

Population-Centered and Patient-Focused Purchasing: The U.K. Experience

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THE REFORMS TO THE UNITED KINGDOM NATIONAL Health Service (NHS) initiated by the Thatcher government in 1989 have attracted interest around the world. These reforms seek to introduce market principles into a centrally planned and publicly financed health service. To use the conceptual framework proposed by the Organisation for Economic Co-operation and Development (OECD), they have transformed an integrated system, in which health authorities both held the budget for health care and managed services directly, into a contract system based on the separation of purchaser and provider functions (OECD 1992). This is consistent with reforms in other countries that are moving in a similar direction (Ham, Robinson, and Benzeval 1990; Saltman and von Otter 1992). As figure 1 illustrates, there are two types of purchaser in the new NHS: health authorities and general practitioner fundholders. Similarly, there are two types of provider: NHS trusts and general practitioners.

A private health care sector exists as a supplement to the NHS and is of growing importance in certain sectors of care. Private expenditure on health care comprises some 15 percent of total health expenditure in the United Kingdom. The contribution of the private sector is particularly significant in relation to nonurgent hospital care. Estimates suggest

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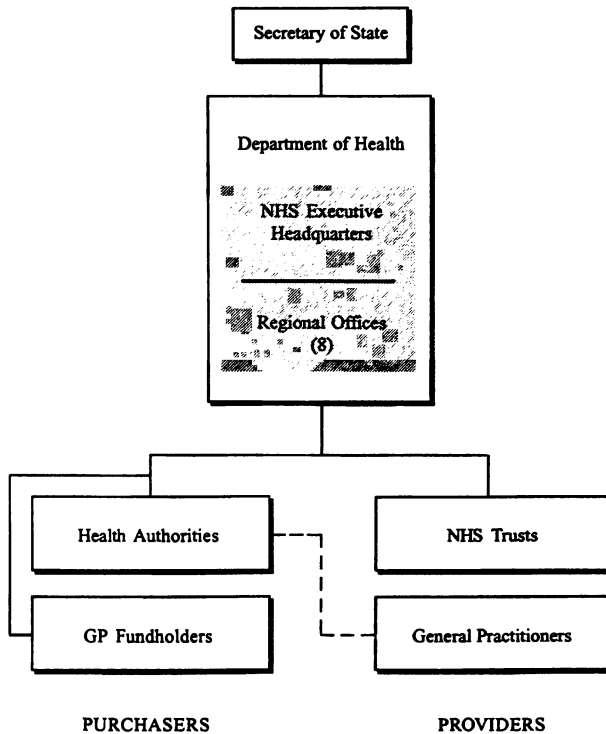


FIG. 1. The organization of the NHS in England.

some 16 percent of common surgical procedures are performed in the private sector, with an even higher proportion being carried out in London and the South East (Nicholl, Beeby, and Williams 1989). The costs of care delivered in this way are met mainly by private medical insurance, which covers around 12 percent of the population and is provided principally as an employment benefit to white-collar workers and their families.

Like the NHS, the private sector is divided into purchasers and providers. There has been increasing competition among private purchasers as new health insurers have entered the market. Private hospitals have also felt the force of competition as capacity has expanded and as NHS trusts have sought to increase their share of the market for private patients. While private patients have always been treated in designated private beds in NHS hospitals, one of the effects of the Thatcher government's reforms has been to blur still further the distinction between the public and private sectors. Thus, just as NHS trusts have attempted to attract additional private patients, so private hospitals have sought to

win contracts from NHS purchasers to provide care to NHS patients. Although the effect of these developments has so far been marginal, in the longer term they could extend still further the mixed economy of health care provision in the United Kingdom, a point I will return to below.

Privatization or Modernization?

Critics of the Thatcher and Major governments have maintained consistently that these changes are leading to the commercialization of health care and will eventually result in the privatization of service provision (Labour Party 1995). In assessing this claim, it is important to remember that the reforms introduced in 1989 have not changed the way in which health care is financed in the United Kingdom. The NHS continues to be funded primarily out of resources raised through the tax system, and there are limited incentives (in terms of tax relief) for people to take out private medical insurance. Furthermore, the government has increased the NHS budget annually to ease the process of implementing the reforms. The purpose of the reforms is less to control NHS spending, which governments have always been able to do, than to ensure that the resources available are used efficiently and that services provided are responsive to patients and service users.

It is this objective that explains the interest on the part of policy makers in introducing market principles into the NHS. Having examined alternative sources of finance for health care and decided to leave the single-payer tax system in place, the Thatcher government turned its attention to reforming the delivery of health care. Inspired partly by the ideas of Alain Enthoven (1985), an influence acknowledged by the secretary of state for health at the time of the Thatcher review (Kenneth Clarke, quoted in Roberts 1990), and partly by similar reforms to other parts of the public sector like education, the government came to the conclusion that an NHS based on centralized planning and without the stimulus of the market was inherently inefficient. Additionally, the system of allocating resources within the NHS created a number of perverse incentives. Foremost among these was the so-called efficiency trap, in which public hospitals funded through prospective global budgets were in effect penalized for treating additional patients because

their income remained fixed while their expenditure rose as a result of the extra services these patients consumed.

In the light of this analysis, it was not surprising that the government's proposals centered on the development of a system in which money would follow the patient. This was intended to overcome the efficiency trap and to reward providers who delivered well-managed care that was responsive to the demands of patients and those who purchased care on their behalf. In order to create a market, the functions of health authorities were separated. Those providing hospital and community health services were reconstituted as self-governing NHS trusts, enabling health authorities to concentrate on purchasing services for the populations they served. In this way, health authorities were free to negotiate contracts with the hospitals of their choice and not simply those they managed directly. Equally, of course, NHS trusts were able to increase their income by winning contracts from a range of health authorities.

Alongside these plans, proposals were formulated to give budgets to groups of general practitioners. These general practitioners, who became known as *fundholders*, received a sum of money with which to buy a defined range of services for their patients. Like other general practitioners, fundholders were also responsible for providing primary care to their patients, which in effect made them both purchasers and providers. Initially, fundholding was confined to larger groups of general practitioners and to practices with the necessary management and professional capacity. The scope of fundholding was also limited to the cost of drugs prescribed by general practitioners, the staff they employed, and the purchase of a number of hospital services such as outpatient care, diagnostic tests, and nonurgent surgical procedures. To avoid the risks of high-cost patients, fundholders were responsible for reimbursing the cost of care up to a limit of £5,000 a year per patient; health authorities picked up expenditures over this limit.

Whether these reforms to the NHS, involving the continuation of tax funding and the introduction of competition into the delivery of health care, justify the claim that health care is being privatized remains a matter of dispute. Government ministers have argued that they are committed to the preservation of a health service that is available to all and that provides services on the basis of need and not ability to pay. This was stated clearly in the white paper, *Working for Patients*, which launched the reforms. In her foreword to the white paper, Margaret

Thatcher noted, "The National Health Service will continue to be available to all, regardless of income, and to be financed mainly out of taxation" (Secretary of State for Health et al. 1989). In essence, the government has argued that the reforms are intended to modernize the structure of the NHS and are not a retreat from the principles on which it was established in 1948.

For their part, the government's critics point not only to the impact of competition on the NHS, but also to the effect of policies pursued throughout the 1980s to make the NHS more businesslike. These policies encompassed putting NHS services like catering, cleaning, and laundry out to competitive bids; introducing general management into the NHS and giving hospital doctors budgets with which to manage their services; and encouraging health authorities to generate additional income through the introduction of car-parking charges, retail developments, and similar schemes at NHS hospitals. More recently, the government's private finance initiative has required NHS trusts to seek funds from the private sector for major building projects before they will be considered for public funding. Taken together, it is argued that these changes are fundamentally altering the ethos and values of the NHS, transforming it from a public service into an organization that has many of the features of the private sector (Mohan 1995).

Insofar as there is agreement on the effects of recent changes, it is that the NHS has been progressively redefined. This was acknowledged by Virginia Bottomley, secretary of state for health between 1992 and 1995, in a newspaper article, in which she argued:

We start by recognising that we have, in effect, redefined what we mean by the National Health Service. The service should not be defined by who provides it, but by the fundamental principle which underpin their work: to provide care on the basis of clinical need and regardless of ability to pay The precise nature of the services provided should increasingly become a matter for local decision In the NHS of the future we can expect to see much greater diversity of provision. (Bottomley 1994)

Put another way, the NHS has gradually shifted from being the more or less monolithic funder and provider of health care into becoming a national health insurer guaranteeing access to necessary medical care for the population. Who provides this care is seen by the government as of secondary importance; the logical (though not inevitable) outcome of

current developments is that service provision will become the responsibility of a variety of public and private organizations. In this sense, the NHS is moving in the direction of other health care systems, in which public finance is combined with alternative forms of service delivery: some public, some private, some for-profit, some not-for-profit. The key question is how fast this will occur and what will happen to the ownership and management of NHS trusts in the process.

In making this point it is relevant to note, *en passant*, that primary care has always been organized in this way within the NHS. General practitioners are independent contractors (in effect, private practitioners) who deliver care to NHS patients under the terms of contracts negotiated nationally between the government and the medical profession. This reflects the desire of general practitioners to preserve their autonomy and to resist salaried employment by the state. Patients do not pay to see a general practitioner, and general practitioners are not allowed to make charges for the provision of NHS services. It could be argued that the changes taking place in other parts of the NHS are simply moving these services in the direction of primary care and that there is no reason to believe this in itself will undermine the principles on which the NHS is based.

Changing Relationships in the NHS

Leaving on one side the intensity of the political debate surrounding the reforms and their ultimate outcome, the fascination for the health policy analyst is the impact of the separation of purchaser and provider roles on the power of different groups within the NHS. Whereas in the past those running hospital and specialist services exerted considerable influence and won the lion's share of resources to develop their services, in the new NHS this has begun to change. Doctors and managers in NHS trusts have been held more accountable for the use of resources by a combination of health authorities and general practitioner fundholders. General practitioners who are not fundholders work closely with health authorities in many places to set priorities for the use of budgets and in this way have increased their leverage within the NHS. While it would be wrong to exaggerate either the extent or the pace of these changes, they have nevertheless had a discernible effect on the delivery of health care to patients. Of particular interest in this respect are the relative

merits of health authorities and general practitioner fundholders as purchasers. There is a key distinction here between population-centered purchasing and patient-focused purchasing. A more detailed discussion follows.

Population-Centered Purchasing

Health authorities are responsible for purchasing health care for all citizens who reside within their boundaries. There are around 100 health authorities in England, and on average each authority serves a population of 500,000, although there are considerable variations around this average. Health authorities are not elected by the people they serve but are appointed bodies nominated to act as agents of the secretary of state for health in purchasing services for their populations. They are governed by a board comprising a chairman, five nonexecutive members, and a group of executives led by the chief executive. The accountability of health authorities is first and foremost to the secretary of state for health, although they are expected to consult local people and take account of their views in deciding which services to purchase.

Health authorities are allocated a budget by the Department of Health on the basis of a weighted capitation formula. This is meant to reflect the need for health care of the population served. With this budget, authorities are responsible for buying all services except those that are covered by general practitioner fundholders in their area. A critical task for health authorities is to improve the health of the population. They are expected to do this partly by purchasing health services and partly by assessing the health needs of populations and taking action to reduce major causes of morbidity and mortality. This work is led by directors of public health, who are required to produce an annual report on the population's health. Furthermore, in 1992 the government published a national health strategy for England, *The Health of the Nation* (Secretary of State for Health 1992), setting out targets for improving the nation's health. Health authorities are responsible for translating these national objectives into local policies and for working with other agencies to address the conditions that give rise to ill health.

Health authorities are also responsible for primary care services. In the past, there have been separate authorities in England and Wales for the management of hospital and community health services on the one hand and primary care services on the other, the latter being known as

family health services authorities. The NHS reforms underlined the need to integrate these responsibilities; the two types of health authority will formally merge in April, 1996. In preparation for this event, however, considerable progress was made in bringing the two sets of functions together (Ham and Shapiro 1995b). This was supported by the policy, enunciated in 1994, of developing a primary-care-led NHS (NHS Executive 1994b). As with the priority given to public health, this policy was intended in part to restore the balance within the NHS and to counteract the emphasis traditionally attached to hospital and specialist services.

A further move in this direction came with the establishment of the NHS research and development program. This included a series of initiatives concerned with health technology assessment and the promotion of evidence-based medicine. These initiatives encompassed the establishment of the U.K. Cochrane Centre at Oxford, the NHS Centre for Reviews and Dissemination at York, and the provision of information to health authorities to enable them to concentrate resources on services of proven clinical effectiveness. The aim of this policy is to create a culture in which clinicians in NHS trusts draw on evidence in deciding which services to provide and purchasers are given the ammunition to challenge providers and achieve the most health benefit with the budgets available.

The priority attached to public health, primary care, and evidence-based medicine promised to alter fundamentally the orientation and approach of health authorities. In fact, change was slow to occur in many places, chiefly because the staff in charge of the health authorities had developed their careers in the old NHS, where the main preoccupation was management of health care institutions. With a few exceptions, it took time to break away from this tradition and to focus on the population and its health needs. The transition from a provider-oriented health service to one centered on purchasing was not helped by the time-consuming nature of the contracting arrangements introduced under the NHS reforms. The establishment of an annual contracting cycle between purchasers and providers meant that health authorities spent considerable amounts of time in negotiating and monitoring contracts for the provision of health care, which preempted their resources for addressing the public health agenda.

Surveys of health authorities and their purchasing plans demonstrated, perhaps not surprisingly, that change was incremental rather

than radical. This was illustrated by work carried out at the University of Bath. In a series of surveys, Rudolf Klein and his colleagues traced the development of purchasing plans and priorities in a selection of health authorities in England (Klein and Redmayne 1992; Redmayne, Klein, and Day 1993; Redmayne 1995). They found that health authorities tended to spread their money around among services, and that authorities were reluctant to challenge established patterns of expenditure. Initially, acute hospital services received high priority, but gradually the emphasis shifted to primary and community care and public health, in line with developments in national policy. Even so, the shift in priorities was not dramatic. This conclusion was reinforced by a study of priority setting in six health authorities, which found that purchasing decisions were strongly influenced by historical commitments and that attempts to set priorities on a more systematic basis were at an embryonic stage (Ham, Honigsbaum, and Thompson 1994).

Yet if survey evidence that health authorities were making a difference as purchasers was lacking, reports by those leading the work of those authorities offered a different interpretation (James 1994). These reports suggested that, freed from the responsibility of managing health services, health authorities were beginning to question traditional patterns of expenditure and to behave in new ways. This was best illustrated by the effort many health authorities expended on consulting with general practitioners and on heeding their views when they made decisions. In fact, this trend was noted in the surveys of health authorities' purchasing plans (Klein and Redmayne 1992), as well as in other reports (Carruthers et al. 1995). A major effort was also made to involve the public in the work of health authorities (NHS Management Executive 1992). While their impact on resource allocation may have been limited, it was possible to detect in these developments a change in behavior and a refocusing on previously overlooked aspects of health and health care.

In recognition of the need to develop the role of health authorities more rapidly, the government committed resources to a development program to support purchasing during 1993. The aim was to help health authorities to acquire the skills and expertise needed in their new role. The minister of health explained the importance of the program in three high-profile speeches on the subject, and in this was supported by the NHS chief executive (Mawhinney and Nichol 1993). The government's initiative in this area reflected a recognition that, in a health

service traditionally commanded by providers, health authorities needed extra support to assume their responsibilities as purchasers.

Patient-Focused Purchasing

General practitioner fundholding also developed slowly at first and in the face of strongly held opposition from many doctors, who were concerned that trust between patients and general practitioners would be undermined by the introduction of the financial incentives contained within fundholding. To ameliorate the adverse effects of these incentives, general practitioners were not intended to benefit personally from any savings made in their budgets. Another safeguard was that budgets were set for fundholders on the basis of the use patients made of the services included in the fundholding scheme rather than by reference to a capitation formula. This was designed to ensure that general practitioners had sufficient resources in their budgets to meet the demands of patients on their lists and would not engage in risk selection. However, the government did commit itself to move toward capitation-based budgets for fundholders over a number of years, although no deadline was set for achieving this.

Fundholders typically purchase care for groups of from 10- to 12,000 patients and the average fundholding practice has a budget of around £1.7 million. Established as a voluntary scheme, fundholding covered 7 percent of the population in the first year in England, increasing to 41 percent in 1995. Coverage varied significantly, however, from place to place, with some districts involving 84 percent of general practitioners in fundholding and others, only 4 percent. To assist with the costs of maintaining a budget, general practitioners were given additional funds to prepare for fundholding. They also received an annual management allowance. This enabled fundholding practices to employ staff to help in the management of the budget and to acquire computers and support systems.

Research into the impact of fundholding in the early phases appeared to suggest that there was little difference between fundholding and non-fundholding general practitioners in the way in which they provided care. For example, Coulter and Bradlow (1993) found no difference in referral behavior in a study of fundholding and non-fundholding practices in the Oxford region. Yet, gradually, a mixture of evidence

drawn from evaluative research and reports from fundholding practices suggested that the scheme was having an effect on the delivery of services. This was apparent in changes in prescribing policies (Bradlow and Coulter 1993; Maxwell et al. 1993), which resulted in savings in drug budgets. In many cases these savings were used to provide additional services to patients. Attitude surveys also suggested that general practitioners involved in fundholding were enthusiastic and that the scheme had changed relationships within the NHS (Newton et al. 1993). In particular, hospital specialists were more responsive to the needs of general practitioners, which was reflected in improved discharge summaries and better communication between general practitioners and specialists.

These positive findings were supported by work carried out in Scotland, which also looked at the impact of fundholding on the quality of care (Howie, Heaney, and Maxwell 1995a). This research found that the clinical care of patients had generally remained stable during the period in which fundholding was implemented. However, the proportion of patients with self-diagnosed joint pain who were investigated or referred to a hospital fell significantly (Howie, Heaney, and Maxwell 1994). The Scottish research also found that patients with some conditions appeared to have benefited at the expense of patients with other conditions (Howie, Heaney, and Maxwell 1995b). Nevertheless, patients reported that they were generally satisfied with the quality of the services they received from fundholders, and remained so as fundholding was implemented. The main concern arising from this and other studies was the workload that fundholding entailed for general practitioners and the additional burden it imposed on busy professionals.

The most powerful support for fundholding came from Glennerster and his colleagues, who, in a series of widely cited publications, argued that fundholders had proved more effective purchasers than health authorities (Glennerster, Matsaganis, and Owens 1992, 1994). In support of their thesis, they maintained that fundholders had achieved greater success in reducing the time patients had to wait for hospital outpatient appointments or to have an operation, had increased the efficiency of diagnostic services delivery, and had encouraged the hospital staff to be more responsive. In addition, they held that the incentives of fundholding had reduced the cost of prescribing and that the scheme had encouraged general practitioners to offer a wider range of services in their own practices. Equally important, their research produced little evi-

dence that the potential adverse effects of fundholding, such as risk selection, had materialized.

It was partly on the basis of these findings that the government announced a major development of fundholding in 1994 (NHS Executive 1994b). This involved the expansion of the original scheme to include a longer list of services together with two new options: total purchasing, in which groups of practices would be allowed to purchase all services for their patients; and community fundholding, in which general practitioners would receive a budget to cover only the costs of drugs, practice staff, and community health services. And, while fundholding remained a voluntary scheme for general practitioners, pressure was exerted on health authorities to persuade more practices to participate (Ham and Shapiro 1995a). In espousing this policy, ministers emphasized that health authorities would have a continuing role as fundholding expanded, although this would shift from the direct purchasing of care for patients to a more strategic and enabling function.

Notwithstanding the enthusiasm of the government for fundholding, independent analysts were divided in their assessments (Coulter 1995). It was argued, for instance, that there had been no rigorous comparisons between fundholding and non-fundholding practices. This made it difficult to assess whether the achievements of fundholders were due solely to maintaining a budget or were the result of other changes introduced by the reforms. While systematic research into the impact of health authority purchasing was also lacking, a number of reports suggested that many of the changes brought about by fundholders had been achieved by health authorities working with general practitioners (Black, Birchall, and Trimble 1994; Graffy and Williams 1994). Furthermore, there was evidence to suggest that one of the most widely quoted changes brought about by fundholding, the reduction in prescribing costs, may have been caused partly by general practitioners using the budget-setting process to increase the resources available for this element of their spending, thereby making it easier to produce savings (Dowell, Snodden, and Dunbar 1995).

Analysis was further complicated by the emergence of a range of hybrid approaches combining features of both population-centered and patient-focused purchasing (Ham and Willis 1994). These approaches were established as some health authorities recognized the need to work with general practitioners and some fundholders acknowledged that health authorities could add value to their purchasing. The models

pursued included locality-based purchasing, the formation by general practitioners of commissioning groups to advise health authorities, and the establishment of networks of fundholding practices that became known as *multifunds* (Shapiro 1994). Consequently, the two approaches outlined in *Working for Patients* multiplied into a range of alternatives. Yet cooperation between health authorities and general practitioners in some parts of the NHS was paralleled by lukewarm relationships elsewhere as the different types of purchaser preferred to pursue a policy of competition rather than collaboration. The introduction by the government of an accountability framework for fundholders in 1995 (NHS Executive 1995) was an attempt to ensure that there were effective links between fundholders and health authorities, but, as much depended on the quality of relationships at the local level, the strength of these links varied widely across the NHS.

Analysis

Five years into the implementation of the reforms, the achievements of health authorities and fundholders continue to be debated. The strengths of the health authority approach include an ability to plan for whole communities and to assess the needs of these communities. Health authorities are also well placed to bring together expertise in different fields, like public health, finance, and general management, in deciding which services to purchase. This has assisted in the development of alliances with other agencies and in accessing information and intelligence to support decision making. A further advantage of health authorities is their ability to lead major changes in service configuration, especially in urban areas.

The strengths of fundholding include direct contact with patients on a day-to-day basis, which leads to an ability to respond quickly to patients' demands. Fundholders have also demonstrated, somewhat paradoxically, that they are able to negotiate favorable terms with providers, even though they control a much smaller proportion of the budget than health authorities. In part this is because fundholders are smaller and more flexible than health authorities and can move rapidly to achieve improvements in the delivery of the services they purchase. It may also be attributable to the fact that the general practitioners involved in fundholding practices are among the best-organized primary care phy-

sicians in the country. The rules on fundholding restricted entry to larger practices with the necessary management and professional expertise to maintain a budget, a "selection effect" that should be borne in mind when evaluating the impact of the scheme.

In relation to fundholding, Dixon and Glennerster offer the following comment:

The financial incentives of fundholding seem to be curbing the upward trend in prescribing costs, but the effect on rates of referral to hospital is unclear. Fundholders are challenging the traditional interface of primary and secondary care and offering more services inhouse. Significant improvements in access to and the process of care have been secured by some fundholders. Giving budgets to general practitioners has been associated with a noticeable change in their relationship with hospital consultants.

Set against these important gains, some drawbacks are evident. The costs to the NHS of contracting with many fundholding practices are unknown but estimated to be high. While fundholders report greater access to care, there is a weight of anecdotal (though not yet hard) evidence that a two tier service is operating. Research suggests that fundholders have been funded more generously than non-fundholding practices. (Dixon and Glennerster 1995, 729)

As this comment indicates, the balance sheet on fundholding is evenly weighted.

In arguing that health authorities and fundholders have distinctive strengths, it is important not to overlook the drawbacks of introducing two models of purchasing and the hybrids they have spawned. Foremost among these is the risk of fragmentation in service delivery (Light 1994). Put simply, there is no guarantee that the sum of multiple purchasing decisions will add up to a pattern of service provision appropriate to the needs of the population concerned. This is linked to the impact of expanding the fundholding scheme on the ability of health authorities to plan strategically for the population's health needs. With an increase in the proportion of the NHS budget under the direct control of general practitioners, it is not easy to see how health authorities can exert influence to improve the population's health. At a time when policy is targeting improvements in the population's health through the national health strategy, it appears that the left hand of government is not always aware of what the right hand is doing.

A further concern, acknowledged even by the advocates of fundholding (Glennister, Matsaganis, and Owens 1994), is that the government's desire to move away from workload-based budgets for general practitioners to capitation funding may create an incentive for general practitioners to discriminate against patients who are older and sicker. No doubt for this reason, capitation-based budgets for fundholders have been established only slowly. And, as research has demonstrated, there are a number of technical challenges in applying a capitation formula at the practice level (Sheldon et al. 1994). This has given rise to the claim that the achievements of fundholders are not the result of their being better purchasers but are a consequence of more generous funding. On this point the evidence is mixed, with some studies suggesting that fundholders have received more than their fair share of resources (Dixon et al. 1994), and others disputing this claim.

The method of setting budgets for fundholders has led to wide variations in the amount of resources available to different practices (Glennister, Matsaganis, and Owens 1992; Audit Commission 1995). It has also resulted in most fundholders making savings in their budgets. The level of these savings and the uses to which they are put have received increasing attention (National Audit Office 1994; Public Accounts Committee 1995; Audit Commission 1995). While average savings comprised only 3.5 percent of budgets in 1993 and 1994, 20 percent of fundholders underspent by £100,000 or more. Studies into how these savings are deployed raised questions about the use of public resources and also cast doubts on the policy that general practitioners should not benefit personally from fundholding. In particular, the use of savings to improve the buildings from which general practitioners practice—the most common use of savings (Audit Commission 1995)—and thereby to increase their value opened up the clear possibility of financial gain, given that general practitioners as independent contractors usually own their own clinics and receive additional money when they sell their equity.

Yet another issue raised by fundholding is the transactions costs involved in a system whose budgets are controlled by a large number of small purchasers. These costs arise partly from the management allowances paid to fundholders and partly from the workload involved for NHS trusts in negotiating contracts with fundholders. Although the latter is difficult to quantify, it is undoubtedly one of the factors behind

the increase in the share of the NHS budget allocated to administration as a consequence of the NHS reforms. In a series of answers to parliamentary questions, health ministers provided information showing that the amount of money spent on managers and administration rose from £1.2 billion in 1989–90 to £2.1 billion in 1993–94 (Brindle 1995). While some of this increase resulted from a reclassification of nurses and other professional staff as managers, the introduction of an annual contracting system between purchasers and providers was also a factor. Fundholding played a part, although it is difficult to estimate the proportion of the overall increase in management costs that can be attributed to patient-focused purchasing.

As this analysis indicates, there is little consensus in the U.K. health policy community on the respective merits of health authority purchasing and general practitioner fundholding. Each has strengths and weaknesses, and as time went on the most interesting question became not whether one approach was superior to the other, but how the best elements of each could be combined. As one director of public health put it, the challenge was to join the “leverage” of health authorities and the “bite” of fundholders (Steve Watkins, cited in Shapiro 1994). The hybrid approaches that were established reflected recognition of this among doctors and managers, and illustrated how the details of policy implementation were driven from the bottom up, not the top down.

The Future

Evidence that management costs had increased led the government to take action to streamline the structure of the NHS. This included a reduction in the number of civil servants in the Department of Health, cuts in the number of regional health authorities and the staff they employed, the merger of district health authorities and family health services authorities, and controls over management costs in health authorities and NHS trusts. Despite these measures, the increase in management costs was one of the factors that prompted a reappraisal of the impact of the reforms as a whole. This process was not helped by the lack of good data enabling comparisons to be made of the performance of the NHS before and after *Working for Patients*. Evaluation was further hampered by changes to the way in which information was collected within the NHS (Radical Statistics Health Group 1992, 1995). With

independent analysts arguing that more time was needed to make a proper assessment and that the jury was still out (Robinson and Le Grand 1994), it was not easy to reach agreement on whether a market-oriented system based on a separation of purchaser and provider roles had brought more benefits than costs (Klein 1995). The assessment produced by the OECD (1994) may have reached positive conclusions, but these were immediately criticized for painting too rosy a picture and being based on inadequate evidence (Bloor and Maynard 1994).

What does emerge from experience is that the reforms contain within their design a number of self-correcting mechanisms. Unlike previous reorganizations, which were planned in great detail with little apparently left to chance, the changes that stem from *Working for Patients* are an example of an emergent strategy (Ham 1994). This is because the White Paper that launched the reforms set the broad framework for change but left out much of the detail. The sketchy nature of *Working for Patients* reflected the tight timetable set by Margaret Thatcher for carrying out the review and the fact that the resulting proposals had only been partially thought through. It follows that policy has been made as it has been implemented, leaving much of the responsibility with local staff in the NHS.

Political ideology has in this way been mediated by managerial pragmatism and an assessment of what was likely to be acceptable to the health care professions. As an example, the workload involved in annual contracting led purchasers and providers to move toward longer-term service agreements, a move that received the support of health ministers. In parallel, the more radical aspirations of promarket reformers were modified by the realization that the competitive scope was limited in many parts of the NHS by the existence of monopoly, or near-monopoly, providers. Even where purchasers had a choice of providers, they often chose to work in collaboration with those hospital and community health service organizations that were particularly significant in their areas. This led to the development of partnership and preferred provider relationships, a move justified in part by experience outside the health sector indicating that many of the most successful companies worked in this way with their suppliers.

A further example of the adjustments made to reforms in the course of implementation concerned market regulation. The potential dangers of competition developing in an unregulated fashion quickly became clear, leading to the development of a number of rules for dealing with

the consequences of competition. Many of these rules were brought together under the guidance of the Department of Health and were presented as a codification of existing practices and case law rather than the development of new procedures (NHS Executive 1994a). This guidance covered issues like provider mergers, purchaser mergers, arrangements for handling providers in difficulty, and collusions. In parallel, the role of regional health authorities and their successors, regional offices of the NHS Executive, came to include market regulation.

One area in which the reforms did not succeed was in enabling money to follow the patients. This was because most hospitals derived the bulk of their income from block contracts, which offered little advantage over the global budgets they replaced. These contracts were largely insensitive to changes in the number of patients treated, and they failed to provide the incentives that Margaret Thatcher and her advisors had desired. Given the importance of this goal in stimulating the reforms in the first place, the failure of money to follow the patient was a disappointment, not only to the government, but also to NHS trusts, which continued to carry most of the risks of variations in patient workload.

The effect of these developments was to modify, in some cases significantly, the aspirations of the architects of the reforms. This was reinforced by changes among the politicians responsible for steering through their implementation. The replacement of Margaret Thatcher by John Major, and the appointment as secretary of state for health of a succession of politicians who were more consensual in their approach and less convinced of the merits of competition than Kenneth Clarke, the secretary of state at the time *Working for Patients* was published, undoubtedly contributed to this process. By 1995, the impact of these changes was that the main structural elements set out in *Working for Patients* had been implemented, but the way in which they were used departed from the original plan in a number of important respects. In particular, the merits of markets and competition were deemphasized, and the priority shifted to cooperation between purchaser and providers in order to achieve greater responsiveness to patients and provide value for their money.

It was therefore not surprising that when the Labour Party published its policy on the health service in 1995 (Labour Party 1995), it exhibited a willingness to adopt a discriminating response to the reforms and to adapt key elements to suit Labour's own purposes. For example, the value of maintaining a distinction between purchaser and provider roles was accepted. On the other hand, Labour expressed its opposition to

general practitioner fundholding, and argued instead for a model of general practice commissioning whereby general practitioners collaborated with health authorities in making purchasing decisions. Labour also committed itself to ending competition within the NHS. However, given that Conservative politicians were themselves emphasizing the need for partnership within the NHS (Bottomley 1995), the differences between the two main political parties on this issue were not as great as they appeared. Indeed, what was striking was the degree of common ground between Labour and the Conservatives, particularly in relation to priorities for health policy. This included cross-party support for a national health strategy, a primary-care-led NHS, evidence-based medicine, and a health service in which the needs of patients received greater attention. To be sure, there remained differences of emphasis and style, as well as lively debates within each party on the direction of reform, but on most of the critical policy questions these were far less important than the areas of agreement.

This suggests that after a decade or more of often acrimonious disagreement on the future of the NHS, there is the prospect of a new consensus. This will not involve a return to the prereformed NHS, nor will it entail a market-driven system. Rather, the NHS will continue to evolve along the path of change that has been set, and there are unlikely to be any further changes in the structure of the service beyond those already announced. The emphasis will be placed instead on collaboration between purchasers and providers (or whatever terminology is used to describe these roles) and the use of competition at the margins, if at all. In relation to purchasing, the most recent indications from the government following the appointment of a new secretary of state in July 1995 are that fundholding is not seen as the only model of purchasing for the future and that health authorities will continue to be closely involved in this activity. Given that a future Labour government would not immediately abolish fundholding, for fear of incurring the wrath of those general practitioners who are enthusiastic supporters of the scheme, but rather would seek to encourage general practitioners to influence purchasing in other ways, here again is an aspect of the health service where the differences of approach appear to be narrowing. To that extent, both population-centered and patient-focused purchasing have a future, although precisely what shape this will take is uncertain.

What this also indicates is that, following a period of activism in U.K. health policy, the prospects now are for consolidation and assimilation, not further major reforms. Having attracted interest from many

countries for being a laboratory of reform, the NHS seems set for quieter times. This judgment is, of course, relative, because change in health care is permanent and is only partly the result of action by politicians. Nevertheless, the stance adopted by the Conservative and Labour parties indicates that the "big bang" produced by *Working for Patients* is becoming an increasingly faint echo (Klein 1995).

Conclusion

After the shockwaves of recent changes, the NHS defies description in the terms traditionally used to classify health systems. Although it remains a national system in name, and in some ways is run in a more centralized manner than ever before, it is also the case that power has been devolved to a local level through both general practitioner fund-holding and the establishment of self-governing NHS trusts. Similarly, although the NHS is mainly a public system, both in terms of financing and delivery, there is an increased blurring of the distinction between the public and private sectors as the mixed economy of health care continues to evolve. And, although a market has developed among providers in some parts of the NHS, competition is used alongside regulation in what is best described as a politically managed health care market. Consistent with trends in health care reforms elsewhere in Europe, the United Kingdom has moved in a similar direction to the Netherlands and Sweden (Ham and Brommels 1994; Saltman 1994), as well as New Zealand (Salmond, Mooney, and Laugesen 1994). In the process, the aim of using competition to increase efficiency and responsiveness has met with some success (Robinson and Le Grand 1994), but it is difficult to determine whether this should be attributed to the reforms per se or to other factors.

What is not in doubt is that the shift from an integrated system to one based on contracts has unsettled established relationships and resulted in an increased capacity to tackle problems in service delivery. Against this gain, transactions costs have increased, and although action has been taken to tackle this trend, there remain concerns about the proportion of the NHS budget spent on administration. The evidence on the respective merits of population-centered and patient-focused purchasing continues to be contested and is confounded by the emergence of a number of hybrid approaches. At the time of writing, both major

political parties in the United Kingdom have expressed a commitment to maintain a separation of purchaser and provider roles, and the differences in their position on the future of the NHS are narrowing. As far as purchasing is concerned, the main lesson from the United Kingdom is that purchasing in a publicly funded health care system needs to combine elements of the population-centered and patient-focused approaches, which in turn must be effectively coordinated if the risk of fragmentation is to be avoided.

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