Observations on the NHS internal market: will the dodo get the last laugh?

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Distinguishing between the theory and practice of the internal market has been obscured by the considerable controversy generated by the reforms themselves. In such an environment both the advocates and the opponents of a market based solution have tended to promote their respective claims by reference to underlying political philosophies and economic theories rather than practical experience. Royce gives his observations of the actual operation of the internal market with particular reference to the commissioning function in Wales. He highlights inadequacies and inequities in the current system and proposes some remedial actions. Central to these are the importance of ensuring equitable funding for all purchasers, acknowledging the necessity of rationing, and promoting efficient and effective health care, sometimes at the expense of patient choice and guaranteed local service provision.

To what degree the government's objective for the internal market was to mirror the economic behaviour of markets described by classical economists is open to debate. Nevertheless, the government set substantial public store on the perceived benefits of a market (managed or otherwise) within health care, particularly in its purported ability to enhance patient choice and improve efficiency and effectiveness.

The foundation of the reforms was the purchaser-provider split and the resultant creation of the internal market. It was always clear that a balance would be required between letting competition loose and managing the process of change, but the point remains that historically the NHS could be characterised as professionally dominated and bureaucratically administered. The reforms were intended to provide a market driven alternative.

Role of the Treasury

The reforms have been implemented while maintaining the strict financial controls which have historically applied to the NHS. Substantive change to the financial regime was never part of the reform package, and arguably the cash limits imposed by the Treasury are the principal reason the NHS has produced so much on so small a percentage of the gross national product. However, the failure of government fully to acknowledge funding issues within the NHS, aggravated by the short term considerations inherent in Treasury annual funding cycles, means that however well the other elements of the internal market operate it will in all probability continue to fall short of public and political expectations.

The Treasury "straightjacket" may ensure short term cost control but undermines the development of the market. This is an important issue when the central

tenet of the reforms is the benefit a market environment will bring. The use of market forces also remains problematical in a system noted for its limited margins for error. Purchasers are expected to spend up to (but not to exceed) their allocation. For example, a 0.5% overspend on a £150m budget produces a deficit of £750 000—a crisis. Likewise the expectation is that trusts will essentially break even. The pitfalls of failure are all too obvious. Trusts reporting a surplus of any size are likely to be questioned over their adherence to cost price principles of costing (whereby funding received should match the cost of treating the patient in question). The capital charges system (the NHS equivalent of accounting and charging for depreciation, as occurs in the commercial sector) seems similarly confused—a view reinforced by the almost universal incomprehension of the scheme by those who are supposed to be taking capital charges into account when making investment and disinvestment decisions.

Managing the market

Economists observe that markets work dynamically and therefore unpredictably, a notion that most NHS managers and health care professionals find disturbing. In truth, what we often cite as a series of problems thrown up by the internal market—differences between providers in costs, quality, outcomes, management competence, etc—can equally be seen as active stimulants to innovation and improvement. In this respect the market concept has highlighted inadequacies in the NHS, but perhaps we are too readily predisposed to shoot the messenger. Dynamism is equally uncomfortable for politicians whenever the changes in question throw up losers as well as winners. Politicians' attitudes seem reminiscent of the dodo's pronouncement in *Alice Through the Looking Glass*—"All have won and everyone must have prizes." For their part the chief executives' predicament can be characterised by three "apocryphal" objectives: meet your financial and activity targets; don't make anyone redundant; don't close anything.

The above captures the management dilemma quite neatly. Clearly, juggling priorities and balancing conflicting yet important objectives are part of the management task. They are one reason why senior managers receive comparatively high salaries. But there remains a difference between setting challenging yet realistic targets and judging performance on inherently subjective constructs such as striking a balance between patient choice, efficiency, and effectiveness. As an illustration of a Machiavellian management technique there can be little to fault it. As the principal means of setting the management agenda, it seems an equally powerful illustration of the strategic vacuum in which the NHS finds itself. In such an

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environment it is unsurprising that tactical, short term considerations will be in the ascendancy.

Patient's charter

The patient's charter has severely limited the capacity of the service to ration in the traditional manner.¹ Few deny that long waiting lists are a genuine problem, but to promote waiting time as the standard measure of health service performance lacks balance. Clinically, elements of the charter are of dubious value. Rigid application of the charter has meant that once patients are referred into the secondary care system and the option to treat exercised not only must they be treated but, if the standards are in danger of being breached, the longest waiters must be accommodated regardless of their clinical priority.

As pressure grows to eliminate all exceptions to this rule, as standards become more onerous, and as resources struggle to keep pace with demand clinical freedom will have to take second place to administrative dictate. We may legitimately question why such cases are put into waiting lists, yet recognising this as an issue does not make the concerns cited irrelevant.

The irony is that adherence to this particular policy undermines other government priorities such as the development of primary care (by concentrating resources into hospitals in pursuit of these targets) and nullifies effective health care by giving equal weight to all conditions (provided they have an elective element). The common denominator becomes length of time waiting, not whether the condition really merits treatment given competing demands or indeed whether any benefit will result. Furthermore, that denominator applies only to those waiting for services defined in the charter standard.

For purchasers not only is this intellectually incoherent but it creates a longstanding tension between "public" values of the strategic plan—care in the community, primary care development, efficiency, effectiveness, etc—and values as expressed through contractual expenditure. The resulting dissonance makes it unsurprising that politicians and the most senior management of the NHS alike have an ever widening credibility gap.

Patient choice

A further weakness of the current arrangements is that patient choice is being promoted as a key indicator of success while at the same time continuous pressure is placed on purchasers to negotiate cost effective contracts. The two objectives can and do conflict on occasions. Policy makers seem unduly reluctant to acknowledge the necessity of trade offs between important competing objectives. Though patient choice is clearly not irrelevant, advocating its primacy while building in no economic incentive for the patient to choose the most cost effective and efficient provider undermines effective purchasing and leads to the sort of undesirable features of health service provision so clearly seen in the United States.

Historically, in the United States insured patients made choices on patient care with little or no regard to economic cost. As a result expensive clinical practices are encouraged; for the insured patient the service at the point of delivery seems free. Britain has yet to see the worst excesses of the American system, but the issue remains. This is always the problem when those obtaining health care are separate from those actually making the payment. But we currently have a system which gives no incentive for the patient to choose the most cost effective and efficient provider and gives little or no information to the patient along these lines to encourage such a choice.

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Niccolo Machiavelli (1469-1527). *Would he have approved?*

Contract currencies and costing

A characteristic of trusts when negotiating contracts is to have a predetermined contract income in mind and for negotiations to centre on obtaining that income regardless of the volume to be purchased. This inevitably leads to difficulties whenever there is a desire to move away from the status quo. Though increased volume can usually be purchased at marginal cost, decreases in volume are characterised by a response along the lines of, "If you decrease the volume you wish to purchase we will have to increase our prices." This is followed by a justification for a price increase along the lines of cost=price. Providers seem reluctant to accept that the debate should centre on their costs and not on the fact that purchasers seem unwilling to meet their prices.

What is interesting about this exchange is how different it is from the behaviour of firms in more competitive marketplaces. Faced with reduced volumes the typical response of such a firm would be to reduce prices so as to increase demand and to look internally for cost reductions. Economists would recognise trust behaviour as more in keeping with a supplier that considers itself to be in a monopolistic position. Though providers in large conurbations may not be able to act in the manner described, many rural hospitals enjoy natural geographical monopolies. A major issue for commissioning and the development of the market is the ability of purchasers to break down this behaviour.

In a previous paper I observed that it was a characteristic of the reforms that in the intense political debate generated by the ideology of the internal market attention has been diverted from the mechanisms by which that market will operate.² In such a centrally driven organisation as the NHS it might be expected that more policy directives concerning the development of the internal market and, with them, contracting systems would have appeared. However, in this area at least an untypical *laissez faire* philosophy dominates.

It seems perverse that in Wales health authorities must get the personal approval of the secretary of state to replace even a part time typist³ but can effectively develop their own contract currencies. For their part, trusts are coming under increasing scrutiny on issues such as management costs, yet ensuring compliance

with *Costing for Contracting*⁴ seems to be approached in a fairly cursory manner. Some of the most stubborn resistance to accurate costing and contract reform emanates from accountants and managers. The ultimate rationale for this opposition is that it throws up too many awkward issues.

An example might be the underpricing of a regional oncology service, as the income lost by the underpriced oncology service is made up by the provider charging more for its other services which are bought only by its local purchaser. As a result the provider's host purchaser will have unwittingly been subsidising the more remote authorities. This is very uncomfortable for those authorities that are now asked to pay an increased price for the service in question. This is one example of a benefit of "the market" being perceived as a problem because it threatens the status quo.

In Wales a move towards contracting based on diagnosis related groups is scheduled for the financial year 1996-7,⁵ and the above comments should not be interpreted as a complaint that there is no movement on these issues. Rather, it is the relative weight being given to the plethora of objectives the NHS is set. The propensity of trusts to act in a monopolistic fashion has already been noted. The central edict that cost equals price does not act as an effective counterbalance. The proposition itself has a somewhat dubious logic if we are trying to use a market based solution to promote efficiency and effectiveness. However, directors of finance admit privately that cross subsidisation of services is commonplace. This coupled with inaccurate costing makes *Costing for Contracting* a flexible doctrine. Providers tend to quote it when it suits their purposes and ignore it when it proves inconvenient. In fairness to trusts cross subsidisation, whether intentional or not, is almost certain to persist while fundholders and health authorities continue to operate different funding methods and contract currencies. (Most health authorities contract at specialty level whereas fundholders typically contract by chargeable procedure.)

Promoting contestability and increasing efficiency are important objectives. If market mechanisms are of limited use (or are not allowed to be used to their full effect) central price regulation needs consideration⁶ accompanied by aggressive use of benchmarking and external review of the methods by which trusts construct their tariffs. Current auditing of trust financial accounts appears inadequate for this. Reclassification is inflating activity (and helping to secure trust income) but means that some of the oft claimed productivity increase credited to the reforms has little substance. An ability to count patient activity more accurately, though commendable, does not in itself constitute an improved health service.

Rationing

Effective commissioning must have at its heart the capacity to make choices—to take unpopular but necessary decisions. In other words, it must undertake the rationing process. How can we start to do this effectively when politicians seem so reluctant to acknowledge the word as having relevance to the NHS—as if in some Orwellian fashion denying the need to ration eliminates the conditions which make rationing necessary? Attempts to engage in such an exercise are usually condemned by an atypical alliance of politicians, press, professionals, and pressure groups. The recent extensive coverage given to

Cambridge and Huntingdon Health Authority's decision to withhold further treatment from a 10 year old child with acute myeloid leukaemia is a case in point.⁷

The purchaser-provider split has allowed some progress and debate on this key issue but we still have widespread local variations in access to and quality of treatments, ranging from subfertility and renal services to hip replacements and community services. If we wish to operate a national health service within a defined sum of public money the importance of the executive engaging in a systematic review of services to be provided cannot be emphasised enough. Anything less is an abdication of responsibility.

Conclusion

What I have described lends weight to the widely held view that the internal market and its agents (purchasers and providers) operate in a confused environment. Conflicting messages and priorities predominate.

Some 13 years after the introduction of the Griffiths reforms⁸ we still require a paradigm shift in the way decisions are made in the NHS—starting at the centre. We require a decision making process based on facts; a genuine commitment to equality, efficiency, and effectiveness; and an intellectual honesty which carries neither fear nor favour.

The following five ground rules, if observed, might start this paradigm shift:

- (1) Political acknowledgment that the NHS cannot provide complete coverage given existing resources.
- (2) A mandate to the NHS Executive to put forward a coherent rationing process to be applied nationally.
- (3) Explicit recognition that improving clinical efficiency and effectiveness in a public funded service should, in the final analysis, take precedence over patient choice and "local service" provision.
- (4) An auditable commitment to refine contracting currencies, benchmarking, open flow of information, and accurate costing.
- (5) Ensure all purchasers, whether health authorities or fundholders, are funded on a capitation basis and subject to a uniform regulatory framework.

We remain a considerable distance from these objectives being fulfilled. As such I wonder what the future holds, not merely for commissioning authorities but for the NHS as a whole.

The views expressed in this paper are mine alone.

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