ing amounts of financial risk and clinical responsibilities for managing not only primary care but also the specialty and public health care of their populations. The integration of primary care and specialty care is long overdue, and the proposal to integrate primary care and public health could rapidly become a model for other nations, including the United States.

No U.S. market models have resulted in as forward-thinking a framework for community accountability, universal access, resource efficiency, and quality improvement as the British proposal has. The NHS is far from perfect, but its leaders have developed and are putting in place an ambitious plan for system reform. We agree with Enthoven that remarkably absent from the NHS reforms are the necessary support resources and human resource development strategies that one might imagine are needed to make this plan a reality. While in the past the British have demonstrated an incredible capacity to implement change with limited capital, some critics have suggested that the Blair government’s “Third Way” (that is, a “modern” blend of top-down social welfare planning and bottom-up consumer-focused market responsiveness) cannot succeed. If it fails, Enthoven’s ideas, which may appear far-fetched within a British context today, might be positioned to become the mainstream solution tomorrow.

NOTES

Judging The Success Of Reform: The View From Within

by Graham Hart

A l a i n  e n t h o v e n ’ s a n a l y s i s , a s a l a w a y s , is perceptive and stimulating, and I agree with nearly all of it.

Before commenting on a few points in the lecture itself, I wish to say something that is addressed not to Enthoven’s analysis but to some of the mythology now surrounding the 1991 reforms. It really is not right to judge the success or failure of the reforms by a standard their designers never set for themselves. In particular, we were never under the illusion that we could or should institute anything remotely similar to the U.S. health care system, which is probably the nearest thing one can find to a market in health care. For a long time we avoided the word market altogether, and this was not just political reticence.

There were many reasons why an effective market could not be created. For example, the government was going to remain the principal
source of finance for the NHS and thus politically accountable for it; they were going to continue to limit total spending severely, so that shifts in funding of services had to be part of a zero-sum game; the NHS was to continue to be free of charge; and the United Kingdom had (and has) among the lowest number of hospital beds and doctors per head of population in the Western world, so there was comparatively little spare capacity in the system.

Ministers did, of course, build the reforms around the idea of separating the planning and commissioning of health care (later “purchasing”) from its provision—a system that had operated in primary care in a rudimentary way since 1948. GP fundholding, the new scheme under which GPs could be given a budget to buy some hospital services for their patients, had real scope to create a market and to some extent did so, but its coverage was limited.

My point is that although the 1991 reforms certainly imported some new features from the marketplace into the NHS, they were always likely to have a relatively small effect on the British health care system—fortunately, many people would say. Of course, commentators, for varying reasons, have found it desirable to play up the extent of the change. But I maintain that it is not relevant to judge the reforms by a test of ideological purity that was not in the minds of their designers.

I now refer to what Enthoven calls “political space.” It is sometimes said that ministers were guilty of not allowing market forces to operate; if only they had, packs of entrepreneurs would have been unleashed to revolutionize the NHS. The reality is rather more mundane. Ever since 1948 ministers had been willing to agree to changes in the NHS where there was a good case for them. That is why the NHS inherited 3,000 hospitals in 1948 and today has about a third of that number. The number of beds fell steadily through the 1960s, 1970s, and 1980s. The decline continued for the first four or five years after the reforms at about the same rate. The issue for ministers was, and is always going to be, not one of stopping change but of controlling its pace.

As to NHS entrepreneurship, there was—and is—quite a bit of it about, but it is patchy. It is interesting that although NHS trusts were free for a period of four or five years to introduce their own radically different pay systems for staff, very few did so. What did emerge, of course, was the entrepreneurship of many GPs in their fundholding activity. Far from stifling this, ministers encouraged it by progressively enlarging the scope for fundholding.

Finally, I am not denying that the degree of centralization in the NHS is an issue. We are locked into a problem here. One reason why the NHS offers such extraordinary value for money is its method of funding. But this inevitably requires political accountability to be exercised, and no minister can altogether stand back and disown responsibility. The degree to which ministers will stand back is very much a matter of personal and governmental style, but it is undeniable that over the fifty years of the NHS the general trend has been toward centralization. There must come a point—but how soon—at which centralization becomes counterproductive for ministers themselves, and then there are some interesting questions about what to do next. But that is another story.