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Prologue: Changing political and economic tides during the 1980s forced the British government to examine anew its National Health Service (NHS). Former Prime Minister Margaret Thatcher’s Conservative government, pushed by the three-fold forces of budgetary constraints, rising public expectations, and demands for increased productivity, undertook a revision of the service that enraged the medical profession. For the first time in forty years, British general practitioners (GPs) will cede some of their prized clinical autonomy to managers and purchasers. In this article, Patricia Day and Rudolf Klein examine the revisions to the NHS. They state, “In the context of the NHS culture, this move from . . . trust to contract is truly revolutionary and has perhaps the farthest-reaching long-term implications” of any reform to date, This, rather than competition, is going to “distinguish the new-style NHS,” the authors assert. Day, who received a sociology degree in London, has been a social policy research officer at the University of Bath since 1980. She has researched internal communications and organization of London hospitals, has studied the purchasing and supplies organization of the NHS, and also has studied public housing in the London borough of Camden. Klein, born in Czechoslovakia, received his master of arts degree in modern his tory from Merton College, Oxford, and spent several years working as a journalist with the London Evening Standard and Observer. Currently he is director of the Centre for the Analysis of Social Policy at Bath, which he founded, and is professor of social policy there. He has been a specialist adviser to the Social Services Committee of the House of Commons, joint editor of Political Quarterly, and consultant to the Organization for Economic Cooperation and Development. He published an article on the NHS in Health Affairs, Spring 1985, entitled “Why Britain’s Conservatives Support a Socialist Health Care System.”
Britain’s National Health Service (NHS) is at once the envy of the world and its butt. It is the envy of the world because it provides, with remarkable parsimony, a comprehensive service to the entire population. The service is tax-financed and free at the point of delivery, with remarkably low administrative costs. Whereas U.S. expenditure on health care is now touching 12 percent of its national income, Britain’s spending has only just topped half that figure. It is the butt of the world because the NHS provides care that, if usually high in quality, is delivered in an often dreary environment to patients trained to defer to the discipline of the queue and service routines. Since its creation in 1948, the British health system has always been undercapitalized and dominated by providers, who have defined the needs of patients rather than responding to the demands of consumers. Not surprisingly, therefore, the NHS has provided illustrations for countless American sermons on health care during its forty-year history. It is extolled by those who hold up its achievements as demonstrating the virtues of the national health care model. It is excoriated by those who use its failings to chill American spines about the dangers of socialized medicine.

In the future, however, both of these sermons may need revision. On 1 April 1991, the changes in Britain’s NHS first announced by Prime Minister Margaret Thatcher’s government at the beginning of 1989 came into full effect. They represent an attempt to demonstrate that it is possible to combine the advantages of the national health service model (financial parsimony and social equity) and those of a market system (responsiveness to consumer demands): to show that the acknowledged weaknesses of the NHS—such as provider paternalism and waiting lists—are not necessarily inherent in its design. It is a remarkably ambitious strategy, even though the government has largely stumbled into adopting it rather than marching purposefully toward some ideological vision. It is also a high-risk strategy. Its outcome is uncertain. Any benefits may take the best part of a decade to work their way through and will be diffused. The costs of implementation, however, are immediate and largely fall on a concentrated, well-organized constituency: doctors, nurses, and others working in the NHS. Moreover, NHS providers have the power to bring about some of their prophecies of doom by resisting or distorting the implementation of change.

In a service that has a record of periodic confrontation between the government and the health care professions—roughly one such crisis every three years since 1948—never before has the debate been so ferocious as in the past two years. The medical and the nursing professions, the trade unions representing health care workers, and the Labour Opposition fought the administration’s legislation and its implementa-
tion step by step. Kenneth Clarke, the secretary of state responsible for
the reforms, became the most pilloried politician in the country. The
British Medical Association (BMA) plastered the country’s advertising
billboards with its attacks on him. Nor has the battle ended. Health policy
reform will be one of the main issues in Britain’s next general election.
Yet, despite all the professional passion and political furor, the service will
remain free at the point of delivery to all who seek it. The NHS will still be
tax-financed and provide universal coverage.

What has begun to change already, however, is the management
structure and style of the NHS, a process that has accelerated since 1
April 1991. This reform attempt rests on the belief that it is possible to
achieve the best of all possible worlds by improving management, remov-
ing perverse incentives, and dealing with the organizational rigidities that
have afflicted the NHS—which has often been held up as an example of
the more general British problems of institutional and economic sclero-
sis.1 These changes, in turn, present a challenge to the existing managerial
and professional order in the NHS. In this article, we explain the pressures
that drove the government to adopt this ambitious, controversial, and
risky strategy of reform. We then describe the program of change and
analyze why it has had such a dramatic effect on the politics of health
care, though not, as yet, on its delivery. We then discuss the extent to
which the policy objectives are likely to be achieved. In doing this, we
distinguish sharply between policies for hospital services and those for
primary health care.2

Pressure For Change

Since its birth in 1948, the NHS has always been perceived as being
underfunded, a perception encouraged by those working in it. All gov-
ernments, Labour as well as Conservative, have sooner or later incurred
the charge of starving the NHS of resources. In this respect, the 1980s
were no different. What distinguished the decade was that the perception
of an NHS tottering on the edge of collapse became so intense and
pervasive that it pushed the government into its review of the NHS and
the subsequent program of reform. The political price of successful cost
containment had become too high. This rising sense of crisis can perhaps
best be explained by the interaction between three sets of factors. First,
there were the actual budgetary constraints on the NHS, reflecting as
much the troubled state of the British economy for much of the decade
as the government’s ideological commitment to keeping down public
expenditure. Second, public expectations were rising, in the shape of
greater demands for health care responsive to individual wants rather
than professionally defined needs. Lastly, the government’s attempts to satisfy rising demands within constrained budgets led to greater pressure on NHS providers to increase productivity. In turn, the aggrieved providers reacted by denouncing the government’s meanness and fanning public discontent, thus establishing a cycle of demoralization.

**Budgetary constraints.** The 1980s were a decade of financial austerity for the NHS. Continuing a trend set by the previous Labour government in the late 1970s, following a series of economic crises, the Conservatives kept health care spending on a tight rein. Public expenditure on hospital services, which accounts for 70 percent of the total NHS budget, rose by little more than 7 percent in real terms over the decade (Exhibit 1). There is much debate about how such figures should be calculated. However, there is no doubt that the rate of growth in public spending on the NHS was lower in the 1980s than in the 1970s. The reduced growth rate came as a shock to the system. It challenged the assumption of NHS providers that they could count on an annual increment in the NHS budget—historically set at 2 percent per year in real terms—to meet the cost of rising demands on the service and their own higher salaries.

No one disputed that demands were on the increase. Britain’s population, as is that of the United States, is aging; technological innovation is extending the scope for medical intervention; and unexpected tragedies,
such as acquired immunodeficiency syndrome (AIDS), create new calls for extra spending. The issue that emerged during the 1980s was whether such demands required an annual increment of 2 percent in the budget of the NHS, as previously assumed, or whether growth in services could be financed in other ways. The view taken by the Thatcher government was that service expansion could be financed by increasing the efficiency with which existing resources were used within the NHS. To this end, it introduced a series of changes in the NHS managerial structure. It responded to criticisms about inadequate funding by pointing to improving productivity, switching the debate from inputs to outputs. Indeed, there is no doubt that throughout the 1980s the NHS did improve efficiency, productivity, and outputs. Lengths-of-stay were cut; costs per acute case fell. The number of patients treated in hospitals rose by more than 20 percent over the decade, a far higher figure than would have been expected from either spending trends or demographic changes.

**Increased demand for care.** The rise in the provision of services in the 1980s went hand in hand with a mounting perception of inadequacy. The gap between what was available and what was required appeared to be widening. Most obviously, the NHS’s notorious waiting lists obstinately refused to decline despite a series of special government initiatives designed to reduce them. By the end of the decade, almost one million people were in the queue—mainly for elective surgery—instead of the usual 700,000 or so. In reality, waiting lists are a poor indicator of resource inadequacy or of anything else. They are highly manipulable by providers and a good prop in the theater of discontent. They are inflated by the names of people who have moved, have died, or no longer require treatment. No one has yet found a positive correlation between local resource levels and the length of the local queue. Yet despite all this, they command the newspaper headlines, and their persistence helps to explain the growing dissatisfaction with the NHS.

More convincing, if still ambiguous, evidence of frustrated demand is provided by the expansion of the private health care sector. The number of people covered by private insurance rose from three and one-half million at the start of the decade to almost six million at the end—roughly 10 percent of the total population. But such statistics should be interpreted with caution. The private insurance industry is, in a sense, parasitic on the NHS. It can offer what are, by American standards, remarkably cheap policies because it offers coverage for acute rather than chronic conditions (the growth in Britain during the 1980s of the private, long-stay sector is a different story, since it has been fueled not by private insurance but by Social Security finance). Medical practitioners in the private sector are NHS consultants who supplement their hospital salaries
with private practice, a factor that causes friction and conflicts of interest but that also constrains the sector’s growth. Overwhelmingly, if not exclusively, the private acute sector deals with quality-of-life procedures, such as arthroplasties or hernia repairs, while leaving the NHS to cope with life-threatening or chronic conditions. So, on the one hand, almost 20 percent of the former procedures are carried out in the private sector. But, on the other hand, even the privately insured population use NHS facilities for over half of their hospital stays.

It is, in short, precisely what might be expected if one assumes that the NHS, given resource constraints, gives priority to life-threatening conditions over intervention designed to enhance the quality of life. In this respect, the 1980s conformed to the pattern set in the earlier decades of the NHS’s existence. What appears to have changed is the attitude of a growing section of the population that is less tolerant of queuing. In its near half-century of existence, the NHS has been living off a legacy of deference: a mixture of gratitude and respect for doctors and nurses that legitimized the paternalism of the NHS. By the end of the 1980s, this legacy was wearing thin.

**Pressure on providers.** This transformation, while potentially threatening to the medical profession, was, in turn, accelerated by the attitude of the profession itself. The measures taken by the government in the 1980s to increase NHS productivity were increasingly persuading the medical profession to exploit public discontent. Following the 1983 Griffiths Report, the managerial structure of the NHS was greatly strengthened. Central government set a series of productivity targets for health authorities. The balance between managerial and professional authority began to shift toward the former. As managerial pressure on the medical profession increased, so did the latter’s discontent.

The NHS has always been based on an implicit, unspoken concordat between state and profession. The former set the budgets within which doctors operated. The latter, however, had complete autonomy to decide whom to treat, and how, within the limits of those budgets; British doctors traditionally enjoyed far greater freedom from scrutiny than their American counterparts. The new managerial activism threatened this concordat. The medical profession reacted by questioning the budgetary constraints within which it had to work and denouncing the inadequacy of the NHS. Medical indignation was translated, in turn, into public dissatisfaction with the NHS. The culminating point came late in 1987, when the presidents of the Royal Colleges, representing the prestigious specialists, issued a public statement warning that the NHS was facing ruin. This statement, it is said, so infuriated Thatcher that she announced her review of the NHS to the surprise of even her own ministers and civil
servants—a review that, against all precedent, excluded the medical profession. So began the process that was to end in the introduction of the program of change.

A New Set Of Incentives

The dilemma in which Thatcher and her advisers found themselves when they started their review of the NHS had one obvious solution: to devise a new method for funding health care in Britain in line with its own ideological commitment to rolling back the frontiers of the state. Urged on by many of its own supporters, the Thatcher government investigated the possibility of moving toward an insurance-based system on the German or French models. But, predictably enough, it rejected this option. Moving to an insurance-based system, as the experience of other countries demonstrated, did not absolve governments from responsibility for overall spending levels (a seemingly international obsession). Moreover, such systems did not appear to be as successful as Britain’s in terms of change; rising public and professional discontent expressed itself in demands for a better NHS (by which was meant a more generously funded one) rather than for a different health care system.

One option, clearly, was simply to soldier on: to continue with the policies designed to improve productivity by strengthening the management of the NHS. To a large extent, this was precisely what happened. Most of the reforms heralded by the 1989 review document, Working for Patients, were built on the foundations laid earlier in the decade. But there was one crucial new element: the revolutionary notion (in the British context) of splitting responsibility for buying health care from that of actually providing services. Hitherto, these had been combined. District health authorities (DHAs) had been funded for running the services within their own boundaries. If those living in a district sought their health care in neighboring health authorities or in prestigious London teaching hospitals, the resulting transfers of money did not reflect real costs. In short, the system of NHS finance did not provide any incentives to increase productivity, since greater activity simply added to costs without bringing in any corresponding revenue. Hence, underused operating theaters and hospitals’ deliberately restricting the output of their surgeons caught the public eye.

Since April 1991, the system is radically different. The roles of purchaser and provider are separated. DHAs will be funded according to the size and demographic composition of their populations, not according to the services for which they are responsible. Their function will be to buy the best services they can from a variety of providers. The key principle
is that money follows patients. Patients can be treated in the district’s own hospitals, in other NHS hospitals, in the private sector, or in NHS hospital trusts, a new category created by the 1989 review that allows hospitals to turn themselves, under certain conditions, into self-governing trusts. This status gives hospitals considerable freedom to determine their own policies and salary scales, as well as to raise capital, provided they attract enough patients to generate sufficient income.

The introduction of this new notion, whose full implications are only gradually becoming apparent, dealt with one of the major criticisms of the earlier managerial reforms, which was advanced by Alain Enthoven in his much-discussed reflections on the NHS, published in the mid-1980s.\(^\text{10}\) (See also Enthoven’s article, “Internal Market Reform of the British NHS,” in this issue of *Health Affairs.*) Enthoven’s notion of an NHS “internal market,” to allow DHAs to buy and sell services, looks remarkably like the solution adopted by the government four years later.

While there is no doubt that Enthoven was extremely influential in helping to shape the vocabulary of debate and extending the range of possible options, there were indigenous influences as well. Those involved in Thatcher’s review often draw attention to the government’s reforms of the school system, which preceded those in the NHS by some two years, as a model.\(^\text{11}\) These reforms gave schools the right to opt for self-governing status and largely limited the roles of the local education authorities to providing funds for individual schools. Money followed pupils. However, the education changes went much further in one respect. In the case of schools, the dynamic of change was to be parental choice and competition between schools for pupils—one step short of education vouchers, but following much the same logic.

So, although much of the rhetoric of *Working for Patients* was about making the NHS “more responsive to the needs of the patient,” the reality in the case of hospital services stopped well short of allowing consumer demand to drive the service. Managers will continue to define the needs of patients, explicitly so in the case of the DHAs, which are charged with determining the needs of their populations when drawing up their purchasing plans. Managers also will have greater responsibilities (and powers) for calling the medical profession to account for their use of public resources. Medical audit is to become compulsory. Future consultant contracts will specify in far greater detail what is expected from the job holder. Distinction awards to consultants, which may double their salaries and greatly enhance their pension entitlements, will in the future no longer be based on clinical excellence alone. Managers will have a voice in making the awards, taking into account the contribution of candidates to the work of the NHS.
This challenge to the autonomy of the medical profession, as much as its manner of production, helps to explain the violent reaction to Working for Patients. Not only had the profession been excluded from Thatcher’s review; the prime minister chose those she consulted precisely because they were not representative of the profession. But the results of the review appeared to present a direct threat to it. It was no wonder, then, that the medical profession fought the implementation of government’s proposals, prophesying that they would create chaos and confusion.

Reforming The Primary Health Care System

In explanations of Britain’s ability to deliver a frugal, comprehensive, universal, and reasonably high-quality service, it is customary to stress the system of central financial control. But an important contributory factor in making this achievement possible is Britain’s system of primary health care. Every member of the population is registered with a general practitioner (GP) and, on average, makes about four visits a year. The GP is the gatekeeper to the expensive hospital sector and the patient’s agent in the choice of route into the complexities of specialist care. In all, there are some 27,000 GPs in England (compared to 45,000 hospital doctors) with an average list size of just over 1,900 patients. The GP is the “family doctor” who, certainly in theory and quite often in practice, provides continuity of care, treats minor and chronic illness, and takes up where high-technology hospital intervention leaves off. Primary health care is a remarkably cheap service. Total expenditure on primary health care represents less than a third of the total NHS budget (Exhibit 1). And of this, only 30 percent is paid directly to GPs and their staffs. A further 46 percent is spent on pharmaceuticals prescribed by GP’s (three-quarters of prescriptions are free; there is a flat rate charge for the rest), while the remainder pays for the dental and ophthalmic services.

Nevertheless, the Thatcher government’s interest in reforming primary health care predates its program of change in the expensive hospital sector. It published its first set of proposals for change in 1986, that is, well before political and professional agitation persuaded the prime minister to set up her review of the NHS as a whole. A number of concerns drove the engine of change. First, the Department of Health wanted to harness the activities of general practice more effectively to its own policy objectives, which in the 1980s were increasingly preoccupied with prevention. Second, the British Treasury was putting increasing pressure on the department to stop up one of the few holes in the NHS budget: primary health care spending, which, particularly on prescribing, is demand-driven and thus difficult to control. This, of course, is why, as
Exhibit 1 shows, expenditures have been rising at a much faster rate than in the hospital sector. Third, within the profession itself—and especially in the Royal College of General Practitioners—powerful voices were arguing for action to improve the quality of general practice, with particular anxiety about the inadequacy of many practices in inner cities.

Lastly, as in the case of hospital consultants, there was a feeling that GPs should be made accountable for their use of public resources. British GPs are independent contractors with the state. They achieved this status in 1911 and have defended it fiercely ever since, with the result that they gained virtual immunity from scrutiny of their activities. However, by the 1980s, ministers (and others) were getting increasingly restive about the variations in GP practices and the implications for expensive hospital services and NHS budgets. At times, there were twenty-to-one variations in the hospital referrals made by GPs, without any obvious explanations.

These concerns largely shaped the government’s first set of proposals. These were designed to provide incentives to improve quality and to introduce a tighter system of accountability, thereby giving a larger and more active role to managers. The proposals also introduced a new policy theme, reflecting the Thatcher government’s bias toward consumerism and the market principle. Although the system of remuneration introduced in 1948 maintained the principle of capitation payment first introduced in 1911, at the birth of national health insurance, this principle was subsequently eroded by a variety of salary elements, for example, allowances to encourage GPs to settle in underdoctored parts of the country. By the mid-1980s, therefore, only 46 percent of GP income was derived from capitation. The Thatcher government decided this trend should be reversed. With list sizes falling, the danger was no longer that GPs would accumulate excessive numbers of patients, but that they would be indifferent or unresponsive to consumer demands. Hence, they should derive a higher proportion of their income, say 60 percent, from capitation fees to give them an incentive to compete for patients.

There followed a stately pavane of consultation with the BMA and others. While persisting with its strategy, the government made some concessions. Yielding to the profession’s objections to merit awards for GPs deemed to be practicing high-quality medicine, the government put forward another battery of incentives: payments dependent on the achievement of specific targets for immunization and vaccination rates. However, the stately pavane turned into a frenzied dance with the publication of the government’s 1989 review. If the prospects of achieving an agreement between government and profession had always been uncertain, now they were extinguished. The knives were out.

The profession viewed two new proposals for change that emerged from
the review as particularly threatening. First, the review brought in the notion of “indicative drug budgets” for individual GP practices, that is, a budget ceiling for prescribing costs. Although ministers stressed that reasonable overshoots would be allowed—that the budgets were indicative, and no more—the medical profession, not without reason, saw this as a victory for the Treasury and a move toward capping their prescribing budgets. Second, the review introduced the idea of GP practice budgets: practices with more than 11,000 patients (subsequently reduced to 9,000) could opt for a budget, out of which they would buy a range of diagnostic and hospital services for their patients (in effect, becoming miniature health maintenance organizations). This move was denounced by the profession, echoed by the Labour Opposition, as being designed to encourage GPs to pinch pennies rather than to pursue the best interests of their patients. This denunciation appeared to assume either that GPs had previously been indifferent to financial considerations (singularly unconvincing, given their toughness in pay negotiations) or that they were overly susceptible to corruption (an unflattering conclusion).

There followed further negotiations between the Department of Health and the medical profession. A package acceptable to the profession’s leadership was worked out; however, it was promptly repudiated by the representatives of rank-and-file GPs. Finally, Secretary of State for Health Kenneth Clarke—who throughout enraged the profession with his combative manner and his lack of deference to them—imposed a new contract on the profession, for the first time in the history of the NHS. As it turned out, in its billboard advertising campaign, the profession had simply advertised its own impotence: its failure to block, or even significantly dent, government policies. When it came to the point, Britain’s GPs had no stomach for a fight; the threat of withdrawing from the NHS was an empty one, given their dependence on income from the state.

The new contract symbolized the changed status of GPs: accountable, at last, for what they did and with explicit obligations to carry out certain contractual tasks. Under the previous contract, GPs had defined their own obligations. If Family Health Services Authorities, the managerial bodies responsible for primary health care, choose to do so, they can henceforth monitor the implementation of the GP contract as never before, as they can monitor referral and prescription patterns.

**Implementation: The Short-Term Impact**

The new-style NHS is very much the product of the Thatcher era. Nevertheless, there is no reason to expect any change of policy, as distinct from style, in the post-Thatcher years while a Conservative government...
remains in power. With the legislation pushed through successfully, the new machinery put into place, the government’s tone has become more conciliatory—a process that was apparent even before the change of cast. But John Major’s government is firmly committed to the reforms. If there remains much uncertainty about the impact of the changes, it is because the new NHS is, in a very real sense, an experiment whose outcome cannot be predicted with confidence.

**Hospital services.** Consider first the case of the hospital services. The timetable of change allowed little more than two years between the announcement of the program of reforms and getting new machinery running. Little preparatory work had been done, and at times the civil servants at the Department of Health appeared to be inventing the machinery on the hoof. Yet it is difficult to exaggerate the complexity and demanding nature of the managerial task involved. The notion of splitting the purchaser and provider roles not only meant developing a new grammar and language of management. It also meant creating a database capable of generating the information needed to operate the new system. Traditionally, the NHS has been information-poor, if awash with statistics. But if doctors were to be held more accountable, it was necessary to know more precisely what they did. If the money was to follow patients, it was essential to know how much they cost. Thus, a massive investment was needed to develop the NHS’s primitive information system, an investment that produced large dividends for management consultancy firms and others with relevant experience, often imported from the United States.

Given the exacting, expensive, and exhausting managerial transformation involved, it is not surprising that the government was widely criticized for its hurried root-and-branch approach to reform. Those hostile to the principles shaping the changes denounced the government for imposing an untried set of ideas on the country without testing them first. Even among those sympathetic to the reform package, many argued it would have been wiser to start with some demonstrations to eliminate bugs and to show doubters that the system could be made to work.\(^{14}\)

It is not quite clear whether such a step-by-step strategy would have been feasible. Social experiments seldom settle political arguments, as U.S. experience shows all too clearly. Furthermore, demonstration projects tend by definition to be atypical. But, in any case, the argument for a more cautious strategy has been largely made redundant by events. True, the new system was in place nationally as of 1 April 1991, but it is already clear that change is being implemented incrementally; that both purchasers and providers are exploring their new roles tentatively and interpreting them variously, and that there is, in effect, a series of experiments,
reflecting local circumstances and understanding of what should be done.

The point can best be illustrated by looking in more detail at how the principle of separating the roles of purchasers and providers is being interpreted in practice. This principle represents the key element in the new NHS. Moreover, it has also encouraged the myth that Britain has adopted the U.S. model of competition in the health care market. In the outcome, there is not going to be much competition or much of a market. British purchasers (that is, the DHAs) are mostly going to stick to the hospitals in their own or neighboring districts that have traditionally produced services for their populations. Most of the purchaser/provider service agreements are block contracts designed to ensure continuity in the provision of health care.\textsuperscript{15} To quote one of Britain’s most sophisticated management teams: “An examination of purchaser/provider relationships in industry and commerce suggests that the most successful companies are those which work closely with supplier partners. . . . A partnership framework for developing service agreements is particularly suited to the Oxfordshire District. This is because, if the DHA is to maintain convenient access for local residents to good quality services, an Oxfordshire provider will often be the only reasonable choice. The rationale for developing explicit service agreements within such a framework is therefore to enhance accountability, not to encourage competition.”\textsuperscript{16}

The story, and the strategies, may be rather different in districts with a large export and import business, and where there is an imbalance between their income (calculated on the basis of the size and composition of their populations) and the facilities within their boundaries. In such cases, competing for customers and contracts may be a condition of financial survival. However, such authorities are a minority and largely concentrated in London. In this, as in so many other respects, the situation in London—with its concentration of teaching hospitals that draw in customers from a wide catchment area—tends to be atypical of the rest of the country. It does, however, attract a disproportionate share of the comment about the NHS because of the propinquity of the media. Too often, the NHS is viewed through the distorting mirror of London, which turns even minor hiccups into headline-catching crises.

If the move toward competition is going to be, at most, incremental and marginal, much the same is true of the transformation of NHS hospitals into self-governing trusts. Such trusts, be it remembered, still remain NHS property, with more freedom to run themselves and to raise their own capital for development. They are also revocable.\textsuperscript{17} Equally, this status is optional: no hospital has been compelled to change its status, although the government has employed both cajolery and bribery to make sure that this model is up and running. Nevertheless, few proposals in the
government's reform package have encountered more opposition. Self-governing status has frequently been denounced as privatization by another name. The freedom of trusts to negotiate their own terms of service for their employees, instead of being bound by national agreements, has been seen as a threat by professional as well as trade union bodies. Right to the end, the process of setting up trusts was accompanied by demonstrations and opposition, often orchestrated by the Labour party. Surprisingly, for those who thought that such trusts could turn out to be worker cooperatives dominated by consultants, the medical profession has been split. As often as not, consultants have voted against opting to set up trusts when managers have tried to set them up. Only fifty-six of the 1,700 hospitals in England achieved self-governing status in the first wave, although that number will probably triple in April 1992, when the second wave is due. There is therefore every opportunity for testing out the model before it becomes generalized.

Rather than a sudden plunge into a competitive health care system, the NHS's "internal market" for hospital care will be a special kind of market, with managers trading with each other and with the consumer conspicuous by his or her absence. Moreover, the trading may have more to do with the reliability, accessibility, and timeliness of services provided than with the price. Managers will be seeking not the cheapest form of intervention for individual patients, but the service package that appears to offer best value and the services required by their population.

Thus it is not competition that is going to distinguish the new-style NHS. Rather, it is the move from the notion of trust to one of contract. For its first forty years, the NHS left explicit treatment decisions to clinicians. Now, however, contracts will spell out what was previously left implicit. The crux of the purchaser/provider relationship is precisely that, for the first time ever, the nature of the services to be provided in the NHS will have to be defined in the contracts or service agreements made. In the context of the NHS culture, this move from the implicit to the explicit, from trust to contract, is truly revolutionary and has perhaps the farthest-reaching long-term implications.

General practitioners. What goes for hospital providers also applies to general practitioners. The first impact of changes in the NHS may, paradoxically and perversely, blunt the incentives to compete and limit consumer choice. Most immediately, and perhaps most importantly, the change has been a financial bonanza for many (perhaps most) GPs who were already vaccinating, immunizing, and screening most of their patients before the contract introduced bonus payments for meeting specific targets. Similarly, GPs who practice in inner cities-and thus qualify for the special "deprivation payments" introduced by the new contract-get
extra compensation for the difficulties involved in reaching these targets when dealing with a mobile population. Add to this the surge in spending on subsidies to GPs for employing practice staff, 70 percent of whose salaries are met out of the public purse up to a limit of two per practitioner, and it is clear that they have emerged from their battle with the government a great deal richer if not happier.

This conclusion needs to be qualified in one respect. Financially, the new deal is an exercise in redistribution of income among GPs, sweetened by what the government hopes will be a once-and-for-all injection of extra funds. The new system of pay is designed to steer money toward those GPs who practice the best medicine, largely defined in terms of their preventive activities and their capacity to organize their practices to achieve the various targets. Conversely, GPs who practice old-style reactive medicine and, often because they practice solo, lack adequate information systems will lose out, although the government conceded a system of transitional payments to ease the pain. It is too early to draw up a balance sheet of gainers and losers; first indications, however, are that only a small minority of GPs will suffer a loss of income. There will also be some opportunities for entrepreneurial GPs to add to their incomes by engaging in fee-for-service activities made possible by the new contract, notably minor surgery and health promotion clinics. But here the profession has a collective incentive to discourage excessive exuberance. The income of GPs is determined by an independent tribunal, which sets the average net remuneration for the coming year. Multiplied by the number of GPs, this then determines the profession’s collective income. If this is exceeded as a result of hyperactivity by some physicians, the excess will be deducted from the following year’s settlement. This inhibition does not apply to GPs who boost their incomes by increasing the number of patients on their lists, since one GP’s gain is another’s loss.

Overall, however, it is clear that most GPs will have no pressing reason to engage in competition for patients. Similarly, it is likely that the most contentious component in the government’s package—the introduction of budget holding for GPs—will also dampen competition. Specifically, budget holding permits GPs to shop around, on behalf of their patients, for the kind of diagnostic and elective procedures that are the core of the waiting list issue. At the same time, it gives them an incentive to deal with patients’ problems themselves, instead of passing them onto the hospital service. Budget-holding GPs thus will be forced to examine the financial implications of their clinical decisions. This caused the BMA, as well as the Labour party, to pronounce anathema on the whole concept. The judgment of GPs, it was argued, would become corrupted. Instead of thinking only about the patient, they would be worrying about their
bottom line. They would exclude expensive patients from their lists.

If developments since 1989 have not stilled the objections of principle to budget holding, they have demonstrated the feasibility of what at first seemed a rather crackpot notion. A surprising number of GPs have voted with their feet against the BMA line; the BMA has been forced to moderate its root-and-branch excommunication for fear of splitting its membership. Some 300 practices became budgetholders in April 1991—roughly 10 percent of those eligible—and this number is likely to double in April 1992. In part, this reflects the generous handouts for the pioneers, particularly for the installation of information systems. In part, however, it reflects a realization among GPs that budget holding gives them power. Instead of being dependent on the goodwill of hospital consultants, the situation may be reversed: consultants may actually come to see them as valuable customers and woo them accordingly. Additionally, budget holding has come to be seen as the cure for the occupational disease of British GPs: boredom. Instead of being preoccupied with dealing with chronic complaints, they face a new, acute challenge. This helps to explain, perhaps, the enthusiasm and skill that has been brought to developing the information systems required to make budget holding work. But the converse of this enthusiasm is that budget holding gives GPs an incentive to build up larger practices and even to form buyer cooperatives with other local practices, limiting competition and choice.

Whether intended or not, budget holding is therefore an experiment; only the experience of the first 300 practices, over time, can yield any kind of evaluation. But two tentative conclusions can already be drawn. The first is that the sheer crudity of the process of determining the level of budgets provides safeguards against predicted dangers. The budgets have mostly been negotiated on the basis of the previous activities of the practices concerned; hence the very considerable variations in the allocations, on a per capita basis, between them. This is precisely the same strategy as that adopted in the case of determining funding for prescribing. But the fact that the budgets are settled by negotiation rather than by formula does offer protection against abuse. If GPs engage in adverse selection, for example, they will be penalized accordingly in the determination of their budgets. Account can also be taken of patients with special needs. Also, it has become clear that GPs will have only weak financial incentives to skimp on patient care. Any “profits” must be ploughed back into practice improvements; they cannot be taken out in cash. So while underspending may improve the practice’s long-term financial prospects by funding investment, it gives no immediate yield and could, if too blatant, lead to a downward revision of the budget.

The other shift in power, made transparent by the process implement-
ing the reforms, is that from the medical profession to the managers of primary health care. The managers are the midwives of innovation. They determine GP budgets, prescribing ceilings, and the allocation of funding for the practice staff. Similarly, managers will monitor the way in which the new system works, particularly if budgetary limits are overshot. At every stage, therefore, managers will have an opportunity to mold general practice and to call GPs to account for their use of public resources. The emphasis in all of this is on persuasion and dialogue; the rhetoric is very much about the enabling role of management, rather than about its powers. But here again there must be uncertainty about how the new system will develop over time, and in particular about the danger that the new regulatory machinery will be captured by the medical profession.

Future Indefinite

What will Britain’s health care system look like by the end of the 1990s? No confident answer can be given to that question, given that the NHS operates in a turbulent and uncertain economic and political environment. If Britain’s economy prospers, so will the NHS budget. Conversely, if the economy remains sluggish, health care will continue to be on short commons. In this respect, the Conservative changes have done nothing to diminish the service’s financial vulnerability to political decisions taken in the light of the government’s overall policies of economic management. Similarly, if the Labour party were to be returned to office at the next general election, due by mid-1992, change would go into reverse gear. Labour has committed itself to both increasing expenditure on the NHS and dismantling most of the Conservative reforms, although its willingness and ability to carry out these pledges would of course depend on its economic inheritance and the timing of the election. If this were later rather than sooner, a Labour government might well plead the problems of disruption and confine itself to some resonant symbolic changes. Abolition of hospital trusts, which inspire much emotion but are marginal to the principle of the internal market, is one such gesture. Whether Labour would also honor its commitment to end GP budget holding might, however, depend on how this worked out in practice and whether a constituency had been created for its survival. However, the purchaser/provider split looks set to survive any change of government.

Assuming, however, that Major’s government wins the next general election, what then? Even if 1 April 1991 has not marked an immediate transformation of the NHS as experienced by its consumers, what will happen as the changes work their way through the system? Regarding costs, it is clear that spending on administration in the NHS hitherto...
an extraordinarily parsimonious system has risen and will continue to do so. Apart from the investment in information technology, probably justified in terms of improving services for patients, there will be the extra costs of billing under the contract system. Using American technology will, in this respect, lead to an American-style cost problem, if stopping far short of it. More intangibly, the move toward demanding greater accountability from the medical profession could backfire if it leads to sullen resentment. Although the NHS may have relied excessively in the past on the relationship of trust between doctors and managers, this still remains one of its greatest assets. It has ensured a degree of medical commitment to the NHS that goes far beyond anything that could be guaranteed by the letter of a contract; most hospital consultants, for example, put in more hours than required by their contracts. Much will therefore depend on whether ministers and managers succeed in their efforts to smooth down the ragged tempers of the medical profession and to restore goodwill.

The move toward explicit contracts is, nevertheless, responsible for some of the most immediate benefits that are emerging. It has forced into the open issues that have remained undiscussed for forty years. Thus, there has been an upsurge of interest in how to specify quality and how to ensure its delivery. Similarly, there has been a new-found zeal for devising standards for patient treatment. This, indeed, is a transformation, even if it will take some time before the effects trickle down to the patients. Again, the emphasis on prevention and health promotion in GP contracts marks a radical shift in public policy, although some of the enthusiasm for regular checkups and screening may be a touch promiscuous. It is not quite clear that it will have the hoped-for effect on health outcomes. In all of these (and other) respects, the NHS has become more self-critical and self-aware. Nothing will ever be quite the same, therefore, even if the program of reform were put into reverse or on hold.

So far, then, the balance sheet seems to come out in favor of the reforms, despite the burdens imposed on managers struggling to implement an extraordinarily complex task against a ferocious timetable. But there remains the question of whether the new-style NHS—whatever improvements it may bring—will actually meet the aspirations of its creators: whether, to return to the argument we began with, it will combine the advantages of the national health service model (financial parsimony and social equity) with those of a market system (responsiveness to consumer demands). Here the verdict must be an open one. For what is most significant about the new-style NHS is that it actually incorporates two different models. While the hospital model is management-
provider-led, the primary health care model is much more consumer-led. Even if competition is going to be mainly conspicuous by its absence in both models—except at the margins—the nature of the markets will be very different. In the hospital model, purchasers are proxy consumers, while in the primary health care model, GPs are proxy consumers.

The two models are incompatible in at least one crucial respect. The responsibility of purchasing authorities is to determine the health care needs of their populations and to buy services accordingly. This is very much in the paternalistic tradition of the NHS; equity has always been defined in terms of experts identifying needs and allocating resources accordingly. In this sense, the hospital model represents the apotheosis of the health expert. In practice, of course, things will be much less tidy; health authorities will also have to provide quick fixes in response to political or consumer pressures. But, quite clearly, the model is at odds with the demand-led, primary health care model. For if responsibility for buying services is to be diffused among GPs, not in accordance with some ideal population-based strategy but in response to the needs (and pressures) of patients as interpreted by individual practitioners, then population-based health care planning is in tatters. To the extent that the achievement of equity does indeed depend on sticking to a needs-based model, then clearly it cannot be combined with a market based on a plurality of buyers. Conversely, to the extent that responsiveness to consumer demands depends on a plurality of buyers, it cannot be combined with equity based on giving a purchasing power monopoly to expertise. So which model will win out?

Clearly, the big battalions are on the side of the monopoly-purchaser, hospital model. Hospital consultants have been remarkably slow to realize the way that general practitioner budgets could tilt the balance of power toward primary health care. But together with the equally threatened hospital managers, they form a potentially powerful coalition. They might therefore be expected to seek to abort the GP budget-holding experiment by a mixture of outright opposition and preemptive change, by demonstrating their willingness to adapt their practices to GP demands. Such strategy could well succeed, particularly if the first wave of GP budget-holders produces a crop of financial fiascos or much-publicized inequities in the treatment of patients—a perfectly conceivable outcome, given that some failures are inevitable in any experiment. Moreover, GPs who are unwilling or unable to become budget-holders might well applaud the collapse of the experiment—as would the BMA—for they are in the position of small shopkeepers threatened by the rise of the supermarket.

Another consideration is pulling in the opposite direction—one at the heart of the debate that prompted the Thatcher government’s plunge into
reform in the first place. This is the question of which model is most likely to ensure financial control. Here, on the face of it, the hospital model is a clear winner. Once a purchaser has decided what services to buy, within the constraints of the existing budget, expenditure is eminently controllable. In contrast, the primary health care model—as yet untested, in any case—diffuses spending decisions among GPs with no experience of budgetary control or tradition of public accountability. So, in terms of financial control, there would appear to be no contest. However, the balance of argument changes when we turn to political considerations. Here the strength of the hospital model turns out to be its weakness, while the converse is true of the primary health care model. In the past, resource allocation decisions in the NHS have been largely implicit—part of the concordat between state and profession, which has left the individual doctor to ration at the point of delivery. The new system, however, forces purchasers to be more explicit about what services will be provided for their populations. The purchasing authorities will have to give visibility to decisions about what to buy and, more important, what not to buy. While the concentration of financial power and decision making reinforces control, it also increases the risk of political embarrassment. Without intending to do so, the government may have created a system that will add to the pressures for more public expenditure on the NHS. Significantly, the public spending plans for fiscal year 1991-1992 envisage a larger rise, in real terms, in the NHS budget than at any time in the 1980s. Conversely, while the primary health care model is weaker on financial control, it diffuses the decision-making process. It makes the consequences of resource constraints much less visible and, in this respect, would mark a return to the traditional British approach of making rationing largely invisible by leaving it to individual physicians and disguising it as clinical decisions.

So, in effect, two quite different futures for the NHS are on offer, apart from the possibility of muddling through with an unresolved conflict at the heart of health care policy. One would represent a reversion to tradition, modified at the edges; the other would mean a more radical break with the past. The present mix, however, is likely to prove unstable. The way in which future governments jump will depend on a variety of factors: the outcome of the present experiments, political ideology and expediency, economic prospects, and the attitude of the medical profession. Only one prediction seems reasonably safe: that Britain’s health care system will continue to change before it reaches a stable state. In the meantime, it will continue to send out confused and conflicting messages to those who want to use it as a text for sermons.
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NOTES

2. Throughout we refer to hospital services, where strictly speaking we should be referring to hospital and community services, that is, to the outreach programs, such as community nursing, which conventionally are grouped under the hospital heading, particularly in public expenditure statistics.
5. *Laing’s Review of Private Health Care 1989/90* (London: Laing and Buisson Publications Ltd., 1990). This is the most comprehensive, up-to-date source of information about private health care.
18. The splits have been gleefully reported by the *British Medical Journal*. See, for example, the reports in the issues of 5 May and 16 June 1990 (pages 1158 and 1539, respectively).
19. See the regular surveys of general practitioner incomes published in *Medeconomics*, for example, the July and November 1990 issues.
20. This is the Review Body on Doctors’ and Dentists’ Remuneration. Although its recommendations are not invariably accepted by governments, over time it effectively determines medical pay.