

# Big Bang Health Care Reform— Does It Work?: The Case of Britain's 1991 National Health Service Reforms

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**H**EALTH CARE REFORM HAS BEEN ONE OF THE worldwide epidemics of the 1990s. But among the many countries that have either attempted or contemplated the reform of their health care systems (Hurst 1992; Organization for Economic Co-operation and Development 1994) Britain stands out from the rest. The reforms of the National Health Service (NHS) introduced in 1991 by Mrs. Thatcher's Conservative government were driven by the much the same set of concerns and ideas that shaped the international vocabulary of debate. In particular, they reflected the widely held belief that the best way of improving efficiency was to change the incentives to providers and that some form of marketlike competition was the best tool for achieving this aim (Saltman and van Otter 1992). In all these respects, there was nothing all that special about Britain. What makes the British case special, and worthy of further study, however, is the ambitious scope of the reforms and the relentless determination with which Mrs. Thatcher's government implemented them. In the United States, the Clinton reforms plan foundered on the rocks of congressional opposition; in Sweden, a succession of local experiments and committees of inquiry failed to create a national consensus about the direction of health care policy; in the Netherlands, an ambitious plan of reform was

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agreed to in principle but subsequently became entangled in the barbed wire of coalition politics; in Germany, a gradualist strategy of incremental change was adopted. But, in Britain, the Thatcher government—disdaining consensus, experiment, and incrementalism and overriding strident opposition from the medical profession and others—introduced and implemented systemwide changes: a big bang approach to health care reform.

Britain's case carries one very obvious lesson. It underlines the importance of institutional factors (Immergut 1992) in explaining the evolution of health care policies. If Britain did not have a political system designed to give the government of the day an automatic majority in the legislature, then clearly the 1991 reforms of the NHS could never have been introduced. Only New Zealand—another country with a Westminster-type constitution—matched Britain's record of radical changes swiftly implemented (Salmond, Mooney, and Laugesen 1994). By the mid-1990s, therefore, Britain already had four years' experience of change, while other countries were still deadlocked or hesitating. In this article, I will analyze, and reflect on, this experience. In doing so, it is important to distinguish between an examination of the political and managerial processes involved in introducing the 1991 changes and an evaluation of their impact on the delivery of health care service. If we examine the *process* of change in Britain's NHS—the mechanics of introducing the reform—it is possible to draw some reasonably confident conclusions: Britain's experience suggests, it will be argued, that imposing reforms on the medical profession and other health care providers may carry high political costs in the long term. If we attempt to evaluate the *impact* of the reforms, however, no clear-cut conclusions can be drawn: the new model NHS was designed, whether by intent or by accident, as a self-inventing institution (Day and Klein 1989) that continues to evolve and adapt, thereby elusively frustrating attempts at evaluation. I will first briefly summarize the 1991 reforms, then analyze the record of the NHS prior to introduction of the changes before moving on to examine the available evidence about their effect. Finally, I will speculate about the possible future of the NHS. The analysis throughout is of the situation in England only; the structure of the NHS in the rest of the United Kingdom is somewhat different. Any attempt to compare developments in different parts of the United Kingdom would, however interesting, have added an extra dimension of complexity to what is already a many-threaded story.

## Changing the Dynamics of the NHS

The 1991 reforms of the NHS were designed to change the dynamics of Britain's health care system while preserving its structure and method of financing. In *Working for Patients*, the document setting out the plans for change (Secretary of State for Health 1989), the government was emphatic about its intent to maintain all that was best in the NHS: "The principles which have guided it for the last 40 years will continue to guide it into the twenty-first century. The NHS is, and will continue to be, open to all, regardless of income, and financed mainly out of general taxation." So the NHS has remained a universal service offering free medical services at the point of delivery: after 1991, as before, the only charges made are for dental and ophthalmic services and prescriptions for drugs, with a generous system of exemptions. In all these respects, nothing has changed.

In contrast, the internal organization of the NHS has changed radically. Before 1991 district health authorities (DHAs), funded by and accountable to central government, were responsible for providing the health care services needed by their populations: that is, they directly ran and managed all hospitals and community services. After 1991, the DHAs, funded on the basis of a per capita formula weighted for population characteristics, became responsible only for purchasing health care, with the freedom to buy the services required from whomever they pleased (including the private sector). Money was to follow patients, instead of being attached to facilities. The providers of health care—both hospitals and community services—became separate entities, although they still remained public bodies. They were to be turned into independent NHS Trusts—each with its own governing body accountable to the secretary of state for health—which had to earn their keep by attracting the custom of the purchasers. A system based on hierarchical bureaucratic control was to be replaced by one based on competition between providers, with purchasers acting as proxy-consumers on behalf of their populations. So was created the NHS's new "internal market": a system supposedly mimicking the operations of a free, competitive market within the framework of a publicly funded service. There was one further innovation: general practice fundholding. General practices above a given size could opt to hold their own budgets for buying health care for their patients directly from providers, in effect becoming miniature HMOs (although they were responsible for only a restricted range of ser-

vices, excluding the more expensive forms of treatment). So they, too, became purchasers operating—on behalf of the patients registered with them—in the NHS's new mimic market.

The government's intention in all this was to create an NHS where competition between providers would compel greater efficiency and sensitivity to the requirements of patients. The development of services would no longer, as in the past, be driven by the medical profession and other providers. Instead, the DHAs would devise their purchasing plans to meet the needs of their populations. Conversely, the new NHS Trusts would have not only the freedom but also the incentive to innovate, once they were emancipated from bureaucratic control and able to devise their own strategies.

A number of other features of the 1991 reforms must be noted if we are to make sense of subsequent developments. First, the plans as originally announced were little more than outline sketches. The details were filled in during the course of implementation. If legislatively the reform of the NHS was an example of big bang politics, the changes themselves were phased in over a period of years. Moreover, the design of the post-1991 NHS changed during the process of implementation in important respects: the new-model NHS was a car that was being constantly re-engineered even while it was whizzing round the test track. So, for example, what started as a competitive market soon evolved into a managed market: when competition threatened to cause chaos in London, central government quickly intervened to constrain market forces (James 1994). Similarly, in the case of GP fundholding, the unexpected success of the experiment encouraged the government to lower the list size required to qualify and to extend the activities covered by the budgets. Further, there followed a series of changes in the administrative machinery of the NHS, such as the abolition of the regional authorities and the amalgamation of DHAs.

Second, and most important in explaining the interpretation placed on events after 1991 by those working in the NHS, the reforms were rightly perceived as a challenge to health care providers in general and the medical profession in particular. In formulating, publishing, and implementing its plans for change, the Thatcher administration ignored the medical profession and defied its campaign of opposition. In doing so, it demonstrated the impotence of the profession in the health care policy arena (Day and Klein 1992) and created an enormous sense of resentment and suspicion that colored all subsequent reactions. Moreover,

further fueling resentment and suspicion, the 1991 reforms reinforced the position of managers in the NHS. Doctors had already felt threatened by the new managerial structure of the NHS introduced in the 1980s, following the recommendations of the Griffiths report (Griffiths 1983; Harrison 1994). Now it seemed that the trend toward managerialism in the NHS would accelerate even more threateningly: for example, managers were for the first time ever to have a voice in channeling distinction awards to consultants. As the medical profession saw it, therefore, the 1991 reforms were one step further along the road of strengthening managers at the expense of doctors. Any evaluation of what has happened since 1991 must therefore take into account the bias of the most significant (in the eyes of the public) witnesses to what was happening.

### A Solution—But What Was the Problem?

The first step in trying to assess the impact of the 1991 changes is to come to some understanding of the nature of the NHS's problems to which the reforms were supposed to be the answer. Any assessment of the situation after the 1991 reforms must therefore start by drawing up a balance sheet of the NHS's achievements—and failures—before the changes were introduced. Measured against the aims of the original architects—reaffirmed by the Royal Commission on the NHS (1979)—how had the service performed?

The first aim of the NHS, as spelled out by Aneurin Bevan in 1948, was achieved by the act of creation itself. The introduction of a free health service automatically meant that the ability to get treatment was divorced from the ability to pay. The financial barricades having been torn down, the way was open for achieving equity in access to health care: of ensuring that the only criterion for treatment or care was need, as defined by service providers. In the outcome, equity of access has indeed been achieved (Collins and Klein 1980; O'Donnell and Propper 1989). The poorest members of the community—who are also likely to be those with the greatest need for health care—make proportionately greater use of the NHS. However, the NHS appears to have been somewhat less successful in achieving equity in terms of the quality of care provided once access to the system has been achieved. Inequalities in the distribution of articulacy, knowledge, and social confidence (which is not necessarily identical with social class) may still play an important a part in determin-

ing the way health services are used, even though inequalities in income distribution no longer determine access. The NHS remained a multi-tiered service, accurately mirroring the multi-tiered nature of the society in which it operated. Moreover, the continued existence of a private sector of health care, alongside the NHS, inevitably meant a dilution of the equity principle.

Turning to Bevan's second aim, "to provide the people of Great Britain, no matter where they may be, with the same level of service," the NHS can only be rated a qualified success. In this respect, the single most important achievement of the NHS was perhaps to bring about a better distribution of specialist manpower by maintaining strict central control over the creation of new posts (Godber 1975). But geographic equity in the distribution of resources, and access to services, still remained to be achieved by the end of the 1980s. Over the previous decade the inherited inequalities in funding between the regions had been greatly reduced, but inequalities *within* regions remained large. And inequalities in the allocation of funds to DHAs were compounded by two further factors in the process of translating resources into services for the population. First, DHAs varied greatly in the way they allocated their budgets between different services. Second, as in the United States, there were considerable variations in the practice patterns of clinicians (Ham 1988)—with the all-important difference that whereas in the United States high activity rates tend to attract suspicion, in the United Kingdom they are held out as proof that the NHS could improve its performance if only all consultants matched the performance of the most productive. Taking all these factors together, it is not surprising that there are great variations in the "level of services"—as measured by the number of operations or procedures carried out per 1,000 population—provided by different DHAs (Department of Health 1992, 1993). For example, rates for removing cataracts varied by a factor of 7 and for hip replacements, by a factor of 40. Some of the extremes in the distribution may be statistical flukes; other variations could no doubt be explained, in part at least, by differences in the composition of the population. But, even allowing for such problems in the interpretation of the figures, the conclusion is clear: more than 40 years after its birth, the NHS had yet to offer everyone the same level of service. Similarly, significant regional variations remain in the number of "avoidable deaths" for conditions amenable to health service intervention, either preventive or curative. In the case of cancer, the range is from 59 percent above the

national average to 44 percent below it. In the case of hypertension and stroke, the range is from 32 percent above the national average to 26 percent below it (Chief Medical Officer 1988).

If equalizing opportunities of access across the country to specific forms of treatment proved difficult, Bevan's most ambitious aim—to "universalize the best"—turned out to be impossible to achieve. In retrospect, the NHS's achievement lay not in universalizing the best—a flamboyant piece of political rhetoric devoid of any real meaning—but in universalizing the adequate. The NHS was an instrument not for ensuring that everyone got the best conceivable treatment—that the technological magic of modern medicine would be on tap without any budgetary constraints or that everything possible would be done for the chronically ill—but for rationing scarce resources. Political decisions about the NHS's budget were translated and diffused into clinical decisions about whom to treat and how. By international, and in particular by American, standards this often meant that British patients received less than optimal treatment (Aaron and Schwartz 1984). This conclusion must be interpreted with some caution: the more conservative approach of the British medical profession toward the use of new technology reflects not just resource constraints but also a proper skepticism about overheroic treatment or the use of as yet untested procedures. However, even bearing this reservation in mind, there are some clear examples where the NHS has been slow—compared with other health care systems—to make potentially life-saving treatments available to all who might benefit from them. The case of renal dialysis in the 1970s is one example; that of coronary artery bypass surgery in the 1980s is another. The pattern is not uniform: for example, in the case of bone marrow transplantation Britain appears to be ahead of the United States (U.S. General Accounting Office 1994). But overall, the point remains, and could be made even more forcibly, about treatments designed to improve the quality of life, such as joint replacement and other forms of elective surgery, rather than to save lives. If the NHS offered no incentives to its providers to rush into the adoption of new technologies, or to increase their incomes by multiplying the number of diagnostic tests carried out, neither did it offer any incentives to maximize their activities in providing effective treatment. The pathology of the American health care system—and others based on item-of-service payments to doctors—is the risk of overtreatment. Conversely, the pathology of the NHS is the risk of undertreatment.

So far this attempt to draw up a balance sheet for the NHS, in its pre-1991 incarnation, has taken as its starting point the aims of the service's architects. But what if we change the perspective of evaluation to ask whether the NHS was satisfying the expectations of the population? The 1970s saw the rise of a more aggressive consumerism, both in the health care policy arena and more generally. The trend was continued in the 1980s; indeed one of the criticisms made of the Thatcher administration was precisely that it encouraged the public to regard themselves as consumers seeking to maximize their individual welfare rather than as citizens seeking to maximize the collective welfare. It would therefore be logical to expect increasing evidence of consumer frustration with the NHS. And if that were the case, then one way of interpreting the 1991 reforms would be as a response to the failure of the NHS to respond to the changing environment and rising consumer expectations.

Intuitively plausible though this interpretation may be, it is surprisingly difficult to back it with evidence. The evidence of public opinion surveys in the 1980s is ambiguous (Judge and Solomon 1993). Support for the NHS remained rock solid, while dissatisfaction with the service provided increased. But the meaning to be given to rising dissatisfaction — particularly among members of the general public who did not necessarily have first-hand experience of the NHS as patients — is not self-evident. Did it reflect frustrated expectations, or was it induced by the providers? More substantial evidence about the NHS's lack of sensitivity toward consumers is provided by a survey carried out in 1988 based on the experience of patients (rather than the views of the general public) in four health districts (Prescott-Clarke, Brooks, and Machray 1988). Overwhelmingly, people were given no choice of date when offered an outpatient appointment; between 15 and 37 percent described the outpatient department as depressing; between 18 and 32 percent considered the length of time spent waiting to see the specialist as unacceptably long; between 75 and 85 percent reported that the specialist offered no choice of treatment and made all the decisions; over 50 percent, in all four districts, agreed with the statement that "hospital appointment systems are designed to suit hospital staff, not patients." Yet, illustrating the ambiguity of public attitudes, a much higher proportion — well over 80 percent — considered that "hospitals do as well as they can considering their financial problems": the providers, clearly, had managed to convince the great majority of the public that any shortcomings were attributable to underfunding. The experiences, and attitudes, of people as inpatients were much the



same. Between 21 and 37 percent would have preferred a single room to a bed in a ward (but less than half of this group got one); over 50 percent, in all four districts, considered that “doctors talk in front of you as if you weren’t there”; between 14 and 29 percent were bothered by the standard of hygiene on the ward; between 36 and 52 percent were only told that they were going to be discharged on the day concerned.

More difficult to interpret is the increasing propensity to complain that characterized the 1980s and the start of the new decade. The fact that there was such a tendency is incontrovertible. It affected all parts of the NHS. In the period from 1983 to 1991 the number of complaints about primary care rose from 1,313 to 2,205 and about hospital services, from 16,218 to 44,680 (Williams 1994). The number of complaints to the Health Service Commissioner (1994), over the same period, rose by some 50 percent. Similarly, the General Medical Council (1994) reported a rising tide of complaints about the performance of doctors. One way of interpreting this trend is that rising complaints simply mirrored falling standards. Equally plausibly it can be argued that the greater readiness to complain reflected increasing consumer assertiveness: a decline in deference toward the professional providers and a decreasing willingness to accept shoddy or incompetent treatment. On this view, if there was a gap between consumer expectations and the NHS’s standards, it was because the former were rising more rapidly than the latter: the problem was not that the NHS was deteriorating—all the evidence pointed in the opposite direction—but that its rate of improvement did not match the rate at which expectations were increasing.

The most conclusive, and least ambiguous, evidence about the NHS’s failure to meet expectations remains that provided by the growth of the private sector. Even the recession of the early 1990s did not stop the expansion of private health care insurance: by 1991, some 6,500,000 people were covered by such schemes, an increase of 1,500,000 over five years (Laing 1994). This did not represent people voting with their feet against the concept of the NHS. Exit did not imply disloyalty: in many cases, those using the private sector did so reluctantly and only occasionally (Calnan, Cant, and Gabe 1993). But it did demonstrate the NHS’s failure to respond to consumer demand. A service predicated on the assumption that its function was to give priority to professionally determined need inevitably did not respond quickly or easily to the demands of consumers. Collective medical priorities were in competition with individual consumer priorities within tightly constrained budgets. If wait-

ing lists were an inaccurate measure of the NHS's failure to meet demand (as distinct from need)—if they reflected as much the inefficiency with which resources were used as inadequacies of funding—they were nevertheless a politically powerful symbol of the NHS's inability to satisfy consumer expectations. And the fact that they had become so politically salient in itself suggests that those expectations had risen. The phenomenon of waiting lists was as old as the NHS itself. The political unacceptability of waiting lists was, however, comparatively new: the product of the 1970s and 1980s. In the early days of the NHS, the waiting list was part of a culture of queuing bequeathed by wartime experience: it was acceptable because bolstered by a sense of social solidarity and shared hardship. By the end of the 1980s, the waiting list had become an anomaly: the queue was seen as a sign of failure.

Remarkably, though, this failure was not blamed on the design of the NHS. Similarly, any shortcomings were not put at the door of the doctors and staff running the service. Perhaps the most outstanding achievement of the NHS at the end of the 1980s—just before the reforms were introduced—was therefore that it had established itself as Britain's only immaculate institution. If there were flaws, these were attributable to government interference. If there were complaints about falling standards and mounting inadequacies, the blame fell on ministerial niggardliness. If there was rising criticism, it fell on the heads of politicians, not providers. It is this which explains an apparent paradox. For the rest of the world, Britain's NHS offered a model of how to contain costs while still offering a universal, equitable, and reasonably adequate health service: why, then, change it? But for British governments it was precisely the political costs of this success in containing costs that impelled the drive toward reform. For the Thatcher administration the problem posed by the NHS was that, as the 1980s progressed, there was an ever-widening conflict between two policy aims: to minimize public expenditure (including spending on the NHS) and to maximize its own political credit.

The 1991 reforms can therefore be interpreted (and evaluated) as an attempt by the Thatcher administration to reconcile these policy aims. On the one hand, the government sought to maintain those features of the NHS that made it such a popular institution: in particular, the fact that it provided a free and universal service. On the other hand, the government hoped to reconcile its economic and political aims by improving the NHS's capacity to respond to rising demands by increasing its effi-

ciency rather than its budget. In a global sense, the NHS provided a most efficient service: compared with most other health care systems, it provided a remarkably comprehensive service at a remarkably reasonable price—6.1 percent of the gross domestic product in 1989, the year in which the government unveiled its reform plans. But in detail, the NHS provided endless examples of inefficiency or poor productivity (Audit Commission 1990, 1992). In evaluating the reforms, the first question must thus be whether they can both build on past achievements *and* remedy past inadequacies. In trying to transform the dynamics of the NHS model, do the reforms risk also changing the nature of the model itself? If the virtues and vices of the NHS spring from the same source—that is, the institutional design chosen in 1948—then could the Siamese twins be separated without killing the patient?

### Assessing the Impact of Change

Anyone visiting a hospital or general practitioner surgery in the days, weeks, and months following April 1st, 1991, would have been hard pressed to discover any evidence that the NHS had been transformed. The introduction of the reforms may have meant radical administrative changes, but their impact on the delivery of services turned out to be both extremely gradual and almost imperceptible. The shock to the system—the new demands made on health care professionals and managers by the introduction of the mimic market—did not translate into any immediate changes as far as consumers were concerned. The NHS ground on very much as before, defying both the prophecies of impending disaster and the promises of a new dawn in the history of health care delivery in Britain. The most visible symbol of change was the epidemic of new names, logos, and signs that engulfed the NHS. Even now, more than three years later, it remains extraordinarily difficult to isolate and pin down, let alone measure, the impact of the reforms on service delivery: “changes are transformed by the processes of change” (March and Olsen 1989, 63). Precisely because the 1991 reforms marked only the beginning of a process of experiment and adaptation—with the NHS re-inventing itself on the trot—it is impossible as yet to draw more than interim and tentative conclusions about specific aspects of the reforms. The time for drawing up a definitive, overall balance sheet has not yet come. As the most comprehensive attempt yet to evaluate the changes

since 1991 has put it: “Anyone who has come to this book hoping to find a definitive answer to the simple question as to whether, overall, the NHS reforms have had a positive or a negative impact will be disappointed” (Robinson and Le Grand 1994, 243).

The problems of assessing the 1991 reforms are many. Some have been identified already. Given a constant stream of new government initiatives, such as changing the rules of the game for fundholding GPs, the ground is constantly shifting under the feet of any would-be evaluator. There is a lot of confounding noise in the machine: it is not easy to disentangle the effects of the 1991 reforms from previous or subsequent changes in the environment. If any improvements are noted in the post-1991 period, should these be attributed to the reforms themselves, to the new managerialism introduced by the Griffiths report, or to the government’s willingness to grease the path of change by spending extra money on the NHS? Most difficult of all, perhaps, is the question of how much time should be allowed before attempting to draw up a balance sheet. Can change be expected to have immediate dividends or can the 1991 reforms only be judged after, say, a decade? Given such perplexities, the strategy here will be to concentrate on the dynamics of the new system: to ask about the direction in which the NHS is traveling rather than to inquire about whether it has reached its destination. In doing so, three sets of questions will be addressed, recognizing that any attempt to assess the 1991 reforms must do so from a plurality of perspectives. First, to what extent do the dynamics of the post-1991 model reinforce or undermine the achievements of the original 1948-model NHS? Second, to what extent have the aims set out by the government in *Working for Patients* been achieved? Third, have there been any surprises and, if so, what has been their impact?

The post-1991 model, as we have already seen, remains firmly based on the original model to the extent that it provides a universal, comprehensive, and tax-financed health care service to the entire population. But one effect of the 1991 NHS reforms has been not so much to create new problems as to give extra visibility to old ones. In effect, the NHS reforms forced the mass exhumation of skeletons, which—until the post-1991 era—everyone had preferred to ignore. The point can be illustrated by examining how the responsibilities of the NHS are defined. In contrast to many other health care systems, the NHS has never offered consumers a menu of entitlements. It has from the start excluded some types of treatment—such as osteopathy and spa cures—that are offered

by health care systems in other countries. The consumer's only right is to have access to the health care system: once that has been achieved, it is for the professional providers to determine what treatment is appropriate. British courts have invariably held that it is for the secretary of state and health authorities to determine how best to use resources and, provided they do so reasonably, the judges will not substitute their own views for those of the providers (Longley 1993). In a sense, therefore, in 1994—as in 1948—the scope of the NHS's services, the degree of its comprehensiveness, remains a matter of professional convention and local decision making. However, in 1994—in contrast to 1948—the separation of the purchaser and the provider functions means that the former have to be explicit about what services they propose to buy on behalf of their populations. They have to publish an annual purchasing plan, in which they set out what they propose to buy and from whom.

Although, in theory, the new system should force NHS purchasers to define explicitly the services that they propose to provide for their populations, in practice this has not happened (Klein and Redmayne 1992; Redmayne, Klein, and Day 1993). In the first place, purchasing plans show a general reluctance to limit explicitly—or ration—the availability of NHS services by redefining their scope more tightly. Examples of such decisions are rare. In a 1992 survey only 12 out of 114 health authorities had restricted the menu of services available to their populations. A year later, the proportion of health authorities making the denial of services explicit was smaller still. In all cases, explicit rationing was limited to relatively trivial procedures (in terms of their impact on the total NHS budget) where the precise boundary between medical and social need is blurred: for example, tattoo removal, general cosmetic surgery, buttock lift, surgery for adult bat ears, and sex change operations. In the second place, although purchasing plans usually specify the number of patients to be treated and the number of operations to be carried out, they only rarely translate such figures into a currency that allows the adequacy of service provision to be assessed. The NHS continues to ration—not so much by restricting its scope but by limiting access to the available services. And the process of rationing—despite the expectations set up by the purchaser/provider split—tends to be largely invisible, diffused among the clinicians who decide which patient is going to be treated and how (Klein 1993a). The logic of translating collective decisions about resource allocation into individual clinical decisions—and thereby making rationing decisions largely invisible—has not changed.

In this respect, too, the new-model NHS is again remarkably like the old-style NHS. The purchasing plans of most health authorities are only gradually, and incrementally, modifying the inherited variations in the pattern of services. In part, this policy of gradualness may be a transitional phenomenon. The constant process of change within the NHS, and the accompanying demands on local managers, have diverted energies from the difficult task of developing purchasing skills. The adoption of the capitation funding formula for purchasers will clearly accelerate the movement toward equity in the level of resources available locally, just as it compels the losers to reassess their priorities radically. However, it is not clear as yet how quickly any movement in this direction will translate into equity in the geographic availability of different types of services. In the 40 years before the 1991 reforms the NHS, as we have seen, failed to eradicate such variations. The dynamics of the new-model NHS suggest that convergence toward national rates is likely to be considerably faster than in the past. Not only is there increasing pressure from the center, as the Department of Health (through the NHS Executive, the body at the top of the NHS's managerial hierarchy) sets specific targets for the achievement of particular rates of activity, but to the extent that purchasing plans put evidence about local underprovision into the public domain, and give greater visibility to underperformance, so local pressure may reinforce central exhortation.

Conclusions about the effects of the new-model NHS on equity in access to, and the use of, NHS services by different social groups have to be more speculative and tentative still. On balance, however, the dynamics of the new NHS do not suggest that the poorer or more vulnerable groups in society will necessarily suffer. To the extent that purchasers set themselves targets in terms of health outcomes—as required by the government in its strategy document, *The Health of the Nation* (Secretary of State for Health 1992)—so, in theory, there could be a temptation to direct intervention to those groups that can be reached most easily. Similarly, to the extent that the contracts of providers set particular targets of activity, so there could be a temptation to give priority to those patients most likely to respond to treatment. There are, however, countervailing trends. The logic of the purchasing role is to analyze the health status of the population being served as the first necessary step toward defining the “needs” for health services. This means, in turn, identifying those sections of the population or geographic areas where there is a mismatch between health status and health care provision. The bias, in

short, is toward identifying inequity—although, in practice, the public health staff of many purchasers still lack the technical capacity for doing so effectively and comprehensively (Day 1994). Similarly, the new-model NHS offers incentives to providers—where there were none before—to attract funding by developing services for previously neglected populations. Whereas, in the past, difficult-to-reach patients may have been seen merely as a burden, now they may suddenly be perceived as a possible source of extra revenue.

In the case of general practice, somewhat different arguments apply. In particular, fears about the effects of the NHS reforms on equity have focused on the introduction of fundholding. Budget holding, it is argued, gives general practitioners an incentive to adopt “cream-skimming” strategies (Glennister, Matsaganis, and Owens 1994) by refusing to accept onto their lists those patients likely to make the most demands on their funds, that is, the least healthy. In theory, this is clearly a danger. In practice, the method of determining the budgets of fundholders has meant that the threat has not materialized. Fundholding budgets are negotiated on the basis of past patterns of practice, with considerable variations in the sums allocated per patient (Day and Klein 1991; National Audit Office 1994). Because there is, as yet, no national formula for determining fundholding allocations, there is scope for discretion when fixing budgets. In turn, this discretion can be used to discourage “cream-skimming”: a fundholding practice that recruited only healthy patients might well find its budget cut accordingly. Similarly, if eventually a formula for determining fundholding budgets is devised, it could incorporate incentives to take on the least healthy patients by means of differential capitation weightings for specific groups: a difficult task but not an impossible one.

So, again, there is no reason to think that the dynamics of the new-model NHS will necessarily reduce equity; on the contrary, potentially at least, they offer an opportunity to manipulate incentives in such a way as to enhance equity. The paradox may be that a government dedicated to the achievement of equity might find that the post-1991 NHS offers more levers and mechanisms for achieving this aim than the pre-1991 system. The levers and mechanisms are, in themselves, neutral; how they are used depends on political decisions taken by central government.

Turning to Bevan’s aim of “universalising the best”—an objective reaffirmed by *Working for Patients*—there is no reason to think that this is likely to be any more or less achievable in the new environment than

it was in the old. Universalizing adequacy is likely to remain the best that can be achieved, but its achievement may well be accelerated by the dynamics of the new-model NHS. For achieving adequacy implies, in turn, eliminating the inadequate. And one of the characteristics of the post-1991 NHS—owing more perhaps to the changes brought about by the Griffiths report than to those introduced in 1991—has been an emphasis on quality of service. The move from trust to contract has meant that the quality of services in the NHS is no longer taken for granted. Purchasers insist on putting quality requirements into their contracts with providers; medical audit is designed to improve the quality of clinical practice; accreditation systems have been introduced to test the organizational capacity of providers to deliver services to an adequate standard (Scrivens 1995). Much of this may be at the level of rhetoric. The definition of quality used in contracts is often one dimensional, concentrating on such matters as waiting times rather than requiring specific standards in the delivery of clinical services. Rhetoric, however, creates its own expectations, just as the attempt to devise some quality criteria for contracts creates its own momentum for improving the definition of those standards. And the development of better data systems increasingly gives public visibility to information about poor performance—whether excessive postoperative mortality or a high incidence of bed sores. The full potential of this ability to identify poor performers—individual consultants as well as institutions—remains to be exploited. There still are great problems of statistical interpretation: a surgeon who takes on only straightforward cases may have a better record, and so appear more competent, than one who is prepared to operate on complex, difficult cases. But it is clear that the dynamics of the new-model NHS will create ever stronger pressures to identify and eradicate poor practice. In turn, this is likely to accelerate the process—as old as the NHS itself—of continually revising standards of adequacy upward.

### Did the Reforms Achieve Their Aims?

Implicit in the whole process leading up to the publication of *Working for Patients* was one overriding political aim. The reforms were designed to turn the government's biggest political liability into a political asset by demonstrating that a transformed, and therefore more efficient and responsive, NHS could satisfy the expectations of both the providers and



the consumers of services without a massive infusion of extra funds. This aim, as we shall see, was not achieved. In trying to explain this failure, the best starting point is provided by the program of action set out in *Working for Patients*. If the government failed to achieve its political aims, this could be for one of two reasons. One is that the reforms failed to bring about improvements in the performance of the NHS. The other is that the improvements in the performance of the NHS did not translate into political credit for the government. So the first step in the analysis must be to assess the evidence about the extent to which the reforms actually improved the NHS's performance, using the government's own objectives as the currency of evaluation.

The government's program of action was designed to secure two objectives. The first was "to give patients, wherever they live in the UK, better health care and greater choice of services available." The second was to provide "greater satisfaction and rewards for those working in the NHS who successfully respond to local needs and preferences." In short, both consumers and providers were to reap the benefits of change.

Establishing the extent to which consumers have benefited from the changes is extraordinarily difficult, raising all the problems of evaluation discussed earlier. To the extent that the availability and accessibility of NHS services can be measured by activity—the number of patients treated and the number of operations carried out—so it would seem that the post-1991 period has continued the year-by-year improvement in productivity that characterized the pre-1991 period. However, the evidence about whether or not the rate of improvement has accelerated or slowed as a result of the reforms is ambiguous and inconclusive. In the years from 1991–92 to 1992–93, the average annual increases in the rate of hospital admissions and of day cases were, respectively, 1.0 and 16.2 percent, compared with 1.9 percent and 8.7 percent for the whole period since 1979 (Department of Health and Office of Population Censuses and Surveys 1994). The figures might therefore be interpreted as demonstrating either an unwelcome decline in the rate of increase in the number of inpatients treated or as a welcome acceleration in the trend toward treating more people as day cases. Interpretation is further complicated by controversy about the extent to which the figures are inflated by the way in which they are calculated: patients moving from one consultant to another may appear as new patients in the statistics. Perhaps the only conclusion to be drawn, therefore, is an agnostic one: if no great improvements in performance can be deduced from the post-1991

statistics, neither do these suggest any sudden deterioration as a result of the reforms either quantitatively or qualitatively (Clinical Standards Advisory Group 1993).

Much the same point applies to waiting lists. Following 1991, the number of people on waiting lists rose and by 1994 had topped the one million mark. However, the time spent waiting for admission (a more sensitive indicator) fell sharply (Health Committee 1994). Even leaving aside general doubts about the usefulness of waiting list and time statistics as an indicator of the NHS's ability to meet demand, the evidence is still somewhat contradictory. Moreover, with providers under pressure from purchasers to shorten waiting times, it became apparent that the construction of waiting lists was a peculiar art form. The simplest way of reducing waiting lists is simply not to put patients on them or, failing such a radical step, to limit the flow by increasing the time patients spend waiting to see the consultant who will put them on the waiting list (which does not show up in the statistics).

The impression that the predicted transformation of the NHS had not happened was further strengthened by the discovery that money did not always follow the patient in the new NHS and that, in any case, the total amount of money was not elastic. If a hospital managed to treat the number of patients and carry out the number of operations laid down in its contract before the end of the financial year, it did not necessarily follow that the purchaser would have any money left to buy more services, despite various pump-priming initiatives by the NHS Executive designed to ensure that spare capacity would be used to reduce waiting times. Efficiency was not necessarily rewarded by more funding, and staff were left protesting their frustration to the media.

If statistics speak with an ambiguous voice, the experience of patients should provide a clearer guide. Here the problem is how to aggregate individual experience—reflecting the varying (as always) policies and practices of local providers—into a composite picture. National surveys suggest that there has, indeed, been a fall in dissatisfaction with the NHS's performance: between 1989 and 1994, the proportion declaring themselves to be dissatisfied fell from 47 percent to 38 percent (Timmins 1994). It is unclear, however, to what extent this improvement in perceptions reflected direct personal experience as distinct from the fact that the NHS had faded out of the headlines after the dramatic climax of 1989. More clear-cut is the evidence that the post-1991 NHS has begun to accept the Griffiths report's view that patients should be seen as con-

sumers: that the service should seek to satisfy the customer. Outpatient departments have developed appointments systems that do not involve block bookings; providers regularly carry out surveys of consumer satisfaction; hospitals have smartened up their waiting areas. Many of these changes are cosmetic. Patients are still seen as consumers in only a limited sense: they may be consumers of hotel services, but they tend to remain patients when it comes to clinical care. Even though the NHS supermarket is prepared to invest in making access easier and more pleasant, the staff still decide who is to get what: professional paternalism is still, in most spheres, the norm. However, the fact that the NHS has embraced a new language—that both managers and professionals feel obliged to use a new vocabulary of justification—represents, in itself, a recognition that the ground has shifted. The gap between rhetoric and reality, between aspirations and actions, may still be wide, but at least the rhetoric creates a new set of expectations against which performance can be assessed.

Inherent in the NHS's linguistic transformation of the patient into a consumer is a curious paradox. This is that the new rhetoric of consumerism is a response to top-down policies rather than to bottom-up demands. The post-1991 NHS, like the pre-1991 NHS, does not have consumers in the strict sense: that is, people able to choose what they want. For the reforms have conspicuously failed to achieve the government's objective, as set out in *Working for Patients*, of giving patients "greater choice of the services available." Perversely, indeed, they have restricted choice in some respects: GPs, unless they are fundholders, are no longer free to refer their patients to whichever specialist they consider appropriate but must refer them to those providers with whom the district health authority has a contract, unless they obtain approval for such extracontractual referrals. The dynamics of the new-model NHS are driven not by consumers but by purchasers: health authorities and fundholding GPs have become proxy consumers.

It is difficult to establish how effective purchasers are in their role as proxy consumers. Indeed, in the case of the health authorities, there is a conflict. On the one hand, they are expected to aggregate and articulate the *demands* of the population. On the other hand, they are expected to reflect the *needs* of the population in their purchasing plans. It is not clear that the two necessarily point in the same direction. Public views may differ from professional judgments (Heginbotham 1993); populism and paternalism may be at odds. And the evidence is that, although

purchasing authorities do indeed carry out occasional surveys and engage in extensive consultation, they mainly rely on the views of GPs in framing their purchasing decisions.

Health authorities are, of course, monopolists in that their consumers are a captive population defined by area of residence. There is, therefore, no competition between them to demonstrate their effectiveness as purchasers or their responsiveness to their populations. No one can choose which health authority is to purchase health care on their behalf—except, possibly, by moving house. The situation is very different in the case of fundholding GPs. Here the assumption is that they have a very direct incentive to be effective proxy consumers because otherwise their patients will simply switch to a competing practice. Fundholding, in short, provides a model that appears to put the consumer in the driver's seat and to meet the government's aim of giving patients greater choice. However, two conditions have to be met if the model is to work as specified. The first is that consumers have sufficient information to shop around in the medical marketplace. The second is that there is competition between GPs. There is reason for skepticism on both counts. The evidence is that consumers lack both the knowledge and the inclination for making marketlike choices between different practices (Charny et al. 1990; Shackley and Ryan 1994). And the 1992 reforms did little to encourage competition between GPs. They required GPs to provide more information about their practices, and they made it administratively easier to change doctors. Much more crucially, however, they retained central control over the distribution of GPs: when it came to the point, Treasury fear of a rapid expansion in the number of GPs—and a consequent increase in expenditure—overrode the ideology of choice and competition. It may indeed be that fundholding will accelerate the trend toward larger practices—because successful purchasing requires a strong infrastructure of expertise and information technology—thereby further restricting choice in any given geographic area.

To the extent that the government's program of action was designed to give patients greater choice, it must therefore be rated a failure. Similarly, the government clearly failed to achieve the second general objective enunciated in *Working for Patients*, which was to bring about "greater satisfaction and rewards for those working in the NHS." In many cases, the rewards did increase—but they did not bring about a sense of satisfaction. Opposition to the reforms among the medical and nursing professions gradually turned to reluctant acquiescence; a significant minority even be-

came enthusiastic converts. However, there was little perception, and less public acknowledgment, that the reforms might have brought about greater satisfaction or rewards for those working in the NHS. If anything attracted attention—and resentment—it was that the higher rewards appeared to be going predominantly to managers: the effect of the reforms, it appeared to doctors and nurses, was to inflate both managerial numbers and salaries. Nothing that the government did, even when it poured extra billions into the NHS, appeared to be able to dispel the miasma of lingering suspicion bequeathed by the circumstances in which the reforms had been introduced.

The situation underlines one of the central paradoxes of health care reform. To the extent that the 1991 reforms succeeded in their intention of challenging inherited patterns of work and the existing distribution of power in the NHS, so it was inevitable that the changes would be widely resented. However, if the reforms were to be seen as a success, the government ultimately needed to secure the support of those working in the NHS: for one of the characteristics of the health care arena is precisely, as argued earlier, that to a large extent consumers tend to see the service through the eyes of providers. When it came to the interpretation of ambiguous, conflicting, and inconclusive evidence, doctors trumped politicians both before and after 1991. Although the government's ability to impose its reforms appeared to demonstrate that doctors had lost their power to veto change, the aftermath of the reforms suggested that the medical profession still exerted considerable power through its ability to shape the way in which the new-model NHS was perceived. Power, clearly, has many faces.

Politically the NHS therefore remained as much of a liability for the Conservative government of John Major as it had been for Mrs. Thatcher's administration. In the 1992 general election, 60 percent of those who thought that health was one of the most important issues affecting their voting decisions also believed that Labour was the party with the best policies (Sanders 1992). Nor does trust in the government's policies appear to have increased subsequently: in a 1994 survey, 75 percent of the respondents thought that the government was planning to privatize the NHS, and 51 percent thought that the NHS would not exist in 10 years' time (J. Smith 1994). The political costs of successful economic stringency in the 1980s had persisted, even though the policy of stringency itself had been relaxed in the early 1990s (Bloor and Maynard 1993). Whereas in 1989 spending on the NHS represented 6.1 percent of the

national income, by 1992 it had gone up to 7.1 percent: indeed, even taking the period from 1989 to 1992 as a whole, Britain's growth rate was higher than that of Germany and the Netherlands, whereas Sweden and Denmark actually recorded a relative cut in spending (Schieber, Poullier, and Greenwald 1994). Although some of the extra funding was absorbed by rising managerial costs—the new-model NHS turned out to be much more expensive to administer than its predecessor—these did not absorb anything like the full amount of the extra resources made available to the service. But, ironically, the government failed to gain any credit for the reluctant generosity forced upon it by the need to make a success of the reforms. Whatever other benefits were brought about by the new-model NHS, they did not significantly cut either the growth of the economic demands generated by the NHS or its political costs. The political aims that had precipitated the process of change had not been achieved.

### Side Effects and Surprises

Like all reforms, those of the NHS produced outcomes—both positive and perverse—that had not been fully anticipated either by their authors or by their critics. The dynamics of change, once unleashed, created their own side effects and surprises. The most clear-cut and potentially most important of these has been the impact of the reforms on the balance of power between general practitioners and hospital specialists and between the primary and secondary sectors of care. Despite the hostility of general practitioners toward the reforms, and their subsequent protestations about falling morale, it is they who have emerged with increased status and influence in the new-model NHS.

The change is most apparent in the case of fundholders (Duckworth, Day, and Klein 1992; Glennerster, Matsaganis, and Owens 1994). Controlling their own budgets means that they can also decide whose services to buy; if dissatisfied, they can threaten to switch their contract to a new provider. In practice, most fundholders have been conspicuous for their loyalty to existing providers; given that patients appear to attach great importance to the accessibility of services, it is in the interest of fundholders to support local providers rather than to spread their custom. There is little evidence, for example, that fundholders have switched much of their custom to the private sector, apart from buying some diagnostic

services and occasional surgery. But the fact that they can *threaten* to switch means that they can exact a price for their loyalty. They can demand that their patients are seen, and treated, within a given period of time. They can insist on consultants providing prompt discharge notes and justifying repeat outpatient appointments. They can arrange for consultants to hold clinics in their own offices, so that their patients do not have to travel to the hospital for their appointments. To an extent, therefore, consultants have become accountable to fundholding GPs. In turn, fundholding GPs have every incentive to question what consultants do because they will pick up the bill. No longer does their interest in what happens to a patient stop at the hospital gate. It is a revolution (no less a word will do) whose full effects have still to work themselves through, but that clearly represents a new era in the history of the NHS.

This conclusion is reinforced because of the spillover effects of fundholding for general practice as a whole. The changes have meant not only that consultants have strong reasons for courting general practitioners, something they previously did only to ensure a flow of private patients, but also that health authorities, too, have an incentive to engage with general practitioners. Every new fundholding practice meant, in effect, a cut in the budget of the local health authority. The spread of fundholding threatened to erode the financial base—and the consequent ability to control the development of health services—of health authorities. The introduction of the new-model NHS was therefore accompanied by an outbreak of initiatives designed to persuade general practitioners that they did not need to become fundholders in order to influence local purchasing. General practitioners, as already noted, were increasingly and widely consulted about the priorities to be incorporated in purchasing plans. More radically still, a number of health authorities experimented with variations on the theme of “locality purchasing,” effectively devolving purchasing decisions to groups of general practitioners. The impact of fundholding in tilting the balance of power within the NHS toward primary care can therefore be measured in terms not just of its immediate effects but also of the preemptive strategies of health authorities anxious to protect their control of budgets and services.

It would be overly simple to attribute the post-1991 shift in the balance of power within the NHS exclusively to fundholding or any other single aspect of the reforms. The emphasis on developing primary care preceded the 1991 reforms (Rayner 1992) and was part of the more gen-

eral reassessment of policy symbolized by the publication in 1992 of *The Health of the Nation* (Secretary of State for Health 1992) with its focus on population-based preventive strategies. Similarly, the aging of the population—and, with it, the scale of chronic illness—would inevitably have meant an expanded role for general practice. The 1991 reforms, however, did create a framework, and a set of incentives, designed to encourage such trends. Whereas before 1991 health authorities had a vested interest in the promotion of their own providers—hospitals in particular—as purchasers in the new-model NHS, their responsibility was to buy whichever services promised to yield the biggest health dividend. In practice, purchasers—like fundholding GPs—tended to remain loyal to the established providers, while shifting resources at the margins and using the threat of switching contracts to bring about changes in pricing and practice. The reforms did not therefore bring about any dramatic switch in the distribution of the NHS's budget between different services or sectors. They did mark the beginning of a gradual shift of funding from secondary to primary care (Redmayne, Klein, and Day 1993), mirroring the shift in the balance of power between consultants and general practitioners. It is a process that is likely to accelerate to subsequent legislation, giving statutory blessing to the cohabitation of health authorities and family health service authorities, thereby creating unitary health authorities and at long last bringing primary care into the mainstream of service management—50 years after the NHS was conceived.

In the case of general practice and primary care, the direction of change since 1991 is clear. In the case of the distribution of power between the medical profession and managers in the new-model NHS, it is much more difficult to reach a firm conclusion. The notion of “power” is, in itself, multidimensional and slippery; the evidence so far available is inadequate and inconclusive; local variations are all too likely. In formal terms, the reforms have greatly strengthened the ability of managers to call doctors to account: in the case of new consultant appointments, for example, the contract may now specify the duties to be carried out in considerable detail. Similarly, the fact that the financial viability of providers depends on attracting sufficient business gives managers extra incentives and leverage to question the practices of consultants should these risk losing a contract. All this would suggest that the traditional conception of clinical autonomy—defined as the freedom of individual doctors to exercise their professional discretion in the way they use public



resources — is being eroded: a perception probably shared by most hospital doctors.

But before accepting this conclusion, it is important to distinguish between individual and collective professional autonomy. The individual autonomy of NHS consultants does indeed appear to be shrinking. If physicians keep their patients in the hospital for above average lengths of time, if surgeons fail to switch to day surgery, they are likely to find their practices challenged. But the pressure is as likely to come from their professional colleagues as from managers, since it is as much in the interest of the former as of the latter that the hospital remain competitive. In this respect, managers and consultants (as a body, if not individually) have the same incentives. One effect of the NHS reforms has therefore been to persuade the medical profession to accept more collective responsibility for the way in which individual members exercise their craft. Most notably, the post-1991 period has seen the mass production of guidelines and protocols that define good practice (NHS Management Executive 1993). Some of these have been produced nationally by the royal colleges. Many more have been produced locally, often in response to demands from purchasers who want to be assured that they are buying good-quality medicine.

The production of guidelines and protocols is a consensual process; their implementation depends on persuasion and peer pressure. So it is difficult to know how much difference such attempts to influence practice will make in the way doctors go about their work: if the experience of the Effective Care in Pregnancy and Childbirth (ECPC) initiative is anything to measure by, there is a long way to go before evidence-based practice becomes the norm (Stocking 1993). The real significance of these developments is, however, different. It is that the medical profession responded to the 1991 reforms by acknowledging its responsibility for defining good practice more explicitly than ever before and, by so doing, gave greater precision and visibility to the criteria against which the performance of individual practitioners can be assessed. The production of guidelines and protocols is not the only evidence pointing in this direction: the General Medical Council has also moved toward this goal by seeking power to investigate the professional competence of doctors in cases where there was evidence of “serious deficiency in performance” (General Medical Council 1993; Stacey 1992).

To exaggerate only a little, the medical profession appears to be ready

to restrict the autonomy of individual clinicians in order to strengthen collective professional autonomy. To the extent that the medical profession succeeds in this strategy, and carries conviction in presenting itself as the guardian of standards, so it may be able to retain control over the process of defining the currency of medical accountability and thus limit the scope for managerial intervention. The case of medical audit supports such an interpretation. Here the medical profession appears to have been successful in controlling the process and in preventing it from becoming a tool of management (Kerrison, Packwood, and Buxton 1994). The accountability of doctors, in the case of medical audit, is still to their professional peers, not to managers.

To analyze the distribution of power between doctors and managers as a zero-sum game—in which inevitably there must be winners and losers—may, in any case, be to oversimplify a complex situation. To the extent that both doctors and managers have a shared interest in institutional survival, so the new-model NHS may have strengthened awareness of mutual dependence. If managers cannot mobilize the support of clinicians for their strategies, they are unlikely to succeed in achieving the targets on which the renewal of their contracts depends: they may indeed even be forced out of office if they antagonize medical staff (Dillner 1994). Conversely, however, clinicians will not attract the resources they need to develop their services if they block or subvert managers: they need efficient, active management for survival. The institutional dynamics of the post-1991 model NHS, at the level of provider units, may therefore compel professionals and managers to negotiate new forms of mutual accommodation rather than create a new balance of power tilted toward the latter. Medical dominance has not been replaced by managerial dominance (despite some notorious, and usually unsuccessful, attempts to move in this direction) but has been modified by the former's recognition that it cannot command automatic precedence.

This mutual dependence takes many forms. The new-model NHS has, to recapitulate, generated much information about the performance of individual doctors. Similarly, the Department of Health has given high priority to research designed to generate knowledge about the effectiveness of different forms of medical intervention and about the outcomes of treatment (Peckham 1993). Once again, however, it is the medical profession itself that is the interpreter of often ambiguous or inconclusive evidence about the actions of individual clinicians or the effectiveness of treatment. In the new-model NHS, as in the old model,

engineering changes in practices means mobilizing medical opinion and exploiting peer pressure.

Further warning against drawing any precipitate conclusions about changes in the balance of power within the NHS consequent on the 1991 reforms is provided by the story of rationing. As noted above, health authorities have been extremely reluctant to adopt policies of explicit rationing. Rather than following the Oregon model, and limiting the menu of services offered by the NHS, they continue to leave decisions about which patients should be treated, and how, to clinicians. The political rationale for so doing is obvious enough: local decision makers have the same incentive as central government decision makers to diffuse blame. But there is a further rationale. As a resource allocation strategy, the Oregon model is flawed (Klein 1994). To exclude specific forms of treatment on the grounds that they are ineffective, or that the return on the money spent is low, is to ignore the fact that patients are heterogeneous. Even if nine out of 10 patients do not benefit from a particular form of treatment, there may always be a tenth for whom it is cost effective. Clinical judgment is therefore crucial in deciding which patients will respond to particular forms of treatment. Similarly, concentrating on rationing by exclusion risks ignoring the scope for using resources better in the management of patients in the process of treatment: decisions about diagnostic tests, about preventive antibiotic therapy, about lengths of stay, and so on. Once again, clinical judgments are the critical factor. Implicit rationing by clinicians may therefore be more rational than attempting explicit rationing by exclusion (Mechanic 1992). But to acknowledge this is also to concede continued dependence on the medical profession for the way in which NHS resources are used.

Overall, then, the impact of the 1991 reforms on the position of the medical profession within the NHS defies encapsulation in a simple conclusion. If the introduction of the reforms advertised the impotence of the profession in the national policy arena, subsequent developments suggest that the NHS's dependence on doctors for the implementation of policy locally remains almost as great as ever. The most important consequence of the NHS reforms may thus be not so much that they changed the balance of power between clinicians and managers but that they prompted the medical profession to take preemptive action to prevent such a shift taking place. In this respect, the monument to the 1991 reforms may turn out to be — somewhat unexpectedly — the medical profession's new-found enthusiasm for setting and monitoring its own standards.

## Policy Options for an Uncertain Future

On one point there appears to be total unanimity about the future of health care. This is not only that the future will be different from the past, as always, but that it will be so in ways that are extraordinarily difficult to predict (Warner and Riley 1994; Wyke 1994). Technology will transform the art of medicine, in particular the practice of surgery. Electronic networks will give not only doctors but also consumers access to information on an unprecedented scale. The configuration of hospitals will change, services will become more diverse, and activities will increasingly be dispersed to the periphery. On the other side of the equation, the aging of populations will increase the demand for the treatment of chronic conditions (Fox 1993) and call into question the division between medical and social care even more than now. There are also large uncertainties. Will gene therapy provide, as its prophets promise, magic bullets for preventing or curing disease? Will governments maintain their new-found enthusiasm for improving the population's health through social engineering and, if so, will the consequence be to reduce demands for health care or simply to extend the quantity of life? Whatever the answers to such questions, there is general agreement that the pace of change in patterns of health care delivery will accelerate in the coming decades.

The crystal ball clouds over when it comes to predicting the policy consequences of such changes for the financing and organization of health care systems. In what follows no attempt will therefore be made to predict the NHS's future. Instead the strategy will be to analyze available options in terms of a choice between two models of health care, since our perception of what is possible or desirable depends on whether we see the NHS (or any health care system that may succeed it) as a church or as a repair garage (Klein 1993b): that is, whether we see it driven by professional and bureaucratic values, as in the original 1948 concept, or shaped by consumer demands. Table 1 encapsulates the concepts and values implicit in each model as a set of antithetical key words to provide the framework for organizing the discussion of policy options. There is no assumption in this that future policy making will neatly conform to either model. However, sharpening up the contrast between the two vocabularies of political discourse about the organization of health care puts the nature of the available choices into higher relief.

TABLE 1  
The Competing Models

Model 1: health care as church	Model 2: health care as repair garage
Paternalism	Consumerism
Planning	Responsiveness
Need	Demand
Deference to doctors	Doctors as technicians
Priorities	Choice
Trust	Contract
Universality	Pluralistic
Single tier	Multitier
Stability	Adaptability

The model of health care as a secular church represents the tradition maintained and carefully tended over the decades by the disciples of Bevan. Creating the NHS was seen as an act of social communion, celebrating the fact that all citizens were equal in the sight of a doctor (Titmuss 1970). It was also, however, a model based on the assumption that the doctor's judgment would then determine who should get what. The vision behind the creation of the NHS was as much one of technocratic rationality as of social justice (Fox 1986). Indeed, technocratic rationality was equated with social justice. From this flowed the NHS's paternalism. It was the experts who would determine the need for health care, frame the appropriate priorities, and implement their policies universally throughout the NHS.

The alternative model, of health care seen as a repair garage, has never been articulated as clearly. It is implicit in much of the advocacy of moving toward a market-based health care system but would not necessarily depend on the adoption of such a solution for its implementation. In this model, decisions are driven not by experts but by consumer demands: the body is taken in for repair by its owner, who retains control over what happens to it. The doctor is seen as a technician rather than as an authority figure. The ability to choose between garages becomes crucial. Universal provision, in the sense of the same services being available everywhere to everyone, is no longer seen as attainable or even desirable. The multiple preferences of consumers will inevitably create a pluralistic,

multitier system. If equity is to be achieved, it will not be through a top-down process of planning but, rather, through enabling all consumers, if need be by transferring resources to them, to secure such health care provision as they think is appropriate for themselves.

The two models can, very roughly, be identified with left- and right-wing ideological predispositions. But ideological reflexes are not—as the entire history of the NHS demonstrates—necessarily an infallible guide to the pragmatic responses of governments to specific issues. In any case, ideological reflexes have themselves been changing. The rest of the 1990s will be concerned with the new agenda that the 1980s have bequeathed not only to the NHS but to all U.K. institutions, shifting the center of gravity in the arguments about the appropriate balance to be struck between competing aims and values in the policy-making process.

In the case of the NHS, as we have seen, the center of gravity has shifted from paternalism to consumerism, from need to demand, from planning to choice. As we have also seen, however, in no case has the shift been complete. Markets have been managed; choice has been constrained by worries about costs; priorities follow need as well as demand. In short, the NHS remains transfixed between competing values. In seeking to combine the best features of the church with the most attractive characteristics of a repair garage—to design, as it were, a drive-in church—the Conservative government created an institution forced constantly to reinvent itself in the process of seeking to accommodate conflicting policy aims. From this flow the continuing tensions in the NHS and the continuing debate about the future organization of health care in Britain (British Medical Association 1991; Institute of Health Services Management 1993; National Association of Health Authorities and Trusts 1993).

One way of resolving these tensions would be either to revert to the church model (in the case of a future Labour government) or to adopt the garage model without reservations (in the case of a Conservative administration). But it does not seem plausible to predict a leap either into the past or into a very different future. The freedom of action of the Conservatives is constrained by the expectations set up by almost 50 years of experience of the NHS and the sense of loyalty that it has created. Labour's freedom of action is constrained by the new expectations created by the language of consumerism: even if increasing consumer expectations did not drive the changes of the 1980s, the rhetoric of those

changes has in itself introduced a new element into the politics of health care. And all governments, whether Conservative or Labour, are constrained by the fear—so influential in determining the outcome of Mrs. Thatcher's review—that any change in the financing of health care in Britain could lead to an explosion in spending.

There are also other reasons for expecting policy making—whatever the party of the government in power—to continue to be a search for an acceptable hybrid rather than a dramatic lurch toward one or other of the two models. The two models have been presented in terms of their antithetical characteristics. In fact, however, a health care system based on either of the models—in a pure, unadulterated form—would be something of a monstrosity. In other words, the search for an appropriate blend of competing values should be seen not as the original sin of politicians seeking to compromise and trim for reasons of electoral expediency but as a sensible response to the complexities of the health care system.

Consider, for example, the antithesis between paternalism and consumerism. Here the balance has clearly tilted, as we have seen, from the former toward the latter in the 50 years since Bevan first put his proposals for the creation of the NHS to his cabinet colleagues. But it is a consumerism that, as yet, is far from turning doctors into garage hands. This is not only because of the familiar point that there is an asymmetry of information between the providers and consumers of health care. More important, perhaps, is that the information itself is often uncertain, ambiguous, and difficult to interpret. The skill of the doctor lies in taking decisions about how to deal with individual patients in the absence usually of conclusive evidence about the effectiveness of different types of treatment (R. Smith 1991). Half art, half science, medicine operates in a kind of twilight zone, where the patient's trust in the competence and integrity of his or her doctor may be one of the most important parts of the treatment. The point should not be exaggerated: the argument here advanced does not exclude consumers from seeking either more information about which doctors have the most competence or more voice in choosing between different types of treatment, but it does indicate that there are limits in applying the garage model to health care. The balance may, of course, change over the coming decades. To the extent that the spread of new technologies turns doctors into technicians, to the extent that more conclusive evidence about the effectiveness of different types of treatment becomes available, so con-

sumers may increasingly have the information and confidence to make their own judgments. In the meantime, however, neither a reversion to the 1948 form of paternalism nor a move toward a full-blown consumer-driven health care system appears to be a viable policy option: the real policy challenge is precisely how best to achieve an appropriate balance.

Party differences are most likely to reveal themselves in the strategies pursued in trying to devise such a balance. The Conservative strategy appears to be a move toward a “primary-care-led NHS” based on fundholding GPs acting as agents for the consumer (NHS Executive 1994). The size of the patient list required to qualify as a fundholder has been lowered from 7,000 to 5,000; the scope of fundholding purchasing has been widened to include all community and (in some experimental schemes) all hospital services. The power of consumers would be enhanced, at least in theory, by giving them greater scope for choosing their agents—although, as we have seen, the choice is more notional than real. Labour, strenuously opposed to the concept of fundholding, puts more emphasis on “strengthening the voice of the patient at [the] local and national level” (Labour Party 1994) and introducing the notion of patient rights (Coote 1993). Responsiveness to the public would be achieved not by giving consumers greater choice between competing providers but by giving citizens more voice in local decision making about health policy. Political choices would take the place of direct consumer choices. The ultimate logic of such a strategy would be to resolve the tension between local responsiveness and accountability to the center by transferring responsibility for health care to local government. Any such a move would, of course, arouse the ire of the medical profession. More important, unless local authorities were given an independent source of revenue, responsibility for health care would simply reinforce their financial dependence on central government—so making a mockery of local accountability (Committee of Inquiry into Local Government Finance 1976).

It is not only in the case of paternalism versus consumerism that the antithesis between the two models is too neat and that the task of policy making is how best to balance competing objectives. The church model emphasizes planning priorities according to need as defined by the experts, whereas the garage model emphasizes responding to demands as expressed through choice. However, the NHS’s experience before 1991



demonstrated the limitation of planning by experts, whereas experience since 1991 has shown that health care markets are not natural, spontaneous creations but have to be managed and planned in order to ensure that purchasers actually have a choice. Neither a reversion to managerial hierarchy nor an advance to a *laissez-faire* market therefore is a plausible option. The real question would seem to be how best to manage what is bound to be an increasingly pluralistic and volatile system, if only because changing technology is creating constant new possibilities for organizational as well as technical innovation while making many existing institutions obsolescent. If leaving it to the market is not an option, neither is a return to the rigidities of hierarchical control

In this and other respects, the 1991 reforms have clearly shifted the grounds of debate: familiar issues have to be placed in a new landscape. The separation between purchasers and providers is likely to survive. The question has become how that relationship is best managed. The Conservatives favor marketlike tools: contracts awarded to competing providers. Labour, to whom the notion of a market in health care remains abhorrent, favors performance agreements: that is, purchasers planning the delivery of care by specifying what is expected from providers. The two approaches may not be as radically different as party rhetoric would suggest. Effective contracting is increasingly perceived to depend on building up a permanent relationship of trust between purchasers and providers, rather than engaging in promiscuous one-night stands in the marketplace. Labour's approach may therefore be much nearer to evolving practice than the party's reflexive opposition to marketlike transactions in health care would suggest. Similarly, any institutional framework for health care must take into account the fact that the 1991 reforms have blurred traditional concepts of the dividing line between public and private organizational forms: so, for example, NHS Trusts remain firmly in the public domain—and, as such, accountable to the secretary of state for health—but in many respects are expected to behave as though they were in the private domain. The consequent tensions may well prompt organizational innovation. For example, doctors could decide to form cooperatives, leasing NHS facilities and contracting directly with purchasers. A Labour government might find it difficult to resist such an experiment with worker cooperatives, whereas a Conservative government would probably be more sympathetic to inviting bids from rival management teams competing to see who can run Trusts most efficiently.

The scope for maneuvering of any future government will be further limited by another consideration: the balance to be struck between stability and adaptability. To quote Mancur Olson,

In an economist's ideal society, things would constantly be in flux, because of the need to re-allocate resources to achieve optimal conditions in regard to ever-fluctuating popular demands. In a sociologist's ideal society, by contrast, alienation can be minimized and a sense of community achieved only by minimizing social change. The economist's ideal of a constant flux is a nightmare to the sociologist; the sociologist's vision of a stable community implies the negation of economic change. Between these two extreme theoretical ideals, the real world reflects an equilibrium, balancing continuing change and the maintenance of social solidarity. (cited in Rose and Davies 1994, 239)

For economists, read the advocates of the garage model of health care; for sociologists, read the advocates of the church model of health care. If the 1980s saw the apotheosis of the economist's view, the 1990s seem likely to mark a swing back to the sociologist's view, whatever the party in power; in the 1990s all parties have become dedicated to maintaining or recreating "a sense of community." The uncertainties and upheavals created by the reforms of the NHS—like the uncertainties and disturbances created in society as a whole by rapid social and economic change—have generated, in turn, a demand for stability and predictability. The search for a new equilibrium therefore constrains the ability of *any* government to adopt radical policies of change. If the new enthusiasm for social solidarity suggests that there will be no move toward dismantling the NHS as a universal health care system, it also indicates that the option of reversing the 1991 reforms wholesale is not a realistic one. Radical change, in whichever direction, would be seen as disruptive. As always, the past limits future options. The exhausting convulsions precipitated by *Working for Patients* have dampened the appetite for further change just as surely as the political and administrative labors involved in setting up the NHS inhibited a whole generation of policy makers from questioning its design. And to the extent that the 1991 reforms have now become part of history, so have they, just like the act of creation in 1948, extended the stock of ideas in good currency drawn upon by policy makers. If 1948 enshrined the notion of universalism, 1991 marked the acceptance of pluralism in health care. If there is no

consensus as yet about how best to design a universalistic framework that accommodates pluralism, and has the flexibility to adapt to an uncertain future, at least there seems to be emerging agreement that this should be the aim of policy. The NHS is therefore likely to remain a self-inventing institution, responding incrementally both to the evolving and unpredictable pattern of health care delivery and to the ideological biases of whichever party happens to be in power.

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