

Steve Iliffe

The failure of fund-holding in Britain's National Health Service

Introduction

Since the end of the long economic boom health systems in Europe have been exposed to a set of economic, political and ideological pressures that have prompted attempts to reform structures, funding systems and provision of services. To politicians, policy advisors and senior level health care managers ›competition‹ came to represent a way of managing resource constraint in an increasingly complex and demanding political environment (Freeman 1998). Britain's National Health Service is an example of how this policy commitment to increasing competition has been tested and modified. The most important change that has occurred since the election of the New Labour government in 1997 is the abandonment of a retail type of market in health service provision, and of its key mechanism, fund-holding. This paper will describe the failure of the Conservative policy of fund-holding .

Market reform 1991-1997

The objectives of the market reforms of the NHS were clear and unambiguous. Margaret Thatcher made her government's purpose plain: »We aim to extend patient choice, to delegate responsibility to where the services are provided and to secure the best value for money. All the proposals (...) put the needs of patients first.« (Department of Health 1989)

Thatcher's government, and those of her successor John Major, had to deal with a publicly funded health service organised on a ›command and control‹ principles, with a structure as shown below.

STRUCTURE	FUNCTION
Health Minister and Department of Health	Policy making, strategy
NHS Executive	Policy implementation at national level
Regions	Policy implementation at Regional level (14 in England & Wales)
Health authorities	Policy implementation at local level (populations of 500 000 or more)
Hospitals, Community services and general practitioners	Service delivery

In keeping with the Conservative government's desire both to control of the costs of health care and to promote increased choice for ›consumers‹, two distinct and incompatible market structures were created (Iliffe/Munro 2000). These differed by virtue of the characteristics of the purchaser of health care, and have been termed type I and type II markets (Mullen 1989). In both, the providers of care are public sector hospitals and community services, as well as commercial and voluntary sector organisations.

The type I market is based on a ›needs-led‹ model of health care purchasing. In this market, the purchaser is a health authority, acting on behalf of a geographically defined population. In a sense this is a kind of ›managed market‹, a planned economy of health care in which a public agency carefully selects the services that it will buy from hospitals and primary care providers. The basis for purchasing decisions is the utilitarian one of maximising the ›health gain‹ that can be achieved for the population as a whole from a fixed budget. These decisions must also incorporate concern for the stability and continuing function of providers – no organisation serving a defined population should cease functioning suddenly, so the purchaser has an interest in supporting providers and ensuring that change occurs in a planned way. The authority is charged with the responsibility of undertaking ›health needs assessments‹ to determine both the state of health of its population and the services which are required to meet the needs so identified. This process requires evidence on the effectiveness and cost-effectiveness of all possible interventions, so as to maximise the potential health gain that can be achieved. This type of market is very interested in costs, but also sets prices to keep its providers in business, and changes relatively slowly. An everyday example is the supermarket chain that relies on multiple providers, which it helps, supports and cultivates, as long as they produce goods of the right quality for it.

By contrast, the type II market is based on a ›demand-led‹ model. Here, the market exists between providers and those primary care doctors who have chosen to hold their own budget to purchase hospital and community care for their patients – the General Practice fund-holders. The characteristics of the GP purchaser are quite different from those of the health authority. There is no requirement to assess the health needs of a population, nor even necessarily of the list of enrolled patients, but only to respond to individual demand as it presents itself in the consulting room. Nor is there any requirement to assess the likely effectiveness of different possible strategies for prevention and treatment, but only, ultimately, to act as an agent for the individual patient in arranging for

appropriate medical care. This market can change quickly, and GP purchasers can shift contracts from one hospital to another in ways that undermine the capacity of the loser to continue functioning. The everyday example are the independent cafes, restaurants and shops in the High Street which compete with each other in price, quality, range, customer service and atmosphere; all are vulnerable to changing customer perceptions.

The reforms were intended to secure increased efficiency through competition between providers in a market in which, as in any shopping street, prices are published and are visible to all the players in the system so that purchasers – health authorities and fund-holders alike – could ›shop around‹ for the cheapest, quickest or best quality care. Fund-holding was therefore designed to kick-start an internal market in health care, promoting competition between hospitals for general practitioner investment. This conception of a ›primary care led NHS‹ has been a key element in health policy in England, Wales and Scotland since the early 1990s (NHS Executive 1994; National Health Service in Scotland 1997).

Market failure, or sabotaged market?

In reality the NHS internal market had none of the characteristics of a retail market, and stubbornly refused to behave like one (Dawson 1994). It had much more in common with an ›industrial market‹, in which there are few purchasers and providers, the product is complex and infinitely variable and providers carry a high proportion of fixed costs. The result was that packages of specialist care – and their prices – were negotiated privately between purchasers (fund-holders and health authorities) and provider hospitals, and relationships tended to be long term. The lack of fixed and observable prices rendered impossible the health authority's theoretical task of maximising the ›health gain‹ achievable from limited resources.

At the same time as establishing radical new structures intended to encourage competitive behaviour, the NHS Executive drew the lines of regulation and monitoring so tightly that no real competition was allowed to emerge. In rural areas competition was always an unrealistic idea because providers were effectively local monopolies. Yet even in large cities that might have been able to support a competitive provider market, regulation was as tight – or tighter – than anywhere else. The NHSE constantly intervened to impose or refuse mergers between providers, to prevent health authorities from moving their contracts away from under-performing hospitals which might become non-viable as a

result (Le Grand 1994), to regulate capital borrowing by trusts and to disallow cross-subsidies between services within the same provider. Indeed, in some districts with two or more large providers, health authorities came to local agreements with hospitals designating each as the ›lead provider‹ in particular services, effectively neutralising any possibility of competition. The exact reasons for this resistance to the market need further empirical study, but probably include a strong commitment to public sector ethos in the NHS administration and amongst professionals.

The picture of ›managed competition‹ that emerged in the phase of market policy was one in which management heavily outweighed competition. While the Department of Health continued to talk in terms of ›the process of devolution stimulated by the NHS reforms‹, the reality was that political and managerial power in the health service became more centralised (Paton 1992).

The impact of the quasi-market in the NHS was minimal (Glennester 1998), partly because of the retention of central government control and partly because the experiment was based on inadequate understanding of professional and managerial motivations (Le Grand 1999). Market mechanisms function differently in different health care structures. In Britain's system of ›hierarchical corporatism‹ professional and state accommodations temper the pace of change, whilst turbulent transformation is a feature of the US health care system (Tuohy 1999).

For example, competition in the supply of hospital services had only a limited impact on prices of specialist care, with high levels of variability in prices, widespread disregard for pricing rules and only some indications that fund-holders were offered lower prices (Propper/Soderlund 1998). Economic evaluation appeared to play little part in decision-making, partly because of concerns about the validity of economic studies but also because multiple health care objectives were being pursued, increased efficiency being only one (Drummond/Cooke/Walley 1997).

The clinical impact

Was fund-holding a good idea that failed to reveal its benefits because of a failure of political will? Evaluating the policy is problematic because of the multiple and ill-defined objectives of the market reform and the inherent difficulties in evaluating policy impacts in complex organisations like the NHS (Le Grand/Mays/Mulligan 1998). Some evaluations that were carried out suggested that a positive change in primary care had occurred, citing both innovative services provided in a primary care

setting (Glennester et al. 1994), and changes in GPs' attitudes and relationships with health authorities and hospitals (Shapiro 1996).

Others have argued that despite the notable successes of some fund-holders to improve services the overall impact of policy was modest (Miller et al. 1999; Hanlon et al. 1998; Audit Commission 1996; Raftery/Stevens 1998; Mays/Mulligan/Goodwin 2000; Dixon/Holland/Mays 1998). Most studies have reported only limited impacts (Le Grand 1999), with modest differences in communication about hospital discharge, the speed and convenience of treatment for some patients in some practices (Mays/Mulligan/Goodwin 2000), and improvements in inter-professional relationships but no difference in overall levels of patient satisfaction (Corney 1999). Fund-holding appeared to promote greater inequality between practices and reduced the capacity of the NHS to plan strategically (Koperski/Rodnick 1999). Whilst a few general practitioners embraced the concept of fund-holding with enthusiasm at the outset (Houghton 1993), there was widespread concern about the possible adverse effects for practices and patients, including fears that equity of access to services would be undermined and that the administrative structures required would become a considerable extra burden. Fund-holding came to be regarded as problematic (Iliffe/Freudenstein 1994), failing to define or measure the quality of outcomes, damaging to professionals' job satisfaction (Goldacre/Lambert/Parkhouse 1998), inequitable, and fragmenting of both service planning and provision (Maynard 1998).

Fund-holding did achieve some cost savings in prescribing (Bradlow/Coulter 1993; Maxwell et al. 1993; Wilson et al. 1999), but not in referrals to specialist care, and incurred substantial additional administration and transaction costs without demonstrating any improvement in health outcomes, nor any widening of consumer choice (Smith/Wilton 1998). Of course, success in containment of medication costs tells us nothing about either the quality of care, which may decline as medicine costs are cut, nor the long term economic costs of short term savings on prescribing, which may be considerable (Teeling-Smith 1992).

The anatomy of failure

Despite the expansion of fund-holding to cover 40% of the population by 1995, the scheme soon became a policy problem for the Conservative government. First hailed as a success (Glennester/Owens/Matsaganis 1992), it became dogged by limited advantages, high costs and unintended consequences, of which the most politically visible was the

perceived assault on equitable provision of health care. (Evidence for this is assault on equity is anecdotal but widespread, with every area in which fundholding operated having stories of how fundholder GPs helped their patients jump queues for appointments, hospital admissions and operations. This was difficult to prove at the time and remains an area of strong belief and weak evidence). The dichotomy between a patient-centred and community-led identity for primary care organisation was one of the most distinctive features of the fund-holding era, which was intended to influence strategy through a series of marketised, individualistic patient transactions. Put another way, fundholding (as a type II market mechanism) emphasised the importance of the individual patient and her treatment, whilst the old system with its type I market mechanism made the individual's wants or needs fit into a prior plan for health care for the community. In this sense fundholding represents a deontological alternative to the utilitarianism of the National Health Service.

Fund-holding had an impact on service configuration and delivery in four broad ways. It had only small effects on overall strategic resource distribution (macro-level provision) and on local service organisation (meso-level) in most areas, according to most observers (Audit Commission 1996). It made a difference to the care offered to some patients, in terms of access to specialist consultations or to professions allied to medicine (micro-level provision). This supports Glennester's analysis (Glennester 1998) that the main gains were speed of treatment, patient convenience and choice, but not quality of outcome (though speed of access is related to quality of outcome under certain conditions). Throughout the period of the internal market the NHS was managed according to cost and process criteria, not effectiveness of care, and both the Department of Health and the market, such as it is, have failed to define, measure and implement quality outcome policies (Maynard 1998).

While it was accused of undermining the equity of health care at local level, it appears to have had little actual impact on equity because it achieved relatively little change in service provision (at meso-level). A combination of the overall political climate and controversy surrounding fund-holding, its potential influence on trusts' marginal revenues and its inward-looking, micro-level accountability, destabilised health authority planning and commissioning, although the hostile relationship ameliorated over time.

In our study (Craig et al. 2002), the ›meaning‹ of fund-holding was different for fund-holders themselves, non-fund-holders, trusts and health authorities respectively. The first, with some exceptions, generally saw it as a way of getting better (if modestly so) services for their patients,

the rest saw it as a way of reconfiguring local provision. The satisfaction expressed by fund-holders with what they achieved suggests that on the whole they neither intended nor expected to play any role other than that of ›family doctor‹, and had no specific interest in the grander political agenda of reshaping local care or kick-starting the internal market. For fund-holders as a whole, only the micro-level appears to have really mattered. They saw fund-holding as a means to achieving better care for patients.

Hospitals and local community health services, however, appear to have regarded fund-holding as something of a distraction from the main task of providing care, but one which took up considerable amounts of resource. Their denial of favourable treatment for the patients of GP fund-holders may reflect the fact that the number of cases where equity was jeopardised was relatively small. On the other hand, hospital may well have tried to minimise the influence of fund-holding in creating hospitals' tacit collusion in what was generally perceived as inequitable. Nevertheless, the accounts of hospital managers were substantially similar to those of fund-holders themselves, in terms of reporting only minor influences of the latter on activity overall.

In our sampled health authorities, staff were generally hostile to the principles of fund-holding and actively worked against the directives of the Department of Health to promote fund-holding. Operating at the meso-level, they appeared to have readily seen a negative impact of fund-holder micro-level activity, and only occasionally perceived the contributions that some fund-holders could make to service re-configuration.

Conclusions

Thus with hindsight, the fundholding era may be seen to represent a series of poorly planned experiments involving the participation of general practitioners (embodying the micro-level) in the conduct of health care organisation (at the macro- and meso- levels) using a type 1 market model. Historically, the influence of fund-holding as an object of political rhetoric appears to have borne little relation to its true effect in reconfiguring services or in actually creating inequity.

Those to whom power was devolved were neither equipped nor minded to engineer changes in service provision nor take the strategic perspective envisaged by the architects of the policy (Murie et al. 2000; Ennew et al. 1998) The postures adopted by the different stakeholders are better understood in terms of the »competing and frequently

contradictory interests the current structure of the NHS engenders« (O’Cathain; Musson; Munro 1999). Health service policy between 1991 and 1997 involved contradictory aims and means (Iliffe/Munro 2000), and New Labour has attempted to correct this by abolishing fund-holding and the type II market, in favour of a type I industrial market (Iliffe 2001). Long-term contracts have replaced short-term ones, and GP fundholders have lost their purchasing powers, which have been given to Primary Care Trusts responsible for geographical areas. Although New Labour is committed to promoting the interests of individual patients the structures that it has put in place to manage health care have a clear population focus. It remains to be seen whether the new approach resolves these contradictions (Goodwin et al. 1998).

Dr. Steve Iliffe
 University College London Medical School
 Department of Primary Care and Population Sciences
 Royal Free Hospital
 Rowland Hill Street
 London NW3 2PF
 England
 E-Mail: s.iliffe@ucl.ac.uk

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