Competition and quality in health care: the UK experience

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Abstract

Objectives. The aims of this paper are threefold: first to review briefly the theoretical literature on competition and its predicted effects on health care quality; secondly to describe the attempts to introduce competition into the UK National Health Service (NHS); and third to review the outcomes of this experiment and ask how far the research findings are consistent with the next phase of reform that the new Labour Government proposed in late 1997.

Data sources. A search was conducted using electronic data bases Unicorn, Medline and Health Planning and official monitoring statistics within the NHS. All references relating to district-based purchasing, general practitioner (GP) fundholding in its various forms and GP commissioning were reviewed.

Study selection. Preference was given to prospective before and after studies with and without control groups, retrospective studies with and without controls, and case studies which were reinforced by similar supporting case studies.

Results of data synthesis. The evidence suggests that there was little overall change for good or bad as a result of the reforms. The changes that did occur had an impact on speed of treatment, patient convenience and choice, but medical quality was largely unaffected. These benefits were reaped, in particular, by the more competitive agents—the family doctors or GPs.

Conclusion. Although not dramatic in outcome, these changes were significant because speed and convenience were the main deficiencies of the NHS in the eyes of UK consumers.

Keywords: competition, general practice fundholding, markets, UK National Health Service

Economic theory and health care markets – a middle way?

We begin by reviewing briefly theories of both market failure and government failure as applied to health care. We do so as a prelude to explaining the European search for a middle way between free market competition and social equity in health provision. The resultant theory of ‘quasi-markets’ proposed introducing competition as a stimulus to efficiency in publicly funded health care systems. It was the basis of reforms introduced in the 1990s in Sweden, Finland, the Netherlands, Germany, Italy and New Zealand [1]. The approach was taken farthest in the UK. This is not to suggest that politicians read off their proposals from economists’ texts! As with all policy making a far more subtle interactive process was at work, which there is not space to analyse here.

What kind of competition?

In standard economic theory the quality of a service or product is both sustained and extended though innovation in a competitive environment. The continued existence of the organization – the shareholders’ profit, its market share and its employees’ jobs – depend on the firm’s capacity to produce a product that consumers want. Perfect consumer knowledge of the product, or at least good enough knowledge, are required together with ample choice of providers. Competition needs free entry to the market by providers and the capacity of failed producers to go bankrupt. Such has been the basis of economic theory from Adam Smith on. However, since Kenneth Arrow’s contribution to the debate in 1963 [2] economists have come to recognize that markets for medical care had certain characteristics that did not fit this set of founding assumptions. One problem was the nature of uncertainty in the health insurance market. Normal consumers
learn from past experience of services they use on a regular basis, but serious illness does not give that luxury. A wider problem of information failure exists: there is a serious lack of consumer knowledge in the health market. There is also producer ignorance of the likely costs of treatment for individuals who might well have better information than the health insurer about their condition and an incentive to hide this information – this is adverse selection. Where there is knowledge of previous conditions this can preclude the consumer from ever getting insured or only at a prohibitively high cost. Risk pooling, by belonging to a large employer's scheme, can avoid this but insurers wishing to gain the custom of large employers can make themselves attractive by excluding high risk groups and reducing the premiums. That is what competition in many health markets has done, notably in the USA and this has become an increasing focus of research.

Thus, the economic and health policy literature of the 1970s and 1980s built up a formidable set of theoretical reasons why competitive medical care markets might fail [3]. Evidence from the USA suggested that, under certain conditions, increased competition also resulted in medical price inflation. Where there was a soft budget constraint providers competed by raising quality or scale of service offered regardless of cost to capture market share [4]. Third party health insurance, whether public or private, suffered from this deficiency. In the 1990s greater international competition for non-medical products has had its impact on private health insurance. Firms have been very concerned to cut their health insurance costs and hence to encourage more competition between the insurers. In the USA this has had profound effects on health providers.

Observers in Europe, and especially in the UK, were impressed by the cost containing potential of increased competition but they were concerned by the equity implications for health care systems based on the principles of free and equal access. They were especially worried by the theories of adverse selection and 'cream-skimming' that had been developed by American economists in the 1970s [5,6]. Two kinds of result would follow increased competition: the first would be the easiest response – to compete by selecting out the most costly clients – and only secondly would efficiency-based competition take effect. The experience of the USA in the 1980s seemed to bear out that prediction. Reformers in Europe wondered if they could reap the positive gains without the negative equity costs of increased competition.

**Government failure**

While some economists were elaborating theories of market failure in health care, others were developing theories of 'government failure' [7]. In essence, this group of theorists argued that while public agencies may overcome some of the problems associated with market failure, they also introduce many of their own. Traditional public monopolies deny consumer preferences a place and, with captive consumers, health service providers have no driving force to sustain or improve quality. They will also be in a powerful position to dictate to and manipulate government, especially if the professions concerned are powerful; such organizations ultimately decline [8]. Many argued that that was precisely what was happening to the UK's National Health Service (NHS) and to other similar services in the Scandinavian countries [9]. Yet, the public in these countries wanted to retain free access to health care.

**Quasi-market theory**

What emerged was a compromise. Perhaps it was possible to combine public funding and provision, free access to health care and a degree of competition between public providers of health care.

In the UK, district health authorities would buy services for their quite large populations – up to half a million people – from competing hospitals and other providers. General practitioners (GPs) were given limited powers to do the same thing for their own patients. In Sweden county councils would act in a very similar way; in New Zealand large health authorities did so; in Finland local municipalities acted as the purchasers; in Germany and the Netherlands the sick clubs or social insurance agencies were given the right to compete for members. These arrangements would preserve free, or nearly free, access to services. However, on the supply side, care providers would have to compete for the custom of the state instead of simply claiming an annual budget like a state bureaucracy. This would challenge the monopoly power of the public hospital.

The idea of public hospitals drawing profits may seem a strange one but it can be illustrated by quoting two examples. A hospital or its staff can be deemed to be acting as monopolists if they work less efficiently than they would in a competitive situation. It was in the interests of hospital consultants to have long waiting lists for NHS patients. The longer patients waited the more likely the patient would give up and agree to become a private fee-paying patient of the same specialist. This failure to treat quickly could lead to a big income gain for the hospital specialist. Incentives for other staff can also be to work less hard or less efficiently than they would have to in a competitive situation. Before the reforms to the NHS, for example, local GPs in the UK had to wait long periods for the results of their patients' blood or urine tests or X-rays to be returned from the hospitals who had a monopoly of the right to do that laboratory work. Employees in the hospital laboratories explained that GPs came low down their priorities and the consultant upstairs was always given high priority. There was no reason to hurry: when GPs were given the chance to choose which laboratory to go to and hospitals and private labs were given the chance to compete for the opportunity to supply GPs things changed within weeks: overnight results suddenly became possible. So far as could be ascertained this was achieved without significantly lengthening the time consultants had to wait. We should, surely, have heard if it had, although to be fair, no comparable set of waiting time information was available. This experience is merely quoted
to illustrate the kind of ‘monopoly inefficiencies’ reformers claimed existed and could be remedied by competition.

**Limited competition**

In principle we would not expect the results of introducing a quasi-market to be as striking as that which would follow a full market. A true market depends on there being new entrants willing to come in and provide services where poor performing hospitals are failing. In reality the Treasury in the UK would not permit public money to be spent on speculative new entrants and private capital was wary of entering a market dominated by public money and political decisions. Private markets require the ultimate threat of bankruptcy to make firms take competition seriously. In Eastern Europe, where politicians have been prepared to go on rescuing failing firms, their productivity has continued to stagnate even though they have been privatized. In the same way, in practice, politicians do not find it easy to let a public hospital go bankrupt. Failing hospitals thus tend to be bailed out even when the market suggests they should close. This was a major difficulty with the NHS internal market. On the other hand some specialities in hospitals were in competition with others notably in non-emergency work where patients could travel.

This paper is concerned with the evidence of the results derived from the UK experiment that introduced a restricted form of competition. District health authorities were given budgets based on the health needs of their populations. The population of the area was weighted to reflect the probabilities of different population groups using hospitals and costing different sums to look after. These factors derived from regression analyses that included age, sex, those living in different social conditions, with different reported long-standing illness and in areas with differential mortality rates. Family doctors taking part in the scheme, initially, given a budget based on their historical level of hospital use but were subsequently funded on the same kind of basis as health authorities. With this budget they could buy services for their patients from hospitals of a limited kind, community health services and drugs. Later still some GPs were given a devolved budget with which they could buy the full range of health care for their patients. In some areas large groups of GPs, with 50–100,000 patients between them, joined together to pool their budgets and exert more power over the hospitals who served them. These were called multi-funds. Over half of all GPs assumed some kind of devolved budget responsibility. Hospitals competed for their custom. Other GPs disliked such arrangements but came together to advise district health authorities how to purchase services on their behalf. These groups were often called ‘commissioning groups’ of GPs, but they varied enormously in their powers — some merely being consulted about the district health authority plans while others had what amounted to a shadow budget to spend.

In what follows I explore what the research tells us about the relative impact of these varied forms of competition. GPs had several kinds of incentive to get their patients treated quickly and well. GPs suffer personally, in increased working time and aggravation, when their patients have to wait to enter hospital or if the operation is not a success. It is in their interests to insist on good treatment and speedy discharge. They also have the most intimate knowledge of their patients’ needs and of the quality of the care given to them by individual consultants. Health authority staff had no such incentives. On the other hand GPs might be expected to be less interested in broad district-wide health policy and public health issues. Economic theory predicted that the impact of the quasi-market would not be great but that it would differ between the forms of competition that had been introduced. GPs would be more concerned with raising quality and more successful in doing so.

**Quality?**

Defining what quality we might expect the changes to produce is problematic. It was never clearly defined. The following can be deduced from the 1989 White Paper and ministerial speeches. The aim was to increase:

- responsiveness and speed of treatment in non-emergency cases;
- convenience in where and how patients were treated;
- number of treatments of the same quality per unit cost;
- the standard of medical quality per unit cost.

In short, improvements in medical quality were never the main driving force behind the reforms. Speed and convenience and getting more treatments from the same resources were the priorities.

**The literature**

Published material was sought on district-based purchasing, GP fundholding in all its forms, on total purchasing and on locality and GP lead commissioning. Electronic data bases were searched – Unicorn, Medline, Health Planning – as were off print collections, published bibliographies and the grey literature. Directors of public health in England were circulated and asked to suggest relevant papers. A full listing and summary of the research in tabular form is contained in the Report to the Department of Health (pp. 63–81) [10].

Those reported in this paper concentrate on the refereed journal articles and official publications which contain evidence on outcomes.

**Results**

Overall, perhaps the most surprising finding from the published research was how little difference the whole upheaval had made to measurable outcomes. This reaffirmed the cautious broad predictions with which we began. Yet, again in line with the predictions, there was some evidence the changes had made an impact on the crude indicators of
overall NHS effectiveness. These official figures must be treated with great caution. They assume that a patient episode completed is a good outcome which may well not be the case. Yet, overall, we have nothing else. Moreover, unless we think there has been a systematic change over time in bad outcomes or a spurious counting trend the data may tell us something. The Department of Health did do some internal testing to try to judge if the trends could be reflecting spurious counting, such as increases in repeat entry, and concluded that this was minimal. Despite the warnings the overall trends are worth reporting. In the 1980s the increase in the number of patients treated per unit of real spending was rising at a rate of 1.6% a year. After the reforms the average rise was about 2% per annum, and even higher than that at about 2.5% per annum after the first year [11]. This is a non-trivial improvement, especially as it takes into account the increased transaction costs of the market. However, it assumes the very thing we wish to discuss – the unchanging quality of the outcome of the episodes. We now try go beyond that crude measure.

**Improved responsiveness to local populations**

We have seen that responsiveness to consumers was a major goal of government [12] and was reflected in the objectives set by the NHS Management Executive [13]. Yet, evidence that district health authorities had listened to local communities or responded to their views was very difficult to find. Some authorities did survey their users. North Derbyshire Health Authority did make direct contact with users of local hospitals and asked about their complaints and suggestions for improvement. Poor discharge arrangements and communication failures were identified and addressed in subsequent contractual discussions [14]. The paper that reported this does not tell us about long-term impact. Similarly, there is anecdotal evidence of the adoption of users forums but not of their outcomes. A review of purchasing plans in 1995/6 and 1996/7 [15] found that authorities were using various methods to encourage the public to express their views about services – representative panels and ‘road shows’ to get planned changes across. Again, there was little direct evidence of health authorities listening or of outcomes. There was little evidence of systematic needs assessment either. A study of the first 2 years of purchasing in eight authorities reported very mixed and hesitant attempts to do this [16]. The reasons may lie in the regulatory regime. Health authorities were monitored and chief officers were rewarded, not on the extent to which they met locally defined needs, but on the measures of activity – patients treated and waiting lists reduced as well as cost control [17]. Indeed, the whole process of setting contracts at district level restricted GPs’ choice of hospital for their patients. Exceptions could be made if a GP wanted to refer a patient to a hospital with which a district did not have a contract but the process was time-consuming and very costly [18]. All in all it is very difficult to claim that anything like a consumer-based market with competition driving it came to exist at district level. Certainly, from the published evidence, it is difficult to see that district-based purchasing made much difference.

Much more controversial has been the impact of fundholding, which administered a stronger dose of competition. It was only concerned originally with elective non-emergency referrals to hospital. Here most GPs had a wide choice of alternative provider and some choice even in rural areas. As the theory predicted, fundholders were more prepared than districts to use their capacity to choose alternative providers [19]. One study compared GPs’ willingness to give patients a choice of hospital. Fundholders were more willing to do so, and used a variety of hospitals at greater distance for elective surgery [20]. However, one study at York suggested that most patients preferred to use their local hospital [21].

The main burden of evidence derives from a series of observational case studies and interviews with GP fundholders over time [19,22–25]. These all show a consistent picture. Fundholders, at least, were convinced that they had been able, for the first time, to begin to address issues of communication with hospital consultants about their patients. This has been a long-running complaint of both patients and GPs. Fundholders were able to change this. Hospitals did not get paid for the treatment unless an adequate discharge letter was received by the GP. Other practical issues such as appointments systems and the prescribing of particular drugs or unnecessary check-ups by junior hospital staff, were discussed with hospital consultants. Most of these examples concern organizational issues and convenience rather than clinical standards but they are important to patients and most research suggested there was some real movement on these issues.

Quality specifications in fundholders’ contracts were also more demanding than district health authorities but, in one multi-fund that was studied, this was not effective in changing consultants’ clinical practice [26].

Another area where change is generally accepted to have occurred is that fundholders were able to persuade many consultants to visit practices and hold outpatients clinics there. This also proved popular with patients and meant that more attended their appointments. The family doctor clinics were more user-friendly, in familiar surroundings, and saved journey times and time off work [19,27]. Yet, there is dispute about whether such clinics lead to any health improvement [28,29]. Again, it is convenience for the patient and not health gain that has been established.

These results have been criticized on the grounds that those GPs who chose to enter the scheme were the best practices. Such studies are, it is claimed, guilty of selection bias [30]. There is something in both points. Later entrants were probably less radical than the pioneers but they were also learning from the strategies adopted by their predecessors and hence many were at least as effective as change agents. Moreover, most of the comparisons quoted above were based on before and after reform outcomes for the same practices.

Another legitimate criticism of the findings is the likely presence of the Hawthorne effect. Enthusiasm may wane. The fact that such GPs fought so hard to keep the scheme
in the run up to the 1997 Election and after it, however, suggests that there was more than a mirage there. Thus, though these findings may be viewed sceptically, the broad substance and direction seems reliable.

**Speedier treatment**

Speed of treatment and waiting lists for non-emergency treatment have always been the Achilles heel of the NHS. The competition introduced was, perhaps, primarily directed at trying to improve this aspect of service quality. The overall statistics are quite impressive. In 1989 when the Government’s White Paper on reforming the system was published 220,000 people had been waiting for treatment in England for more than 1 year and 90,000 for more than 2 years. These figures had changed little in the late 1980s. By March 1997 this figure had fallen to 31,000 waits of over 1 year and none over 2 years. The problem with assigning these results to the new competitive environment is that the Government also increased the budget for this purpose at the same time. When it tightened the budget again in 1996 and 1997 numbers on waiting lists rose again but, as we see, to nothing like the levels of the late 1980s. Numbers waiting less than 1 year also rose, but this in part reflected the increase in the numbers being treated at all. Everyone treated as a non-emergency case is by definition on a waiting list for some period, however short. All in all it is difficult to deny that the reform package as a whole did have a significant impact on the speed of treatment overall in the NHS.

Did the more competitive fundholders, who had more to gain by challenging the hospitals’ monopoly power, gain any better results? Here there has been a large amount of anecdotal claim and counter claim. The Audit Commission said that they found no difference in waiting times between fundholders and others. But this was a very limited study that took no account of the different reasons for long waits — choice by patient or enforced waits [25]. There is, however, one study that is based firmly on a retrospective follow-up of all the patients referred to hospital for the treatments covered by the fundholding scheme over a period of 4 years in four hospitals [31]. This used a data base of 57,000 patients. Before GPs became fundholders the waiting times of those ‘to be fundholders’ were not significantly different from those of non-fundholders. After becoming fundholders their patients’ waiting times became significantly shorter and did so with each new wave of new fundholders. An analysis of the budgets and resources available to the two groups of GPs showed they were virtually the same. The hospital managers and the consultants were interviewed to explain the outcome. They argued that the hospitals feared that GPs would switch custom and districts would not. GPs were, they thought, much more effective advocates for their patients than district contracting staff were. They pressed their patients’ interests because they were consistent with their own.

**Cost effectiveness**

**Use of cost effectiveness evidence**

The intention behind the introduction of the purchaser-provider split was that the purchasers would have a clear brief to consider the cost effectiveness of the purchases they were making from those who were providing services in their area or to their patients. To this end the Department of Health funded a Centre at York University that would collect and disseminate cost effectiveness studies which would be available for purchasers to use in buying services. What evidence there is suggests that such considerations featured very little in the choice of contracts [32]. Academic cost effectiveness work concentrates on outcomes of very specific treatments whereas health authorities made very general contracts with a whole hospital or specialty, leaving decisions about particular treatments to the medical staff.

**Cost effectiveness judgements**

Allocations to broad specialties and kinds of service do not seem to have changed much. However, as health authorities gained experience they did begin to exclude certain very costly treatments — in vitro fertilization being the most obvious example [33] — or cosmetic treatments. On a more general level the pure average cost per treatment in a specialty did feature as a reason for moving contracts. This was notably true of high cost research led teaching hospitals. Here expensive facilities needed for research and complex cases were cross-subsidized under the old arrangements. This was an inappropriate way to fund such research because it was at the cost of ordinary patients in the areas served by the hospitals, notably in the poor areas of cities such as London. This forced the Government to decide how to fund such research more explicitly. The market thus made the Government consider the issue of quality research vs. current care for patients — present vs. future quality. Whether it got this right or devoted enough to future quality may be debated, but to an economist, forcing the debate into the open was a good outcome of competition.

**More cost effective prescribing**

Fundholders were in a better position to take cost effectiveness studies into account because they were more likely to be considering trade-offs between types of treatment. However, they were also less well equipped to use such material as busy medical practitioners, but one area where they clearly seem to have done so concerns prescribing. Many studies have looked at prescribing outcomes and the early findings were conflicting. Most found early reductions by first wavers but suggested this was short-lived and may have been due to inflating prescriptions prior to entering the scheme. Others suggested that non-fundholders were more successful. These conflicting results were mostly derived from small-scale studies. The most recent and thorough studies have used the national data on prescribing by all practices in the country. There was limited evidence that fundholders did use both cost and efficacy research in making judgements about what prescribing policy the practices should adopt [19]. The national studies showed that first wave fundholders increased their drug spending less than non-fundholders to a significant extent. They had an expenditure of 8% less than that of non-fundholders. The next waves made savings of
In the changes the new Labour Government proposed in late 1997 the soft contracting model became the preferred one. Annual contracting was to be replaced by service agreements probably lasting for 3 years or more. However, the right to change provider – the exit sanction – would remain if the new GP led agencies making these agreements were dissatisfied with the service [42].

Only one study tried to assess the impact of fundholding on the clinical quality of care [43]. This was, however, a before and after study which had no control group so we do not know if the same thing was happening to patients of non-fundholders. It showed that the length of consultation with GPs remained unchanged before and after the change to fundholding status. The prescription of drugs to treat back pain remained the same but patients reported themselves less able to cope with their illness. This may reflect the generally more critical attitude of the public that accompanied the introduction of the reforms. The study also investigated changes in treatment in the case of over a dozen conditions including asthma, angina and diabetes. Here the conclusion was that quality of care had been largely maintained. However, in some areas such as patients suffering from social and psychological problems the quality of care seemed to have declined [44].

Patients’ views about the quality of care they received was surveyed in the case of those GP practices who joined the total purchasing pilots – where GPs controlled the whole medical care budget rather as a primary care lead health maintenance organization (HMO) would. Here there was a control group of non-fundholding patients [45]. The results showed that there was more satisfaction with all aspects of care from patients of the total purchasing groups than with patients of non-fundholders: 51% of the fundholders’ patients felt they had been given choices in their care compared with 35% of non-fundholders.

All in all evidence on medical quality flowing from the rise in competition is meagre one way or the other. While it is difficult to prove that there was a decisive improvement it is equally difficult to show there has been a marked decline. Nor is there evidence that ‘cream skimming’ took place. The incentives in the UK case for this to happen were small. District health authorities’ budgets were set on a population basis and they had no control on who moved into their areas. As far as fundholders were concerned those who designed the system were at pains to prevent it. Patients who cost the GP practice a lot more to treat were covered by an arrangement under which the district health authority met the extra over a given limit in any one case. The costs of treatment covered by fundholding were relatively cheap. The formula funding took account of age and sex driven differences in costs and the doctors themselves did not lose directly if they took on expensive patients. This was different from the very direct incentives to cream skim that applied in American HMOs. Even so residual worries existed that cream skimming might begin to happen without a careful adjustment to the formulae on which funding was based [46].

Medical care quality
As we have seen, improving medical care quality in the narrow sense was not part of the European agenda and especially not in the case of the UK. The aim was to sustain quality while containing costs and improving convenience and consumer concerns of other kinds. Nevertheless, the crucial question is how far these changes may have inadvertently reduced the quality of medical care. There is very little direct evidence on this score.

Defining and measuring quality and holding other factors constant proved beyond the capacity of rather limited research efforts devoted to the topic in the UK [37]. Some research examined the extent to which quality of care indicators had been used to set standards in contracts or to judge outcomes. They found relatively little of this happening. One study found that about 60% of health authorities did demand some quality outcome measures in some of their contracts [38]. However, these were linked to financial arrangements incentives in only 20% of cases. One study reported on three health authorities, one of which attached a series of quality criteria to each clinical contract [39]. These were derived from national advice in such sources as the national Effective Care Bulletins. Using the power to remove contracts from units that failed on the quality criteria proved difficult and sometimes counter productive. Since politicians were reluctant to close a facility or permit staff redundancy, reducing a budget as a punishment merely reduced the quality even more [40]. What was emerging clearly by 1997 was a process of ‘soft contracting’ [41]. Health authorities would take a particular service or specialty for study in 1 year. Concerns may have been raised by GPs or users, or arose from looking at the health outcome data. This service would then be reviewed in depth sometimes using external experts and a constructive discussion engaged in with the professionals concerned about how to address quality issues.

In the changes the new Labour Government proposed in late 1997 the soft contracting model became the preferred one. Annual contracting was to be replaced by service agreements probably lasting for 3 years or more. However, the right to change provider – the exit sanction – would remain if the new GP led agencies making these agreements were dissatisfied with the service [42].
quickly and well – local GPs. They were also independent enough not to be captured by political pressures to prevent the market from working. Yet, this was an administratively costly solution and the overall impact of the changes was not dramatic. Nor was this surprising: GP fundholders, who seemed the most effective agents, only controlled a little over 10% of the total NHS budget. Where GPs had joined together to influence district health authority purchasing or commissioning there was some evidence that they, too, had been effective but not as effective as GPs who held budgets [47]. Those commissioning groups that had been most effective in this respect had something like a devolved budget or strong support from their districts in backing their demands on hospitals and a preparedness to move custom if quality was not improved.

The Labour Party in opposition had been firmly against the market reforms in general and GP fundholding in particular. Faced with the strong support of many GPs who had gained greater say and improved services the pure politics of the situation called for some compromise. However, the mounting research evidence also seems to have had an effect. The changes that the new Labour Government proposed to introduce in England in December 1997 were, at least, compatible with the conclusions we have outlined above, even if it would be naïve to suggest they had a direct influence! The proposals for Scotland were somewhat different. GP fundholding had never taken off in the same way there. This suggests that some future comparative research may be worthwhile.

The most effective champions of patient convenience and speed of treatment – the GPs – will be given the role of buying or arranging services for their own patients in England. The whole, or nearly the whole health budget will be devolved to these units depending on the number of patients served. The size of the budget will depend on a capitated formula reflecting the age and other social determinants of the demand for health care. The basic principle of fundholding is thus to be extended to all GPs. They will be grouped for this purpose into units of 50 doctors or so serving populations of approximately 100 000 or less. They will hold a budget that will cover nearly the whole of the NHS services excluding the very unusual and expensive end. It will include the cost of the drugs they dispense and the whole will be cash-limited. But instead of making annual contracts they will make longer-term agreements with providers, thus reducing the administration and contracting costs. To help in this process a national body will be created to amass the best clinical and cost effectiveness research and give advice on good clinical practice. Parts of the budget will be devolved down to GPs in their natural practice units to spend and innovate with as they please. The extent to which this will be possible is still being argued out. This represents a step back from crude notions of competition and markets but keeps the essence of GPs’ capacity to exit from low quality providers. It was this the research evidence suggested had some impact on the quality issues that mattered to consumers and which the old system was less good at providing – speed and convenience. The attempt to match the incentive power of competition with the equity of tax funding continues. The end of this road is not yet in sight.

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