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Prologue: In 1984, Gordon McLachlan, then director of the Nuffield Provincial Hospitals Trust in London, invited Stanford professor Alain Enthoven to spend a month in the United Kingdom reviewing the British National Health Service (NHS). At the end of his visit, Enthoven was to give a talk to the Nuffield board of trustees, offering his views on which direction the NHS should head as the British government contemplated its reform. Enthoven’s findings were published in 1985 as Reflections on the Management of the National Health Service, a document that eventually reached the hands of then Prime Minister Margaret Thatcher and her advisers. “Enthoven’s notion of an ‘internal market’ in the NHS . . . looks remarkably like the solution adopted by the government four years later,” Rudolf Klein and Patricia Day have noted. In this article, Enthoven examines the concept of internal market reform, which is designed to address the perverse economic incentives that have existed for years in the NHS. “The NHS is intensely political,” Enthoven said. “All over the world, it carries much ideological freight. What I have done is to look at it as a practical problem in organizational management: how to structure the service so that desirable innovations will happen.” Enthoven’s association with Britain is a long and fruitful one. The son of a British father, he studied at Oxford as a Rhodes scholar, received a master of philosophy degree in economics, and returned as a visiting fellow at St. Catherine’s College, Oxford. He received his doctorate in economics from the Massachusetts Institute Of Technology and is Market Eccles Professor of Public and Private Management at the Stanford University Graduate School of Business. More recently, he has studied the Dutch and Swedish health systems and has advanced the notion of “managed competition” in the United States.
The phrases “National Health Service” (NHS) and “market forces” both carry powerful ideological overtones that make calm and practical discussion of appropriate principles of organization and management very difficult. Any serious proposal for change in Britain’s NHS is sure to be attacked as “an attempt to destroy the National Health Service.” Perhaps that is why there has been so little such discussion in public until recently.

The NHS has important strengths: universal coverage, effective cost containment, regional concentration of costly specialized services, and a strong primary care system. The NHS is able to allocate resources, for example, to be sure everyone gets basic primary care, including routine immunizations, before resources are spent on heart transplants or other services with very high costs that convey small benefits to few people. But it has had serious problems: rigidity, overcentralization, and a complete lack of incentives for innovation and improvement in efficiency.

In a 1985 report to the Nuffield Provincial Hospitals Trust, I wrote: “The National Health Service . . . is obviously the democratic choice of the overwhelming majority of the British people. . . . And it produces a great deal of care for the money spent. . . . But the NHS is under increasing economic pressure. The prospects for real growth in the resources devoted to the NHS appear to be very limited. . . . So the NHS will need to find ways to produce even more value for money if it is to make effective new medical technology available to all who can benefit from it at the standards enjoyed in the other industrialized democracies. It will take more than the energy, intelligence, and desire of NHS managers to accomplish this. A supportive environment and some institutional innovation will also be needed.”

The report went on to describe an internal market model in which market forces would work within the NHS; externally, comprehensive care would continue to be taxpayer-financed and free at the point of service.

After an extensive review of the problems and structure of the NHS, the British government published a White Paper in January 1989, Working for Patients, proposing a set of ideas very similar to the internal market model. This was followed by introduction and approval of the National Health Service and Community Care Act, which received Royal Assent 29 June 1990, with a target date for implementation of 1 April 1991.

Some Structural Problems In The Prereform NHS

The following were some of the structural problems in the NHS before reform that the internal market proposal was intended to ameliorate.

Gridlock. The NHS was caught in the grip of forces that make change
exceedingly difficult. The government enforces cash spending limits. Consultants (that is, senior physicians) have long-term contracts with the NHS that leave management with little leverage to make their services responsive to patients’ needs. General practitioners (GPs) have great autonomy. Staff are unionized with national agreements on wages, working conditions, and job security. It is more difficult to close an unneeded NHS hospital than an unneeded American military base. The NHS is extremely politicized. The government is expected to answer in Parliament for anything that happens in the NHS.

Efficiency. There was no serious incentive to make changes to improve efficiency. Nothing bad would happen to a hospital administration whose case-mix-adjusted cost per case was 25 percent higher than average. Nothing good would happen to one whose cost was 25 percent below average. Indeed, those facts would not even be measured and known.

Perverse incentives. Worse yet, there were perverse incentives. A hospital that did an excellent job of improving quality and efficiency in a particular service—say, total hip replacement—and that succeeded in greatly shortening its queue would be likely to attract more referrals, therefore, to get more work without getting more resources to do it. (The process for financial compensation for interdistrict transfers was inadequate.) A district that did a poor job would “export” patients and have less work, but not correspondingly fewer resources, for its reward.

Overcentralization. Pay and working conditions were set by national agreements, leading to great waste and inefficiency. For example, one district general manager said one of his most serious problems was keeping his top surgeons supplied with good secretaries. This is important because surgeons produce good operative notes for medical records. A good secretary can save a surgeon a great deal of time. However, the manager’s district included the European headquarters of a major corporation, which kept hiring away his best secretaries. To make a counteroffer above the national wage scale, he would have needed the approval of the minister in London. And his request would no doubt have been met with cries that it would be unfair to pay these secretaries more than other secretaries doing similar work. So the consequence of this particular bit of fairness is that surgeons edit notes instead of operating, and patients who need operations wait in queues, while secretarial work is purchased at surgeons’ wages. In another example, surgeons at a London teaching hospital wanted to continue operating past three o’clock in the afternoon in unused operating theaters. Patients needed operations, and some nurses would have been willing to work for overtime pay. But a combination of national labor agreements and line-item budgets prevented this.

Provider domination. Each District Health Authority (DHA) was a
monopoly supplier of services to people in its district. A monopoly supplier is inevitably driven mainly by the needs and wants of providers rather than patients. Behind the rhetoric of caring for patients, the NHS was provider-dominated. One aspect of provider domination was that consultant physicians had lifetime contracts with Regional Health Authorities, with merit pay determined by professional recognition, not service to patients. Nobody was seriously charged with the responsibility to measure and prioritize patients' needs and wants and then to use resources as effectively as possible in response.

**Accountability.** In private markets, producers are held accountable for the cost and quality of the goods and services they produce. The normal assumption in the public sector—including the NHS—is that the output cannot be defined and measured, so the producers cannot be held accountable for it. So, in a manner typical of the public sector, producers are held accountable for the use of inputs by budget-line items, such as nurses' salaries, building repairs, and disposable supplies. Then the focus of accountability is not, “Did you produce the greatest output possible with these resources?” but rather, “Did you operate within these budget limits?” This kind of system can explain the following paradox. A hospital administrator, spending millions of pounds a year, complains that the roof is leaking, that it is costing more to mop up than it would to fix the roof, and that this cannot be done because there is no money to fix the roof. What probably happened is that there was a budget-line item for building repair. At the last minute, the government found itself in a budgetary squeeze and deferred all or much of building repair and maintenance, thus not allowing the hospital the flexibility to reallocate funds.

**Capital spending.** Capital has been either “free” to those districts and hospitals that had it or very hard to get, requiring layers of approvals. Capital was budgeted separately from operating funds. Capital spending over thresholds was controlled by regions. Property could not be sold without regional approval, and the selling district did not necessarily get the proceeds. Revenue savings carryovers were limited. The net effect was that efficient tradeoffs between capital and operating expenses were not encouraged. There was no apparent reward for capital-saving methods. There was no incentive, for example, for a hospital to sell valuable real estate and use the proceeds to build a facility in a less expensive area.

**Management information systems.** There was an almost total lack of systematic management information, such as costs per case for different types of cases, caseloads, and surgical mortality for each procedure. Indeed, during a 1989 visit, following the publication of the White Paper, one of the most frequent arguments I heard against rapid implementation of the internal market model was that the necessary management infor-
mation systems did not exist. The fact that such information systems do not exist is not a very favorable comment on the first forty years of the NHS. It suggests that there has not been much performance evaluation or accountability in the use of resources to produce results.

Customer service. Finally, customer service in the NHS has not been good. In 1988, David Owen, former Labour Minister of Health, wrote: “The public concern about the NHS is expressed by ‘waiting:’ waiting for an appointment; waiting then in hospitals or in surgeries for the doctor; waiting to come into hospital; waiting at home for the promised visit.” This is a problem addressed by determined competitors in the private sector. With serious motivation, much could be done to improve patient services in the NHS. A good place to start would be to replace the queue with a diary system for surgical appointments. In the queue system, the patient is told: “The doctor agrees you should have an operation; go home and we will call you to come in hospital a week in advance in the next year or two.” It is a Sword of Damocles for the patient. In the diary system, the patient is told, “Here are the blank places on the surgeon’s schedule for the next year; pick the date that suits you best and plan on it.”

The Internal Market Model

The goals of the internal market model are better care that produces better outcomes for patients, better access and greater patient satisfaction, less costly care, and hence more care and more responsive care within inevitably limited resources. The means for achieving these goals are accountability, competition, and innovation, that is, a process of continuous improvement in quality and efficiency.

My thinking about how to improve the organization of the NHS is based on three insights. First, in medical care, quality and economy usually go hand in hand. The correct diagnosis made promptly, the appropriate procedure performed well, are likely to be best for both the patient’s health and the payer’s bank account. This is especially true if one counts all the costs of poor quality. When resources are limited, such as in the NHS, greater efficiency (that is, desired outcomes produced with fewer resources) can be translated directly into more and better services. More spending is not necessarily the only route to more and better care.

Second, improving quality and economy is hard, tedious work that is not without controversy. It means painstaking analysis of existing processes and a search for better methods. It means doing jobs differently, rearranging power relationships, disturbing comfortable situations, and challenging authorities. Powerful incentives are the key to making this process of improvement happen. There must be a system in which,
broadly speaking, those organizations that improve quality and efficiency prosper and get more patients and more resources, while those that do not improve lose clients and risk failure.

Third, the great majority of the people working in the NHS are good people who want to do the best thing for patients. The role of organization and management should be to encourage and support them in this, not to constrain or repress them out of fear that if they are given a little freedom, they will do something crazy and embarrass the government.

The first basic idea of the internal market model is to create a demand side or purchasing agency that is distinct from the supply side or providers. The model would recast DHAs as purchasers of services for people in their districts. DHAs would develop and exercise expertise in such areas as epidemiology and assessment of patients’ preferences (that is, market research). They would then assess and prioritize patients’ needs and wants and seek to use their limited resources to respond most effectively. DHAs would be able to exercise choices of provider, not necessarily being limited to using providers in their own districts.

Hospitals and their medical staffs, GP practices, and others would become sellers of services to DHAs. They would lose their monopoly status and would have actual and potential competitors. Their budgets would depend on the services they could produce and sell. Money would follow patients. A hospital that developed an attractive service would be paid for providing it to patients from the referring DHAs.

In the White Paper, as a way of further separating purchasing from provision, the government introduced the concept of self-governing hospitals, to be known as NHS Hospital Trusts. Each is to be managed by its own board of directors and function as a free-standing nonprofit hospital.

DHA purchasers would define the services they wished to purchase. Providers would be held accountable for these defined outputs (instead of inputs by line item) through contractual relationships defining the services to be provided and the amounts to be paid for them. At first, DHA purchasers will no doubt find it difficult to define and measure what they are buying. This must be viewed as a progressive development that will take place over a period of years. But such contractual relationships are now quite well developed in the United States, and at least some DHAs have already obtained American advice and expertise.

In this model, provider managers would have much more operational autonomy. They would be able, for example, to reprogram funds to fix the leaky roof without having to appeal to the minister for permission. F.G. Bums, general manager of Arrowe Park/Clatterbridge Hospitals, responded to this aspect of the internal market as follows:
Despite what will inevitably prove to be a much more demanding and rigorous operating environment for NHS providers than anything previously experienced, most provider managers are enthusiastic supporters of the separation of the purchaser/provider role. This arises from an acceptance and understanding amongst provider managers that the price they must pay for genuine operational autonomy is the creation of powerful and effective purchasing agencies which, over time, will be seeking to adjust the balance between hospital and other forms of health care, between professional and public aspirations for service development, and between traditional and more efficient patterns of provision.

Provider managers and increasing numbers of health care professionals recognize the legitimacy of such changes given the inexhaustible nature of the demand for health care and the limited availability of resources. In the internal market model, DHAs would receive needs-adjusted per capita payments from government, not tied to actual provision of services. Thus, per capita payments could be equalized among districts right away, without having to close or expand facilities in districts to bring this about. (In 1976, the Resource Allocation Working Party, or RAWP, recommended a needs-adjusted per capita payment system. But as of the 1980s, large inequalities in payments among districts still existed.) The DHA’s new role is to become the collective purchasing agent for services on behalf of the communities it serves. DHAs should develop expertise in assessing, measuring, and prioritizing health needs and should seek community input. The DHA’s job is to decide what to buy, from whom, and for what price. DHAs must learn to evaluate provider performance, something not done in the past. They should collectively demand systematic information and perform analyses on which to base choices.

In many cases, DHAs will have a choice among competing suppliers. In this regime, hospitals would be rewarded for providing high-quality care and good service, for efficient treatment patterns, use of less costly settings (such as day surgery), and shortened stays where appropriate. Thus, hospitals would have some incentive to study quality versus cost, link resource use to outcomes, introduce cost accounting systems, and learn of their cost per case for different types of cases. In the United States, we see large variations in charges-and presumably cost-per case. Where cost exceeds the best price a hospital can get, management would be motivated to figure out how other hospitals can do it for less, adopt better methods, or get out of the business. The success of staff would be much more tied to the success of their hospital than it has been in the past. Hospital staffs would have strong incentives to work toward continuous quality improvement. The internal market would decentralize much decision making. NHS trust hospitals would be able to employ their own staff, set their own rates
of pay and working conditions, borrow capital, sell assets, adapt to customers’ demands and local market conditions, and choose which services to offer (in light of DHAs’ willingness to pay for them), what to self-produce, and what to contract out.

The White Paper proposed a changed relationship between the NHS and the hospital consultants (senior physicians). NHS trust hospitals would employ their own consultants. DHAs would act as the agents for Regional Health Authorities in contracting with consultants. Thus, consultants would become responsible to DHAs or their own hospitals. Job descriptions would be more explicit and reviewed annually. District general managers would be directly involved in appointing physicians. The current system of distinction awards (in effect, annual bonuses for life determined by the profession) would be modified to include consideration of commitment to management and development of the service, renewable every five years. In other words, management would gain tools to reward doctors who are most productive in meeting patients’ needs. It should not be surprising that this evoked intense opposition from the British Medical Association. The White Paper changes should assist hospitals in their attempts to correct the serious conflict of interest that has existed for many years: the longer the queues for NHS care, the better the private practice for physicians. Moreover, these changes should allow hospitals more flexibility to adjust physician personnel to the needs of the population. Rapidly changing medical technology is changing physician personnel requirements all the time. Hospitals should not have to wait for deaths or retirements to realign personnel.

Each district and trust hospital would have a balance sheet and an income statement. It would be free to borrow up to a prudent limit on debt. A district or trust owning valuable property could sell it, keep the proceeds, and add the interest receipts to its revenues. Districts and trusts would be charged for the use of assets. Thus they would have greater flexibility and incentives to use resources wisely. This should motivate selling off unused real estate, more careful consideration of return on investments, more willingness to create joint ventures to share costly equipment, perhaps more willingness to use operating theaters on weekends or evenings, and generally more economical use of capital.

Finally, in the White Paper, the government proposed to create GP budgetholders, that is, to allow GP practices with lists of at least 11,000 patients to apply for an enlarged capitation payment in exchange for accepting responsibility to purchase for patients a defined list of inpatient and outpatient services. This might be thought of as resembling the “primary care gatekeeper” model used by some health maintenance organizations (HMOs) in the United States. This was not a part of my
original proposal, and there are reasons to question how well it will work. There are problems of biased risk selection, adjustment of capitation payments for the risks enrolled, and incentives for doctors to select good risks and discourage enrollment of poor risks, in such small groups. Most GPs probably do not have the requisite skills for purchasing medical services, and it takes larger population bases than 11,000 to support the desired expertise. On the other hand, GP budget holding represents an important opportunity to develop and enhance the quality and scope of primary care. The Economist recently reported:

Budget holding is encouraging GPs to perform minor operations themselves rather than put patients on hospital waiting lists. Before the reforms, GPs routinely referred patients with rheumatoid arthritis to hospital-based rheumatologists. The waiting time was about six weeks, and each booking cost the NHS £150. Now budget-holding GPs are finding it quicker and far cheaper to do the job themselves.

In cases in which GPs lack the necessary medical expertise, they can use funds to contract with hospital-based specialists to visit their GP surgeries and see their patients in a setting much more convenient to patients. Moreover, it is possible that such GP practices might become competitors for patients, thereby adding an element of consumer choice that has not been present in the NHS. Beyond that, GP group practices might grow in size and scope and come to resemble American HMOs. Thus, this is a very promising idea that ought to be given a serious chance to work. The NHS could benefit a great deal from much more such experimentation and innovation.

Will It Work?

The Labour party has charged that the internal market reform is really a Conservative party plot with a secret agenda to privatize the NHS. If privatization means turning NHS hospitals into private for-profit entities, that certainly was not my intent. And I have seen no evidence to support the charge that it is government’s intent. The NHS already buys some services from the private sector, and patients might benefit from more such purchases. But private-sector provision is not a central or even an important part of the internal market idea. The internal market model could work with no private sector at all.

On the other hand, if privatization means that NHS hospitals would have incentives to seek continuous improvement in quality and efficiency, to be more flexible and responsive to the needs of patients (as opposed to doctors and staff) as competing private suppliers would be,
then the charge has substance. The world seems to be discovering that
centralized, government-controlled industries are inflexible and bad for
workers and consumers; that decentralized market decision making by
freely contracting parties can be much better for both. It should not be
seen as extraordinary to think that these insights can be adapted to the
NHS. Thus, the internal market is an attempt to capture some of the
virtues we generally associate with the private sector and combine them
with the social responsibility and concern for equity we associate with
democratic government.

Successful implementation of the internal market is not guaranteed.
In my 1985 report, I observed, “From an economic point of view, the main
defect in this model is that it still lacks powerful incentives for [District
Health Authorities] to make their decisions in the best interests of
patients in the face of political pressures to do otherwise. That is, there
is nothing analogous to annual consumer choice in the American system
of competing HMOs. There seems to be no substitute for competition
and consumer choice.”

A major concern is whether the government will be able to give the
internal market a real opportunity to work. The government is account-
able in Parliament every day for everything that happens in the NHS.
Under such pressure, the government might adopt an internal market
model in name and form only, while maintaining such tight controls that
no real change takes place.

Initially, the government took a cautious approach. But it has been
encouraged by the early returns and is moving into 1992 more boldly. The
Economist recently reported that

the reformed NHS is beginning to deliver the goods. A survey of the 57 existing
hospital trusts . . . reveals striking improvements in organization and efficiency
since April [1991]. Trusts have increased their workload and speeded up patient
treatment, cutting waiting lists by up to a quarter. They have started to get to
grips with problems which have troubled them for decades. And they have made
themselves more attractive employers by extending performance-related pay and
non-monetary benefits such as . . . flexible working hours.

. . . [T]he first year of the reforms has been little more than a dry run. The
government tried to limit the impact of the changes by obliging health authori-
ties to send their patients to the same hospitals as before. The new contracts
simply described long-established customs. This limited disruption but produced
few improvements.

The government has now decided to risk disruption. . . . [T]he chief executive
of the NHS has instructed purchasers to shop around for the best care at the best
prices when negotiating their contracts for next April, even if this means
breaking with old habits. No matter that the local cottage hospital will go under:
the important thing is to provide cost-effective services for patients. The new contracts will be negotiated in the autumn and start to operate next April. The full-blooded market will produce losers as well as winners.11

Politicians should be concerned with the total quantity and quality of services provided and with the overall design and operation of the system that provides them. They should be involved with what the purchasers do, to encourage the purchasers to seek the best value for the money for patients. However, politicians should not be held accountable for everything that specific providers do. For the internal market to work, providers must be separated from the government, as in NHS trusts, so that the government can evaluate objectively the quality and cost of the services they produce, and deal with providers at arm's length. Finally, government and voters need to focus more explicitly on the difficult but important questions of whether or not the British people are getting the quality and quantity of health care services they should have, and not so much on operational details, such as whether or not Guy's Hospital should lay off 600 employees or who is right in a dispute between St. Thomas's management and nurses.

NOTES

10. Ibid., 42.