is continuing concern about the development of a "two tier" service and whether fundholding represents value for money, as well as the possible disruptive effect on DHA purchasing.
●	**NHS Trusts.** NHS Trusts will shortly provide virtually all NHS health care. they have been cautious about using their freedoms, but will that change? On the other hand, it is argued that they are still hamstrung by too many rules. As the reforms develop and the way in which health care is delivered change merges between Trusts and clones seem likely.
●	**Funding.** The reforms sought to increase value for money on the NHS but did not increase the overall level of funding which is again being questioned. The way in which the "weighted capitation" funding system is worked out is being challenged especially, it is claimed, because it does not allow significantly for deprivation.
●	**New directions in health care.** The way in which health care is being delivered is changing with shorter hospital stays, and for more being possible in the community or as day care. Health authorities have a major role in managing this change.
●	**Managing the market.** There is a divergence between those who believe that the internal market should exist within a structured planned framework, and those who feel that the logic of the reforms is that the market should be given a freer rein on many issues.

Performance of the NHS since the reforms

Ministers frequently make claims about improved performance by the NHS. For example, Mrs Bottomley answering questions following her statement on NHS Management on 21 October:

> "For every 100 patients that were treated before the reforms, 116 are now treated .... In the last year alone the number of people waiting more than one year has fallen by 20 per cent. Before the reforms, about 170,000 people were waiting for more than a year. The figure is now down to below 70,000."

Critics have, however, cast doubt on the meaningfulness of some of the performance figures. This partly arises from the use of "Finished Consultant Episodes" (FCEs) as a measure of patients treated. The FCE records the number of occasions that a patient is under the care of a particular consultant so it is possible for a single illness to lead to several FCEs, as Claude Seng and his colleagues demonstrated[7], although their study was a small scale one. It is further argued that, while in the pre-reform NHS providers had no particular incentive to ensure meticulous recording of all treatments, now they do in order to demonstrate to purchasers that they are fulfilling (or bettering) their contracts. It is also suggested that data collection was poor when FCEs were first introduced, leading to wider recording.

One leading health economist, Professor Alan Maynard of the Centre for Health Economics at York, has commented as follows on the debate over the performance of the NHS following the reforms:

> "In the 1990s NHS activity rates have grown and the Department of Health efficiency index is ringing out the news of success to the Treasury hawks demanding evidence of value for money. the `success' is probably due to the increased funding of the NHS, as the effects of the reforms are unknown due to the Government's decision not to evaluate them.
>
> Despite this ignorance, the Government claims the reforms are a success and Labour derides them as a failure. This politicians' propensity to spray the public with an amalgam of rhetoric, meaningless statistics and a happy smile should not obscure the unwillingness of both parties to confront difficult issues".[8]

The new focus on purchasing

The White Paper *Working for Patients* said very little about the role of district health authorities as purchasers or commissioners of health care. Later documents elaborated the purchasing role but recent months have seen much greater emphasis on it.

---

[7] SENG Claude, LESSOF Leila, McKEE martin. Who's on the fiddle? Health Service Journal

[8] MAYNARD Alan. Politicians, don't you just luv 'em? Health Service Journal 14.10.93

The scene was set by Mrs Bottomley in a speech to a NAHAT conference on 23 February[9]. She said:

> "The key to developing the NHS internal market lies with health authorities and fundholders, the purchases of care. they have five basic tasks: assessing the needs; setting the standards; targeting the resources; demanding value for money; and lastly, monitoring the quality".

She announced a four point plan covering:

- action by the NHSME to concentrate on key purchasing issues during 1993/94;
- earmarking of £4m for the development of purchasing;
- the NHSME/Regional General Managers Focus Group to look at ways of making the best use of the money;
- publication of a guide `Good practice and innovation in contracting'.

Since then the Health Minister, Mr Brian Mawhinney has made a series of speeches in the subject. In the first of these he said:

> "The fact is that purchasing in the NHS is still very new. For over 40 years the NHS has been a provider-driven organisation. From now on the NHS needs to be purchaser driven. A lot of work remains to be done and it needs to be done quickly"[10].

Writing in April 1993 Chris Ham, Director of the Health Services Management Centre at Birmingham University commented that "The importance of purchasing has at last been recognised by Ministers" and he went on to argue that:

> "Purchasing is important because the whole purpose of the reforms is to move the NHS away from a history of provider dominance. The old system of `planning by decibels' in which resources were channelled to the acute services made it difficult to give priority to the so-called priority services. This will only change if there is an effective countervailing force to make an independent assessment of health needs and allocate resources in response to those needs".[11]

---

[9] BOTTOMLEY Virginia. Virginia Bottomley announces new era for NHS Reforms "making it happier". DOH press notice H93/575, 23.2.93

[10] MAWHINNEY Dr Brian. New initiative to improve quality of health care. DoH press notice H93/724, 29.4.93

[11] HAM Chris. Purchasing: The story so far. Health Direct April 1993

The Audit Commission recently took a detailed look at the purchasing (or, as they preferred to call it, `commissioning') role of DHAs. The Commission commented that

> "Freed from the responsibility for particular provider units, and held accountable for improving the population's health, DHAs have a great opportunity to alter the pattern of health care provision. They should be seeking to move to services which are not only more efficient, but also more effective in satisfying the local population's needs, and improving its health".[12]

They go on to say that "Grasping this opportunity will not be easy. Districts are having to make radical changes to their own objectives, cultures and working practices". Some, they note, have responded well, but in other cases progress has been slower.

They say that three things are needed to carry out the commissioning task:

> "- The capability (skills, resources and information) to carry out commissioning tasks;
> - A clear sense or direction;
> - A conducive environment."

And they conclude that "There is room for improvement in all three areas".

Both the current NHS structure, with separate DHAs and FHSAs and the existence of GP fundholders have been seen by some commentators as a potential threat to DHAs properly fulfilling the purchasing role. These issues are commented on later in this paper.

Rationing health care

It is a truism amongst commentators on health services that health care in all systems is rationed, in that no system is able to meet all the demands which might legitimately be placed on it. In the NHS there has always been overt rationing by queuing (waiting lists) and the system under which access to specialist care is through the GP, who acts as gatekeeper has also acted as a rationing device. In addition there has been much informal rationing through the decisions of individual clinicians.

By separating purchasers and providers the NHS reforms have made it likely that rationing will become more explicit because in deciding what to purchase DHAs are deciding what not to purchase. William Waldegrave, then Secretary of State for Health, put it as follows in an interview with Richard Smith, editor of the British Medical Journal just before the NHS reforms came into operation:

Smith:

"Do you think politicians should be more up front that not everything can be afforded?"

---

[12] AUDIT COMMISSION. Their health, your business: The new role of the District Health Authority. HMSO 1993

Waldegrave:

"I do, and I think it will be utterly necessary under the new system - because one of the things that will be thrown up will be a much more explicit definition of what we are and are not buying. That will cause those decisions to have to be justified - not only by politicians but also by the clinicians. The system will become more open and explicit, and therefore more argumentative. I think that must be a good thing, although it will take a little getting used to."[13]

The rationing issue (or prioritisation as many prefer to call it) is discussed more fully in a recent Library Research Paper[14], so is not dealt with further here.

Privatisation

Critics of the NHS Reforms fear that it will lead to an increasing proportion of clinical work being provided by the private or voluntary sector. Others, of course, would see this as a desirable process. In theory it would be possible to envisage a health service which, although largely funded by public expenditure as now, is largely provided by the private and voluntary sectors. Greater private sector involvement means that there will be a greater degree of competition among providers. Some would see this as enabling DHAs to get better care for patients and better value for money, others as meaning wasteful depreciation and in the longer term the break up of the NHS.

Government policy has been set out in a number of speeches by ministers recently. It covers both the provision of private capital or joint public private ventures and the provision of services by private providers.

Tom Sackville announced a relaxation of the rules on the use of private capital finance in the NHS in a speech on 21 April 1993[15]. This followed the announcement of the private finance initiative by the Chancellor of the Exchequer during the 1992 autumn statement.

More recently Mr Sackville set out the Government's wider approach to private finance in a speech on 1 November 1993 to a conference in London on private finance in the NHS. He said:

> "We approach this subject without ideology or prejudice. Health Authority purchasers should show no favouritism in choosing who is to provide health care for NHS patients. Health authorities should be the champion of patients,

---

[13] WALDEGRAVE William. Thinking beyond the new NHS. British Medical Journal 23.3.91.

[14] HOUSE OF COMMONS LIBRARY. Prioritising Health - The debate about health care rationing. Library Research Paper 93/49, April 1993, by Keith Cuninghame

[15] SACKVILLE Tom. Tom Sackville announces greater freedom for the NHS to use private finance. DoH press notice H93/705, 21.4.93

> not of institutions. Whoever can do the best job - whether from the public or private sector - should win purchasers' contracts.
>
> It used to be heresy to speak of the private sector and the NHS in the same breath. Now the old apartheid is breaking down. We want a field where everyone competes on equal terms."[16]

Making in many ways a similar point but from a stance highly critical of Government policy a recent editorial in *Health Matters* comments:

> "The interplay of the internal market, recent national policy changes and the activities of the private sector mean that the boundary between `public' and `private' is blurring rapidly. Soon we may be unable to identify the boundary at all - and that is exactly the point of the Government's strategy .... The end result of all this will be no more than a publicly owned health insurance scheme which pays - when it pays at all - for substantially private care. And all without the Government privatising anything"[17]

Problems of London and other inner cities

The NHS reforms have highlighted the problems of health care in inner city areas, especially in London where they are most acute, but also in other cities. The problems arise because of the combination of a high level of hospital provision, often providing specialist care but a low and often declining local population base, coupled with poor quality primary care. Many hospitals in the past have attracted many patients from outside the city, in the case of London many hospitals patients historically have come outer London and the home counties. Before the NHS reforms districts were funded largely on the basis of the health services provided in their area. Now, under the capitation funding system (discussed in more detail later) funding is on the basis of the size of the local population, weighted to take account of their likely need for health services. As a consequence of these changes:

- many inner city health authorities have a much reduced level of funding because the population is low;

- health authorities in surrounding areas (Outer London and the home counties in the London area) are switching contracts to their own local hospitals, both because they are often likely to be cheaper, and because they wish to ensure the viability of local providers.

---

[16] SACKVILLE Tom. Public service, private finance. Putting private capital to work for the NHS. DOH press notice H93/1034, 1.11.93

[17] Now you see it not you don't. Health matters Issue 15, Autumn 1993

William Waldegrave, in the interview in the BMJ quoted earlier[13], discussing London as "an extreme case of how the present [ie pre reforms] system does not work" said:

> "What the new system will do will force some decisions out of us cowardly politicians who for years have put them off. The new system will brings things to a sharp crunch in a number of places".

The Tomlinson Report[18] on London's health services was published in October 1992.

On 16 February 1993 the Government published *Making London Better* and Mrs Bottomley made a statement to the House outlining Government policy [HC Deb col 133]. This included the setting up of six "speciality reviews" on specialist services, and the creation of a London Implementation Group to take Government policy forward. The Reviews were published on 23 June and Mrs Bottomley said they formed one of the considerations which the Government would take account of before reaching final decisions.

London illustrates in particularly sharp terms the dilemma between providing for planned change and letting the market decide, which is referred to later in this paper.

Structure and Management

"Working for Patients" recognised that the change in the role of DHAs would lead to mergers between them. The main argument is that to have sufficient clout with providers purchasers need to be considerably larger than they were when they were also responsible for managing services. There is also a need to make best use of scarce skills such as in public health medicine and in some areas to improve alignment of boundaries with social services authorities. Immediately prior to the introduction of the reforms there were 190 DHAs. By 1 April 1993 this figure had dropped to 145 and current proposals would leave the figure at 108 by April 1994. The Department of Health document *Managing the New NHS*[19] published in October 1993 envisages an eventual figure of 80-90. The creation of larger health authorities is not without its critics however - see the debate on statutory instruments creating merged DHAs on 10 May 1993[20]. The concern is that such authorities will inevitably become more remote from their local populations and health authorities cannot be expected to be "champions of the people" if they are having to assess the needs of perhaps 500-750,000 people. One way round this is through the idea of `locality purchasing' which seeks to establish a local focus for assessment within the overall purchasingstructure of a larger authority[21]. Critics would also suggest that very large authorities make local accountability, already tenuous, even more limited.

---

[18] TOMLINSON Sir Bernard. Report of the Inquiry into London's health service, medical education and research. October 1992

[19] HEALTH Dept of. Managing the New NHS: A background document. 1993

[20] Debate on motion to revoke the NHS (Determination of Districts) Order 1993 (SI No 574). HC Deb 10.5.93, cols 604-2)

[21] See HAM Chris. Locality purchasing. 1992

Managing the New NHS and the statement by Mrs Bottomley on it[5] resulted from a functions and manpower review set up by Mrs Bottomley in May 1993 and chaired by Kate Jenkins, a member of the NHS Policy Board. The purpose of the review was to examine the overall management structure of the NHS in the light of the reforms. *Managing the New NHS* summarises the changes as follows:

· creating a clear identity for the NHS Management Executive, within the Department of Health, as the "headquarters of the NHS';

· abolishing the 14 statutory Regional Health Authorities and reorganising the NHSME to include eight regional offices, each headed by a Regional Director, to replace both the RHAs and the existing NHSME Outposts;

· appointing non-executive members to the NHS Policy Board to cover each of the eight regions, providing a link between Ministers and local DHA, FHSA and Trust Chairmen; and

· enabling DHAs and FHSAs to merge to create stronger local purchasers, and actively encouraging such mergers.

These changes will support the continued drive towards decentralisation in the NHS, with responsibility and decision making devolved as far as possible to local level.

Primary legislation will be needed to put some of these changes into effect, and they are therefore scheduled to take place from April 1996. In the meantime the number of RHAs will be reduced from 14 to 8 from April 1994.

Encouraging the merger of DHAs and FHSAs is a policy change which has been resisted by ministers in the past. Collaboration has been encouraged however and in a number of parts of the country "health commissions" have been established which are in effect DHA/FHSA mergers although statutorily each body continues to exist.

Few tears seem to be being shed at the passing of RHAs.

The likely consequences of the changes generally will take a while to become clear. Commenting on them in the BMJ, Chris Ham argued that:

> "Viewed as a package, there is much to welcome in the Government's plans. If there are concerns about increased centralisation and the risks involved in greater competition these are offset by the benefits likely to result from the reaction of a single agency at regional level and the establishment of unified health authorities at local level. As with *Working for Patients* much hinges on the detailed work that has been set in train to flesh out the proposals."[22]

---

[22] HAM Chris. The latest reorganisation of the NHS. British Medical Journal 30.10.93

Ham indicates concern about increased centralisation resulting from the changes. David Hunter has commented that "The Civil Service emerges from the review unscathed" and he goes on:

> "RHAs `protected' sub-regional agencies from much of the tactical manoeuvring which passes for policy making at the centre. With regional offices progressively `going native' as they become part of the central machine, purchasers will become more exposed to top-down pressures. For `decentralised' read `centralisation'. And for `central management' read `political control'"[23]

Mrs Bottomley presented the changes in part as an opportunity to slim down management of the NHS. There has been concern about "increased bureaucracy" in the NHS as a result of the reforms but it is not clear to what extent such concerns are justified. there has undoubtedly been a large increase in the number of staff in the "general and senior managers" category but since it was a category which did not exist prior to the implementation of the Griffiths report of 1983 this is to be expected. Many of these staff would previously have been doing jobs with other designations. For example those in nursing management positions who were formerly part of the nursing workforce may now be part of management. Because of concern that clinical staff were having to perform too many administrative tasks there has also been a move to increase clerical support for clinical services. There has also been a feeling amongst some commentators that, in the past, the NHS was undermanaged and so not making best use of its resources.

Chris Ham[22] comments that "Managing the new NHS cannot be done on the cheap, and if the potential of the latest reorganisation is to be realised ministers must resist the temptation to attack the bureaucrats".

Nonetheless the NHSME is clearly concerned at the level of management costs at least in some districts and Sir Duncan Nichol has ordered a review[24]. This review is said to follow a survey by the Health Care Financial Management Association with uncovered wide variations between health authorities. This is reported as showing that purchasers with a budget of £50m employ anything between 5 and 65 staff on purchasing[25].

Accountability

As we have seen, the development of larger health authorities is bound to threaten local accountability. This has to be seen in the context of arguments by critics that the reforms do that anyway. One of the features of the NHS reforms was the removal of local authority nominees from District Health Authorities and Family Health Services authorities. The nature of the new DHAs, with half the members being executive members and the others appointed

---

[23] HUNTER David. Protect and Survive. Health Service Journal 18.11.93

[24] BRINDLE David. Health chief orders check on managers. Guardian 19.11.93

[25] BUTLER Patrick. Nichol tells English health managers to stand up and be counted. Health Service Journal 25.11.93

by RHAs (or the Secretary of State on the case of chairmen) has led to criticisms of a loss of democratic control and (contrary to the stated intention of *Working for Patients*, repeated in *Managing the New NHS*) of centralisation of power on the Department of Health. Similarly NHS Trusts have been criticised on the grounds of limited local accountability, with non-executive board members appointed by the RHA or the Secretary of State and the requirement to hold only one public meeting a year. On the other hand it is argued that the new role of DHAs has encouraged them to do for more consultation with the public on health needs and related issues than was hitherto the case. The NHSME publication Local Voices[26] encouraging such developments while Trusts, aware of the need to market their services and obtain contracts if they are to survive are, it is argued, being more open than their predecessors. Community Health Councils, in some instances at least, are finding relationships in the new NHS more co-operative than previously.

Nonetheless longer term fears about accountability continue, exacerbated by some well publicised examples of financial mismanagement such as those in the West Midlands RHA and over the supply of Information Technology services to Wessex RHA. One solution that has been put forward for example by the Association and Metropolitan Authorities is that the purchasing role should be given to local authorities, as was done with community care provision.

GP Fundholding

GP fundholding remains a controversial part of the NHS reforms. It is widely recognised that a gain from the reforms has been that DHAs and GPs generally have had to collaborate more closely than before the reforms over issues such as where to place contracts and what quality standards they should contain.

The continuing concerns about fundholders are that at the macro level they weaken the purchasing position of DHAs and at the micro level they give benefits to some patients not available to others, leading to a two tier service.

The macro level concern arises because the part of the fundholders budget relating to hospital services and community nursing comes out of the overall DHA budget. Although the services covered represent only a relatively small part of the cost of hospital services used by the patients of fundholders, with some kinds of treatment (`cold' surgery for example) if a large proportion of patients are in fundholding practices, planning services in those areas may become very difficult. Chris Ham put it as follows:

> "The nightmare scenario is of DHAs and fundholders operating independently of each other in a way which results in increasing fragmentation of service provision and an inability to plan services on a long term basis. This cannot be what ministers had in mind and in must be avoided at all costs. Yet as

[26] National Health Service Management Executive Local Voices. the views of local people in purchasing for health. 1992

> things stand, there is no evidence that these issues are being grasped at the centre, and clarification of the Government's position is urgently needed"[27].

The Audit Commission argued that "current expense of the fund-holding scheme suggests that there is benefit from this dual commissioning arrangement" (ie fundholders and DHAs) but they went on to warn

> "However, there is a need to monitor whether fundholding practices and health authorities are working in co-operation. They should therefore be required to agree on a strategy for addressing the health needs of local people. the contracts set by both would have to confirm to the strategy"[28]

The concern at the development of a two tier service arose in the very early days of the implementation of the reforms, with hospitals being prepared to give preference to the patients of fundholders. On 11 June 1991 the NHSME and the Joint Consultants Committee (JCC) jointly sent out guidance which said "It is not of course acceptable for patients to be afforded differing standards of clinical care whilst undergoing hospital treatment by virtue of the contracts covering their care".

However, claims of hospitals giving preferential treatment to fundholders have continued to appear, especially towards the end of the financial year if hospitals have fulfilled their contracts with providers.

There have also been concerns that fundholders have been able to gain other benefits for their patients which are not available generally. This view has been criticised on the grounds that fundholding practices are often in the forefront of developing services for patients and that these developments are then extended to others.

Whilst there is widespread support for the greater involvement of GPs in purchasing there is some disagreement about the way forward. Options include

- Gradual extension of fundholding, but keeping the existing rules in practice size, so they are always likely to be a minority;
- Giving the benefits of fundholding (or some of them at least) to all GPs;
- Widening the scope of the services to be published by fundholders;
- Abolishing fundholding all together.

The Audit Commission recommended as follows:

> "A more flexible contract for GP practices and primary health services would allow the balance between centralised commissioning by DHAs and local,

---

[27] HAM Chris. How go the NHS Reforms? British Medical Journal 9.1.93

[28] AUDIT COMMISSION. Practices make perfect: The Role of the Family Health Services Authority. 1993

> practice based commissioning to be negotiated locally. The presumption should be in favour of practice-based commissioning ... provided the practice wished to exercise that responsibility and was judged managerially competent to do so."[16]

The future accountability of fundholding following the abolition of RHAs is still unclear. *Managing the New NHS* says that accountability arrangements for fundholders and other purchasers will be examined in detail before the legislation is introduced. Fundholders fear that as a result of the changes they may in practice be accountable to and funded by commissioning authorities created by merging DHAs and FHSAs, thus losing a degree of freedom[29]. Fundholders are unhappy at the prospect, but the changes may be used to meet the risks in fundholding identified by the Audit Commission and Chris Ham.

NHS Trusts

With the ever wider coverage of Trusts some of the passion has gone out of the arguments over whether particular providers should move to Trust status has evaporated. Some two thirds of hospital and community health services provision is currently provided by Trusts and that will rise to over 90% from next April, following the announcement by Mrs Bottomley that 99 new Trusts would become operational on that date[4]. The principle of devolution of management is, in any case, widely accepted even if Trusts are disliked as a way of achieving it.

Many of the well publicised problems of individual Trusts leading to cuts and ward closures flow from loss of contract income under the internal market which presumably would have happened whether or not the unit was a Trust, since all providers need to attract contracts in order to survive.

One of the main freedoms of Trusts is that they can set their own pay and conditions of service of their staff. The evidence suggests, however, that they have been cautious about using this freedom. For example a survey by IRS Employment Trends[30] of first and second wave Trusts found that the use of non-Whitley Council employment packages was spreading only slowly. The survey found that "two years on, it is still very much a case of `early days' for many of the Trusts in the survey, many of which plan to consider a wide range of employment issues in the coming months. The survey also found that over 40% of respondents expected staff numbers to fall in the coming 18 months. The Health Committee also found Trusts had been cautious in using their freedoms in this respect and concluded that "it is still too early in the development of Trust policy to determine a more general trend and any wider implications"[31]

---

[29] CHADDA Dolly. Tier today - gone tomorrow? Health Service Journal 4.11.93

[30] Local bargaining inthe NHS: A survey of 1st and 2nd Wave Trusts . IRS Employment Trends No 537, June 1993

[31] HEALTH Select Committee. NHS Trusts: Interim conclusionsand proposals for future inquiries. 1st Report 1992-93, HC 321. Laid 30.11.92

Some observers, such as Eric Caines, former Director of Personnel on the NHS Management Executive have criticised Trusts for their cautious use of their new powers, but others would argue that there are many instances where devolution has led to more imaginative, effective management than before.

For the future mergers between Trusts and closures seem likely as the internal market develops and the way in which health care is delivered changes. The extent to which this change will be managed is still unclear and is dealt with later. Those sceptical of government assurances that Trusts remain fully in the NHS still see them as a stage towards eventual privatisation.

The Health Committee concluded that "Since Trusts will in future be the predominant, if not the only, form of provision of health services within the NHS, there is little value in attempting to continue the very difficult comparison between them and DMUs".

But they noted three key areas where concerns expressed by the Committee's predecessor "cannot as yet be said to have been totally allayed". These were:

- "The potential loss of the benefits of strategic planning".

- "The potential problems associated with the dismantling of a national framework for the negotiation of terms and conditions".

- "The effectiveness of provisions to ensure the future involvement of users of the NHS in consultation about how financial resources are to be allocated, including clarification of the role of NHSME outposts and their accountability to the public, as well as the essential concomitant of the accountability of providers of these services".

Funding

An important change brought about by the reforms was to "weighted capitation". Under the pre-reform NHS the principle of funding was that DHAs received an allocation based on the health facilities provided and numbers of patients treated within their districts. Target allocations were calculated using a weighting process which took account of the age structure of the population and mortality ratios (as a proxy measure for morbidity, for which no suitable measure could be found). Over the years the RAWP (Research Allocation Working Party) process had sought to move actual allocations closer to the target.

The funding principle enunciated in *Working for Patients* was of "weighted capitation". Essentially RHAs, and through them DHAs, are to be funded according to the size of their local population, rather than the health facilities on the patch and the number of patients treated. As with the RAWP process the population is weighted by age and to take account of the likely need for health care. This has meant that districts with a small resident population but substantial hospital facilities are losing funding while those with a large population but more limited facilities are gaining. There is no national deadline for achieving

full weighted capitation in allocations to districts and regions should take account of local circumstances, but regions are being asked to report on their progress in 1993-94[32].

Many of the districts losing funding under the capitation system are in deprived inner city areas because historically they have had large hospitals in the area. There have been criticisms that the funding formula does not take sufficient account of the needs for health care generated by social deprivation. For example the Tomlinson report[14] argued that

> "Further work needs to be undertaken to ensure that the approach is systematic and fair. We have no desire to roll back the proper application of the principle of weighted capitation, but we have not seen convincing evidence that it is always applied fairly to inner London districts." [para 231]

The Report goes on to deal in particular with the measurement of health needs in areas of deprivation. Similar arguments have been advanced, for example, in the case of Birmingham and Manchester.

The other area of funding that has attracted attention is that of overall funding. The Review which led to *Working for Patients* was set up at a time of intense concern about NHS funding levels. The reforms sought to deal with the issue but did not in themselves increase the overall amount of money available. Chris Ham puts the point as follows:

> "Notwithstanding the progress made in the last two years, the reforms in themselves have done little to compensate for the long term underfunding of the NHS."[27]

New directions in health care

Any system of health care in place will have to take account of the fact that the way in which care is delivered is changing fast and will continue to do so. Among the changes are:

- Increased use of Day Surgery (50% of all surgery as day surgery is considered the target by the Royal College of Surgeons);
- New surgical techniques leading to shorter stays for those who do go into hospital;
- Technological developments meaning that far more people can be treated as out patients or at home or in units away from main hospital sites.
- Conversely, the complexity of some treatments meaning that they need to be concentrated on fewer sites to preserve quality.

---

[32] SACKVILLE Tom. HC Deb 20.1.93 col 317W

These changes are likely to result in fewer changes in hospitals with fewer in patient beds but development of other services, fewer hospitals overall, more demands on general practice and the community health services.

Managing these changes so as to maintain the availability of care that is both comprehensive and high quality and ensuring both access and equity for patients will be a major task for purchasers of health care in the coming years.

Managing the Market

There is a divergence between those who would like to see existing constraints in the internal market lifted, in the belief that the market will deliver appropriate solutions to current problems, and those who see the need to continue to plan and manage the market. Others, of course, would not accept the market philosophy as a means of delivering health care at all. In practice the divergence tends to be about the extent of control over the market, with relatively few arguing the case for a completely free market. The Tomlinson Report puts the dilemma as follows, in words which could apply to many parts of the country, not just London:

> "Change is inevitable owing to the forces of the internal market highlighting inequity and inefficiency in the present distribution of hospital facilities. **If this change is not managed firmly - and in certain cases urgently - the result will be a serious and haphazard deterioration in health services in London**." [Emphasis in original][14]

The London dilemma, but again applicable to the internal market more generally, was put as follows by Robert Maxwell, Chief Executive of the King's Fund[33]. After pointing out the immediate threat to inner London hospitals such as University College and Middlesex, Maxwell says:

> "Some people will argue that the only thing necessary is more money to maintain services as they are. Market purists, on the other hand, will maintain that the market will sort the situation out.
>
> Ministers have already rejected both arguments and have opted for a strategy of planned change .... But planned change will not wait. there have to be clear guidelines for next year, with minimum further delay. Otherwise the market will operate by default."

---

[33] MAXWELL Robert. Letter to The Times, 25.10.93

Essentially, the planning or market dilemma is illustrated by a recent headline in the *Health Service Journal* "LIG [London Implementation Group] may force HAs to ignore market and dissolve Trust" over a story claiming that the LIG was seeking the dissolution of a Trust that was a market winner in the interests of the overall management of change[34].

A caustic view of the issue of market regulation is offered by the health economist Professor Alan Maynard:

> "Another issue avoided by the politicians is the regulation of the internal market .... The 1989 NHS proposals failed to confront the regulation issue .... Why doesn't the NHS management executive regulate the internal market? It could learn from the public utilities and from the US how to do it. Or does it prefer to allow the NHS internal market to fragment and produce perverse outcomes? Both Labour and the Tories have demonstrated by their silence their ignorance and lack of concern about how the existing incomplete set of contradictory NHS Regulation will affect patient care"[6]

Another commentator suggests that managers, too, need to be providing more knowledge of the effects of the NHS reforms. Commenting on recent reports from the National Association of Health Authorities and Trusts and the Institute of Health Services Management, Allyson Pollock argues in a recent BMJ leading article that what is needed from managers is "an immediate and honest evaluation of the impact of the internal market on equity, comprehensiveness and equality of access to health care for the people of Britain"[35].

Conclusion

Reform of health care is not just a British phenomenon. As Rudolf Klein recently put it "Health care reform is rapidly becoming a global epidemic"[36], as countries grapple with meeting the increasing demands on health care systems while trying to control public expenditure. Solutions involving greater use of markets, and separation of purchasers and providers are being tried in other countries.

In the UK the debate is balanced between those who wish to push the reforms further and faster, with greater privatisation, perhaps insurance funding (the reforms did not change the basic system of funding care through general taxation) on the one hand: they could argue the case on grounds of greater efficiency and consumer choice and broadening the funding base. On the other hand are those who recognise the value of the purchaser provider split (although they might like to see it implemented in other ways than through the present internal market) but, in the interests of the traditional NHS values of equity, comprehensiveness and universal

---

[34] BUTLER Patrick. LIG may force HAs to ignore market and dissolive Trust. Health Service Journal 18.11.93

[35] POLLOCK Allyson. The future of health care in the United Kingdom. British Medical Journal 26.6.93

[36] KLEIN Rudolf. Health care reform: The global search for Utopia. British Medical Journal 25.9.93

access want to keep the market firmly under control. Others still could continue to reject the whole package, though to do so convincingly they need to demonstrate how they would meet the challenges which all systems are having to face in terms of rising demand and pressure on public expenditure.

Further pressures are likely to come from those seeking less regulation - that managers should be freer to manage with less central control. This is a stated aim of the reforms but the extent to which it has happened is challenged for example by the Institute of Health Service Management[37]. But if central control is lessened the issue of parliamentary accountability arises.

There is, then, a set of issues surrounding the health reforms to be worked through in the coming months and years including:

- letting the market decide as against regulating the market, or indeed whether there should be a market - in short, how to manage change;

- the overall level of funding and whether general taxation should continue to be the principle method of funding;

- the outlook for the NHS values of comprehensiveness, equity and equality of access;

- the extent of private provision;

- national and local accountability of the service and the extent to which managers should be unfettered;

- the preservation of quality of the service in a competitive environment and the extent to which regulation is needed to achieve this;

- how developments in methods of treatment will affect the pattern of service provision and how structures can cope with these changes.

In short, there seems no prospect, after the rapid change of recent years, of a quiet period in the field of health care.

---

[37] INSTITUTE OF HEALTH SERVICE MANAGEMENT. Future health care options: Financial Report. IHSM Policy Unit