has allowed community services to be set up well before the anticipated savings from the hospital sector are available. Northern Ireland has also benefited from integrated health and social services, avoiding arguments over who funds what and lessening the likelihood of vulnerable people being caught in the crossfire. Finally, the closeness of the community and the strength of the church and of family ties may have saved at least some from ending up on the streets.

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Managing the new NHS: breathing new life into the NHS reforms

Gordon Best, David Knowles, David Mathew

The essence of the NHS reforms is that they bring market forces to bear on organisations providing public services, while allowing those organisations more freedom to respond in ways that will improve the efficiency, effectiveness, and appropriateness of their services. The new structural changes to the NHS—a leaner management executive and fewer, slimmer regions—could be used either to strengthen these features of the reforms or to frustrate them by allowing ministers and top management to intervene even more at local level and “overmanage” the market. To ensure that the aims of the reforms are not frustrated ministers and the management executive must restrict themselves to laying down clear strategies and then allow purchasers and providers to meet those strategies in their own ways. They also need to ensure that the whole NHS can learn and benefit from local experimentation and devise ways of managing the crises that will inevitably arise; otherwise they might be tempted to become involved in managing the market at too local a level, and the NHS will suffer the worst of both worlds: stifling bureaucracy at the top and parochial self interest locally.

The latest round of reorganisation in the NHS is a watershed in the evolution of the NHS reforms. It entails removal of regional health authorities and their replacement by fewer, slimmer bodies that are also executive arms of the NHS Management Executive.¹ This could either revitalise the original commitment to decentralisation or create the ideal circumstances for

ministers, the management executive, and the Department of Health to “repossess” the NHS and impose even higher degrees of central control.

The temptation for ministers to exert even greater control is high. Not only is there little prospect of any extra funding for the NHS; the very workings of the reforms also pose innumerable possibilities for political embarrassment. Yet centralisation would undermine the potential benefits of the reforms, and in working out the details of this latest restructuring of the NHS the management executive needs to consider the processes that determine how the NHS is managed day to day. Here we consider some of the forces at play in the health service that might tempt the centre to lose its nerve over change and interfere defensively, and also suggest ways of managing the service that will help secure the benefits of the reforms.

Temptations to interfere

The King's Fund traditionally provides a “safe haven” where NHS managers, clinicians, policy-makers, and others can meet to explore and develop ideas and to reflect on management within the NHS. Our impression from taking part in many such discussions is of a momentum for change generated by the 1991 reforms—which has yet to realise the full potential generated by the separation of purchasers and providers. This momentum is, however, accompanied by concern about a widening gulf between the centre, including the management executive, the Department of Health, and the political leadership of the NHS, and those who actually provide or purchase local services. There are several interlinked components to this gulf. All provide reasons why it would be tempting for the centre to intervene and reasons why it should not—and reasons why it is important to clarify the relation between the centre and the rest of the internal market.

The internal market, separating purchasers and providers, has created a new dynamic in the system, which makes choices of health care priorities more explicit. The amount of public interest in this rationing process at a local level is constantly increasing. This has raised awareness of the inherent complexity of maximising value for money in health care and also highlighted the potential for controversy. These are welcome outcomes of the reforms, but they do pose serious difficulties and potential political embarrassment for the secretary of state and the management executive.

Public expenditure—The process of introducing the reforms while sustaining a reasonable level of services has been helped by relatively good outcomes for the NHS from the annual negotiations on public spending. This is unlikely to continue, with little growth money expected at least until 1996-7.

NHS priorities—Within the NHS there is now a

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Is the NHS best thought of as a market...

CALDER/IMPACT

... or as a command hierarchy?

momentum to give effect to *Health of the Nation* priorities and to accept the challenge of reshaping services to meet the targets. Many directors of public health and general managers of purchasing authorities are now prepared to shift resources from existing acute services to programmes of health promotion and community services, to promote the explicit policy priorities of the NHS. Achieving this task without major political controversy would probably be manageable if overall spending were increasing. Achieving it without new money presents much greater political risks.

General practitioner fundholders—There is widespread assumption within the NHS that fundholders have had a pampered introduction into the internal market and that, as more general practitioners enter the scheme, the budgetary pressures will increase. Many general practitioners still affect to be unaware of the inevitability of rationing. Indeed, many see rationing as inconsistent with their professional responsibility for individual patients. Yet fundholders will inevitably run out of money. Sometimes, as with health authorities, it will be because of poor management. More often, as the range of services which they purchase increases, it will simply reflect the reality of demand exceeding supply. There is no coherent process for holding fundholders accountable, and, given their professional priorities and their propensity to behave in ways which reflect their semi-autonomous relationship to the rest of the NHS, the likelihood of rough water ahead is high. In particular, unless these issues are brought out into the open and addressed explicitly the management executive will find it increasingly difficult to maintain a "hands off" position in relation to fundholding. In some circumstances general practitioners will make purchasing choices that are at odds with the guidance issued by the secretary of state. When that happens what will the secretary of state do? Take sanctions against the general practitioner? Withdraw funding?

The NHS: market or hierarchy?

There is still an enormous and unresolved tension about whether the NHS is best thought of as a market or a command hierarchy. On the one hand there are clearly market-like forces at work in the competition between providers. On the other hand, this market has overall social aims and a global spending limit. The tensions are most acute for purchasers and providers, who feel they are competing in a market yet are subject

to a stream of hierarchical commands about issues affecting their competitive positioning. These are not simply rules about how this market is to operate in general but detailed commands on how particular players must behave. The notion of a national internal market with overall sociopolitical goals and how to manage it well is not yet clear.

In his classic work on markets and hierarchies Williamson wrote 20 years ago that hierarchies were generally better than markets when: (a) the transactions between players have a high degree of uncertainty; (b) decision makers must act in the light of insufficient information; and (c) there are relatively few competitors in any particular market.²

Hierarchies are better in these cases mainly because the central value system and level of trust that pervade a hierarchy improve the organisation's ability to cope with uncertain transactions flexibly. If markets operate in these conditions, however, high transaction costs can be expected as players in the market clarify in contracts the precise nature of the agreements they have reached. The costs of this formalisation are both financial—an army of contracts managers replaces unspoken agreements between professionals—and cultural in terms of lost trust and collaboration.

On the other hand, markets are better where real competition exists and there is easy access to information about product specifications, quality, and cost—conditions that are now beginning to emerge in the NHS. There is also clear evidence from within the NHS and elsewhere in the public sector that market forces and contracting out often improve both efficiency and service quality.³ In a market that needs to be managed for the overall social good, nevertheless, local competition and improvements in service quality and efficiency may be at the expense of service provision in the broader market as individual players feel no allegiance to the performance of the market as a whole; this is a problem in a market that needs to be managed for the overall social good.

The NHS is therefore both a market and a hierarchy with at least two distinctive features. Firstly, the overall performance of the market is more important than the performance of any individual players. Secondly, ministers are accountable to parliament for the performance of the market. Unless a theory and practice of market management appropriate to the NHS are developed the NHS may suffer the worst of both worlds: stifling bureaucracy at the top combined with parochial self interest and purchaser-provider confrontation locally.

Breathing new life into the NHS reforms

Whether the latest reorganisation will be used to promote or blunt the development of the reforms will be determined not by the structural changes as such but by the management processes which bring them to life. In particular, we believe that there are six elements of the overall management of the service that need to be articulated, understood, and secured in the new arrangements.

Be clear on strategy; stay out of tactics

Ministers must be encouraged to have clarity about the strategic direction of the NHS and to agree a relatively small number of key issues that really matter—for example, financial performance, the patient's charter, *Health of the Nation* targets. Then they must allow local purchasers and providers to be imaginative in the use of their new freedoms to find ways of delivering on these issues. The strengths of markets for innovation, effectiveness, and efficiency derive partly from their freedom from bureaucratic control.

Allow for local experimentation and learning

Uniformity is neither possible nor desirable. This implies that providers particularly will be allowed to experiment and learn how to use most effectively their new freedoms to improve the services they offer to their own communities. In this way, the NHS may become the first example of a "learning market," with commissioners, providers, and users collaborating to shape service provision. In east London, for example, family and community based health services are being radically reshaped: a unified commissioning body has been formed from the district health authority and the family health services authority, while a new provider organisation (City and East London Family and Community Services; CELFACS) manages services provided by both family practitioners and community based health service staff. Users have been helped to define the form the services should take.⁴

Devise specific arrangements for managing crises

For such freedom on the ground to be acceptable to ministers, there will need to be an effective procedure for managing the crises that will arise as purchasers and providers try different ways of using their new freedoms. The approach to managing the service day to day should not therefore be the same as the approach to managing crises. Indeed, there should be an explicit procedure, which would override normal procedures. Such "red button" arrangements often exist in the private sector. The circumstances under which these arrangements could be invoked should be clearly set out. For example, when a district health authority is not getting its waiting lists down or is significantly overspent the normal local management arrangements could be suspended temporarily. A "crisis" team would be deployed in the district to re-establish the necessary control and accountability. After six months or so (never longer than a year) the crisis team would hand back to the local management team, no doubt after some changes in personnel, probably of the chairman or chief executive.

Clarify how purchasers are to be held accountable

Whatever else they do, purchasers need to use the internal market to improve the efficiency, effectiveness, and appropriateness of the services available to their populations. When purchasing is more broadly defined, however, it is less clear how purchasers should be judged. If, for example, purchasers see their responsibilities as encompassing the general health of their populations problems immediately arise over how their performance should be measured. If such factors as genetic inheritance, the distribution of income and wealth, education, and housing are the real determinants of general health how can purchasers be held to account for the health of the populations they represent? Presumably purchasers cannot be expected to influence such factors, but clearly they will have to balance their responsibility for purchasing services with that of investing in activities to pursue more broadly based health targets.

Clarify the conditions for entering and leaving the market

One of the stark contrasts between the United States and the United Kingdom is that in the United States entry into education and other public sector markets by new small scale providers is actively encouraged.⁵ Set up costs and formalities are reduced as far as possible to lower barriers to entry. This can, however, be a source of difficulty, particularly in health care, where new entry providers cannot secure effective and continuing high quality services.

This reinforces the need for clarity about the conditions for entry into the market. In practice new players will probably enter the market at the edges,

where the small organisations can gain a foothold; indeed, examples can already be seen in community services and short term contracts, specifically for waiting list work. Some trust chief executives already see their sites as offering facilities that small groups of professionals could buy into, and some purchasers, especially fundholders, are actively looking at buying services from new providers—some from outside the NHS.

Some clinicians too are actively considering moving their practices from current trusts to more attractive and marketable sites. This raises the possibility that clinicians, rather than hospitals, might act as the focus for provider organisations. This process gives new meaning to the term "doctors in management" as professionals come to realise that if they are running their own "businesses" new sorts of arrangements with fellow professionals might be more conducive to their survival and success than their current institutional base.

Market "exits" will need careful handling too: NHS hospitals cannot be allowed to close at short notice, and the recent trend towards trust merging may well be a more appropriate mechanism. Nevertheless, if mergers become too centrally planned or lead to a diminution of local competition they may carry dangers of a reversion to prereform inflexibility.

The difficulty and challenge are to resolve the tension between two distinct dynamics in the system. Firstly, the market should demonstrate which hospitals and provider organisations are failing (because they are too expensive, located in the wrong place for their patients, provide poor quality service, or whatever other reason). Secondly, there is a need for the process of change, and in particular the process of hospital closure, to be managed at a pace that is consistent with the interests of local communities and of the staff who work in those organisations.

Guarantee the free and public flow of information

The availability of information in the marketplace has to be actively managed: in profit driven markets information is power. Providers who introduce new developments use them to develop their share of markets at the expense of other providers, and, where possible, at the expense of purchasers. The challenge in public markets is to encourage innovation but also to encourage collaborative sharing of that innovation so that all parts benefit quickly from best practice—the "learning" market again. For this to happen collaborative relationships need to be fostered between purchasers and providers. The NHS organisation is the whole market of purchasers and providers, not a collection of isolated health care battle grounds.

This collaboration is made more difficult if information becomes secret and relationships become distanced and contractual. Maintaining the traditional NHS values of collaboration and trust will take hard work and encouragement. Many examples of collaboration already exist, but it is still far too easy to find clinicians who are forbidden by management from talking to purchasers and relationships between purchasers and providers which range from stand offish to hostile.

Conclusion

Managing the New NHS hints at a vision for managing the internal market of the NHS in a way that can realise the potential inherent in a public service market, combining the strengths of both markets and hierarchies. It also carries with it the shadow of a defensive political centralisation. Opening up the debate about the most appropriate management pro-

cesses for the new NHS—to which we hope this article contributes—will help to ensure that the light shines through.

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Managing the NHS market

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The purpose of the present NHS reforms is to introduce a managed market; developing some of the incentives for greater efficiency that are often found in markets while still being able to regulate proceedings to prevent market failures. If government intervenes too much there will be no incentive to improve efficiency and streamline operations: too little intervention may result in some areas having inadequate health service cover or monopoly powers abusing their position. Effective management of the NHS market requires eight core elements: openness of information, control of labour and capital markets, regulation of mergers and takeovers, arbitrating in disputes, protection of unprofitable functions such as research and development, overseeing national provision of health services, protection of basic principles of the NHS, and handling of closures and redundancy. Management of the market would best be performed by the NHS management executive and health authority purchasers acting within a framework set by politicians.

The key challenge facing ministers in implementing NHS reforms is to strike the right balance between competition and regulation. Although the term internal market is often used to describe the reforms, it would be more accurate to call it a managed market. One reason for preferring this terminology is that competition is not confined to NHS providers but includes providers outside the NHS. Even more important is the fact that it has never been the intention, as some observers have contended, to introduce a free market. Rather, the aim has been to develop some of the incentives that are often found in markets in the structure of the NHS and to regulate the operation of these incentives to avoid the problems of market failure.

Implementing the reforms

In the early stages of the reforms ministers pursued a policy of gradual and controlled change. The watchwords in 1991 and '92 were "steady state" and "smooth take off," indicating the government's wish for the minimum of turbulence as purchasers and providers took on their new responsibilities. Since then some of the controls imposed from the centre have been relaxed, and this year the secretary of state for health has said that the time has come "to make it happen." In particular, she has emphasised the need for purchasers to act as the engine to drive the reforms and to use their purchasing power to bring about improvements in both health and health services. The effects of the government's policy have been felt particularly in London and the larger conurbations, where the pace of change has been greater than in other parts of the NHS and where the market has already caused casualties.

The example of London is especially instructive. Ministers responded to the problems that arose in

Core elements for management of NHS market

- Openness of information
- Control of labour and capital markets
- Regulation of mergers and takeovers
- Arbitrating in disputes
- Protection of non-profit making functions
- Overseeing provision of health services
- Protection of basic principles of NHS
- Dealing with closures and redundancies

London not by allowing the market to do its job but by setting up an inquiry under Professor Bernard Tomlinson. As an interim measure, extra funds were also allocated to the Thames regions amounting to over £100m in the current year—to make up for the shortfalls in hospitals' budgets caused by changes in contracts. In this way, the signals thrown up by the market were managed with a strategic overview and transitional funding in an attempt to ensure an orderly process of change.

CONTRADICTIONARY SIGNALS

As yet unanswered is the question of whether it will be possible to ensure that change is managed efficiently without this blunting the very incentives that are meant to be a stimulus to improve performance. The indications on this point are contradictory. On the one hand, some health authorities are moving contracts more rapidly than anticipated by Tomlinson, thereby making it difficult to implement a strategy for rationalising hospital provision in a planned fashion. On the other hand, ministers have recently intervened in the market in London to prevent Camden and Islington Health Authority from undermining University College London Hospitals by switching services to less expensive providers. The secretary of state for health justified her intervention on the grounds that a managed market required regulation from the centre in particular cases. For his part, Bernard Tomlinson has expressed concern that the government has not intervened sufficiently in the market, both to provide additional resources to smooth the process of transition and to manage the run down of hospitals.

Dangers of intervention—The problem for ministers is that if they do intervene more than has been the case so far they run the risk of weakening the incentives to providers to cut their costs and raise standards. A culture in which providers who are unsuccessful receive political protection and extra funding to balance their budgets would not be conducive to the improvements in efficiency and quality that ministers want. If such a culture were to develop, competition would function only at the margins and the market would be tightly managed to maintain inefficiency. Thus the

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