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REFORMING UK HEALTH CARE TO IMPROVE HEALTH:

The Case for Research and Experiment

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INTRODUCTION

The current debate about reforming the NHS is surprising in a number of ways. Timmins (1988) points out that it was unforeseen and not part of the Government's main concerns after winning the election in June 1987. It is surprising in another way because it is only six years ago since there was another debate about the NHS which resulted in no radical change. This raises two questions: what was it that led to the debate emerging so quickly in late 1987, and what has happened in the last six years which could lead to the current debate producing proposals for change in contrast to the debate of six years ago?

Timmins (1988) supplies a clear guide to the first question, and it is not our purpose to add to his account. What matters for this paper is that the way the debate was forced onto the political agenda has understandably largely determined the initial focus of the Government's secret Review, and the wider-public debate which has sought to influence that Review. The Review was a response to an alleged financial crisis in the NHS and closures of acute hospital beds. These may be seen as inevitable consequences of policies of giving priority to services other than acute within a total contrained by cash planning with cumulative underfunding of inflation since 1982-83 (Timmins, 1988). A purpose of the financial squeeze of cash planning was to create incentives for more efficient use of health care resources: DHSS performance indicators suggest considerable variations between districts in the intensity with which resources are used. Unfortunately, using resources more intensively commonly increases total costs, and does not therefore necessarily ease financial pressures.

To set the context for a different approach, new values were taken to be important for a service created in a time of rationing: the need to regard patients as "consumers" and to provide choice to

enable those who are able to pay more to get benefits from doing so. Introducing choice implies ending the virtual monopoly of the state over finance and delivery of services. Greater pluralism in finance has been seen as one way of easing financial pressures on health care, because private finance of health care in the UK is much lower than in the other OECD countries (OECD, 1987).

The context of the Review has thus resulted in concerns with finance, acute medicine and introducing consumerism. It is assumed that providing more acute care in response to consumers' choices will be beneficial. Introducing choice into the finance and provision of health care means that individuals can buy convenience and luxury privately and it is intended that hospitals through competing in a market will become more "efficient" (i.e. reduce costs). Such changes may not, however be without problems: they may lead to dual standards of care; and will the "efficient" hospital actually be more attractive to patients - another supposed benefit of choice? Thus attempting to introduce consumer choice may threaten other values which are the concern of this paper: promoting equity of access to health care according to need; and improving the impact on health outcomes from the limited budget available for health care in the UK. The primary questions considered by this paper are: how effective are different types of health care, is the current balance between these types appropriate, and how could this balance be altered to improve cost-effectiveness and equity?

This paper argues that answers to these primary questions require research into health care rather than the imposition of generalised solutions which are deemed to work in organising the production and distribution of other economic commodities. Health care differs from other economic commodities in three important respects. Firstly, as is explained below, there is consensus that those in need of care ought not to be denied access on grounds of ability to pay, hence equity is a fundamental objective. Secondly, "consumers" of health care do not know how ill they are, what methods of diagnosis and treatment are available, their likely costs and outcomes. And indeed an important part of the

relationship established between "consumers" and their physicians may include passing the burden of making decisions on diagnosis and treatment to physicians (McGuire et al, 1985). Thirdly, little is known about the effectiveness of most health care. Fuchs (1985) suggested, as a plausible hypothesis, that 80% of secondary care improves individual patients' health, 10% has no effect, and 10% reduces health status, but that we do not know for much of health care the category to which different components belong.

Paradoxically, however, it seems that the greater the problems posed by the special characteristics of health care, the greater the need to believe that generalised methods will provide a solution. The reason for this paradox has been identified by Evans (1988):

> "What they (those responsible for health care policy) are able to hear is heavily influenced by what they want and expect to hear, their background system of beliefs. This in turn changes the external environment and pressures they perceive: beliefs are shaped by needs (although it may be that individuals do not change their beliefs, but are simply replaced)."

For Evans (1988) the contradiction between beliefs cherished by those responsible for health care policy and findings from research is illustrated by the US fondness for 'free enterprise' as a solution to the problems of health care:

> "Just as victims of cancer, when conventional treatments offer no hope, turn to laetrile and other nostrums, so the US has turned to 'free enterprise', competition and the profit motive - rhetorical symbols which give great comfort (as well as substantial profit opportunities) - to solve an apparently intractable problem. The

> belief in the efficiency (of these solutions) stems not from the evidence, which is not there, nor from the a priori argument, which as always points both ways, but from the acutely felt need for a solution."

This paper examines below the current fashion for introducing a provider (or "internal") market into UK health care. Without research to illuminate further what such change might lead to, the UK would be repeating mistakes of previous reorganisations of health care. The NHS was reorganised in the 1970s on the basis of a belief in planning, and in the mid 1980s on a belief in management. These reorganisations have been based on passing fashions, rather than a well-researched argument about how to optimise the use of the scarce resources available for health care for improved health. Although the organisation of health care needs to take account of changing views about the most effective ways of organising enterprises, it is also necessary to recognise the elusive nature of assessing effectiveness in health care and the little we know about the cost-effectiveness of these activities.

Past changes to the NHS have been a mix of wholesale change and piecemeal social engineering. The changes are wholesale in that they apply universally in England with ripple effects into the different systems in Wales, Scotland and Northern Ireland. However, there is no monitoring of changes or the use of experiments to determine their precise effects. The changes are piecemeal and ad hoc in that each seeks to remedy obvious inadequacies of previous arrangements, but there is no regard to whether each intended remedy in turn creates new problems: official proposals for reform have tended to consider only one of two important issues in the organisation of health care. Thus the original structure of the NHS, the 1982 organisational changes, and the Griffiths' Report on General Management focused on the running of hospitals to the neglect of creating a structure capable of organising health services for the bulk of the population; and the

proposals leading up to the 1974 reorganisation had the wider purview, put failed to provide an adequate structure for running hospitals (Bevan, 1984). This means that there is no convincing sense of progress over the forty years of the NHS in terms of its structure, organisation, management, and performance.

Finland provides a dramatic contrast with the way health care has been reorganised in the UK. The Social Insurance Institution of Finland appointed a Committee which proposed a series of studies to examine the use of medical services and levels of morbidity during the years in which the National Sickness Insurance Scheme was to be graudally introduced. These surveys provided feedback to those responsible for these changes by giving them information on their impact. The surveys analysed factors influencing access to and use of services in relation to morbidity before and after the changes were introduced (Purola et al, 1968, 1974). These surveys pointed to the need to further reform of health care in the 1970s as described below (Pekurinen et al, 1981).

All countries face difficulties in organising and financing health care. There is no panacea awaiting implementation. Thus any system which currently operates has advantages and disadvantages. Reorganisation will alter the balance of these, but, given poor knowledge about the cost-effectiveness of health care, it is not possible to design a blueprint for the future which will achieve efficient and equitable outcomes. It is therefore essential to identify the likely advantages and disadvantages of innovation by experiment, and to decide, by considering these against objectives for health care, whether such changes would on balance be an improvement. The truism which is often ignored is that reorganisation, whatever its longer-term benefits might be, imposes immediate transitional costs, and thus, before these costs are incurred, a clear case ought to be established for the long-term benefits of planned change.

This paper continues by discussing types of health care in terms of their effectiveness, it then considers the objectives of health care in the UK. This sets the context for both reviewing proposals

for reform, and outlining research and experiment, which may show how health care in the UK may be reorganised to improve cost-effectiveness and equity.

THE SCOPE OF HEALTH CARE IN THE UK

There are four types of health care: preventive, primary, secondary and tertiary (rehabilitation). This section reviews what is known about the cost-effectiveness of each type for: maintaining health; preventing and curing sickness; improving quality of life; and slowing the rate of deterioration in quality of life.

Preventive Care

The main examples of known effective means of preventing disease through formal health service intervention are limited to two main types:

(i) Immunisation: has had a profound effect on the incidence of conditions such as poliomyelitis, smallpox, tetanus, and diptheria. Immunisation has diminished rapidly and markedly the incidence of these childhood diseases and therefore the burden of illness in the first year of life and subsequently.

(ii) Secondary prevention: prevents the onset of disease. Cost-effective measures include screening for phenylketonuria, hypothyroidism, Down's syndrome, high blood pressure, breast cancer and cervical cancer.

There is little scope for implementing new preventive measures within health care which are cost-effective (Russell, 1986; Wainwright, 1978; Stone, 1977). What is required is improvement of coverage of preventive measures which are currently used: immunisation (Lakhani et al, 1986); and mortality is still too high both within the UK and

the EC for conditions for which proven measures of secondary prevention exist such as cancer of the cervix and hypertension and stroke (Charlton et al, 1986; Holland, 1988).

There is a third category of preventive measures where concerted action is required outside health care as such: cigarette smoking, and alcohol consumption. The prevention of individuals from taking up or continuing to smoke cigarettes has had a marked effect on the incidence of cancer of the lung, chronic bronchitis, coronary heart disease, and many other conditions and has undoubtedly had a major impact on the expectation of life and the burden of disability in our population. Action is now required: to stop building cigarette factories; to increase public knowledge; to maintain real prices of cigarettes and alcohol after taking account of purchasing power increases. (The Government is, for example, committed to reducing consumption of alcohol by 25% within nearly a decade as part of the WHO Strategy of Health for All by the Year 2000.)

Primary and Secondary Care

The next logical step from seeking to prevent disease is caring for those who become sick and need treatment. This section considers primary and secondary care together because in many countries there is no well-developed system of primary care. The next section considers the continuation of care through rehabilitation after initial diagnosis and treatment.

The important difference between the UK and the rest of the world is not in the average number of contacts with the health care system (OECD, 1987; Kohn and White 1976), but their nature: in the UK, approximately 90% of all contacts with the health care system begin and end with the individual going to see a General Practitioner (GP); in almost every other country, no such "gatekeeper" function exists. The Review's financial perspective means, however, that its focus on the delivery of services is on acute hospital services which account for most of NHS expenditure. That this may be inappropriate is illustrated by the Finnish review of health care.

The assessment of the National Sickness Insurance Scheme by Purola et al (1974) showed that utilisation of services was still not commensurate with the estimated need for services, or with the distribution of morbidity and mortality rates among the population (Pekurinen et al, 1987).

In the 1950s and 1960s, Finland, in common with most other countries directed health care resources into acute hospital care. This was implemented by a programme of building new hospitals to achieve a national hospital network. Pekurinen et al (1987) state that by the beginning of the 1970s this policy was being questioned because of:

(i) High cost: the annual rate of growth of health care expenditure was nearly twice that of growth of GDP.

(ii) Failure to match services to the need for care: Surveys had estimated need for medical care of the Finnish population (Kalimo, 1979); and "there was growing awareness that the major structural distortion of the health care system was the inadequate supply of primary health care services": the acute sector accounted for 73% of total health care expenditure with only 6% of spending on primary care; and the annual increase in expenditure on acute care was greater than the total annual expenditure on primary care.

(iii) Poor results: the state of health of the population improved only slowly or in some cases even deteriorated.

Pekurinen et al state that, to achieve the intended shift from acute to primary care given Finland's strongly decentralised system of decision-making for health care, it was necessary for the Government to introduce a system for planning and state subsidies to local authorities responsible for providing health care. This system was introduced in 1972, and become fully operational in 1974 (Pekurinen et al, 1987). The result has been that Finland appears to have been

the only country to succeed in shifting the balance within total health care expenditure from acute inpatient care towards primary care.

It is unclear, however, what the impact of Finnish reforms have been in terms of health status, because this would require experiment. Indeed, as relatively few of the procedures used by medical practitioners either for diagnosis or treatment have been thoroughly evaluated in terms of effectiveness, little is known about the effectiveness of much of primary and secondary care.

It may seem odd that there are questions over the effectiveness of medicine given significant medical advances. Yet the capacity for cure for the common killer diseases of cancer and coronary heart disease, to take two important examples, remains limited. Although there have been significant improvements in some cancer treatments over the past fifty years, through the use of better and more directed radiotherapy and chemotherapy, for only a few conditions has there been improvements in terms of survival. In the main, improvements in treatment of cancer have reduced pain and disability. For coronary heart disease also, treatment has done little to improve survival, but disability has been reduced and the quality of life has been improved.

The UK's well-developed system of primary care is believed to be cost-effective because it is likely to be less costly in both diagnosis and treatment than direct access to specialists. If the decision following contact with a physician is that no further treatment is necessary, this decision will be made with fewer resources by a GP than if contact is direct to a specialist. The GP does not have immediate access to costly investigations such as X-rays, chemical pathology etc., and would only use such facilities when in serious doubt. In contrast, the specialist usually uses these facilities for various reasons: they are readily available; he has greater knowledge of possible diagnoses; he may feel that it is incumbent on him to use these facilities, because his skill in their use and interpretation is one reason why he has been consulted; and he may gain financially from their use. The comparatively low rates

of admission to hospital in the UK are probably due the GP's role as a gatekeeper -- in other countries individuals typically chose specialists themselves who are paid fees in terms of the services they provide. Given the uncertainty over the need for treatment, direct approaches to specialists are likely to lead to higher rates of treatment. There is scant evidence that higher use of specialist services leads to improved health.

Rehabilitation

As there is little scope for introducing new measures of prevention which are cost-effective, and there is limited potential for cure from hospital treatment, inevitably much of the need for health care is helping individuals cope with their diseases. Such services may broadly be classed as rehabilitation, although effective rehabilitation is a preventive service (Gloag, 1988a), and hospital care is not effective without some form of rehabilitation (Gloag, 1988b).

Gloag (1985a, 1985b, 1985c, 1985d, 1985e, 1985f, 1985g, 1985h) in her survey of rehabilitation for various diseases (including old age) consistently identified considerable unmet need which suggested unnecessary suffering on a massive scale. With an ageing population the need for rehabilitative services will increase: Findley and Findley (1987), for example estimated that a 20% increase in the population aged over 65 in Rhode Island would mean an increased need in hospital rehabilitation services of 15% based on current patterns of care.

Although it is possible to identify massive potential need for rehabilitation, problems remain because of uncertainty over its cost-effectiveness. Furthermore, although these services may often be vital for aiding recovery from diseases, they are not always best provided from the medical model, and, to be effective, require cooperation between agencies.

Scope for Reform of UK Health Care

The characteristics of health care which need to be confronted by proposals for reform may be summarised as follows:

(i) In all countries there are wide variations in practice with levels of treatment by capita varying enormously and often with low treatment areas exhibiting no complaints (for a review of the literature see Copenhagen Collaborating Centre, 1988).

(ii) There are wide variations in the performance of practitioners in terms of activities and outcomes, and good outcomes for some therapies (especially some surgical procedures) require activity to be above some minimum level.

(iii) The majority of therapies in the NHS and all other health care systems, public and private, have unknown costs and benefits: other countries which spend more on health, and have more doctors, appear to have little better outcomes in terms of the health of their population.

(iv) Doctors create demand for health care and to control the demand for the cost of provision it is essential to control supply: i.e. expenditure control and the pursuit of efficiency is incompatible with clinical freedom.

As mentioned above, the UK differs from most other countries because its system of primary care provided by GPs who play two roles. GPs provide care within resources financed by rules of Family Practitioner Committees (FPCs), which account for about 18% of total NHS spending (including drugs). GPs are also the gatekeeper to resources financed by health authorities, which account for about 64% of total NHS spending. Acute hospital services account for most of health authority spending, but these services have only limited potential to cure illness. Thus the crucial problem is caring for the sick and how this may be optimally organised. When examined in Finland this pointed to a shift in emphasis to primary care. And in examining options for reform, this paper advocates research and

experiment in which care is organised around GPs' choices in their role as gatekeeper to other services. To proceed directly to reforming the NHS in this way without research and experiment would be mistaken as there are questions about the way GPs currently fulfil their gatekeeper role.

Wide variations have been found in GPs' use of diagnostic services and in referrals to outpatients: Acheson (1985) reports a 25 fold variation in referrals to outpatients. No satisfactory explanation has been found for these variations. Gloag (1985h) points out that although GPs are often best placed to demand rehabilitation services for those who would benefit from them, GPs are commonly ignorant of the kind of services that exist, and training of future GPs also neglects rehabilitation services. Thus there are questions about equity and cost-effectiveness in the way GPs currently act as gatekeepers to other services.

WHAT OUGHT TO BE THE OBJECTIVES OF UK HEALTH CARE?

Access to effective health care?

The objectives of the UK health care system are diffuse but it is essential to define and rank the goals of the system if proposed changes are to be evaluated.

The Churchill Coalition Government set out the following objective for the post-war health care system in the 1944 White Paper:

> the Government .... want to ensure that in the future every man and woman and child can rely on getting ... the best medical and other facilities available; that their getting them shall not depend on whether they can pay for them or on any other factor irrelevant to real need.

An outline of the Labour government's NHS bill in 1946 stated that it

> imposes no limitation on availability e.g. limitation on financial means, age, sex, employment or vocation, area of residence or insurance qualification.

More recently Mrs. Margaret Thatcher, at the 1982 Conservative Conference and in the 1983 manifesto, argued that:

> The principle that adequate health care should be provided for all, regardless of ability to pay, must be a foundation of any arrangements for financing health care.

All these statements combine rhetoric with ambiguity and are subject to interpretation. They are all concerned with access to health care, but do not explicitly consider that this access will be rationed in some way. It is therefore essential to consider how rationing should take place, and in doing this it is vital to consider the effectiveness of health care and the capacity of different services to improve health.

Arguments about reform are that: the NHS is underfunded, the funding of UK health care needs to be augmented through private finance, and consumers should have more influence over the type and scale of health care provided. These arguments are now considered in terms of their impact on health.

Increasing funding of the NHS

Increasing funding of the NHS would certainly increase the number of jobs and prospects for promotion in health care. Substantially increasing private finance would dramatically increase incomes for those employed in providing health care. In the US, for example, with its high levels of private finance, the average income for physicians before taxes in 1986 was reported to be $119,500

(Iglehart, 1988), which is approximately equivalent to the salary of a NHS consultant with an A plus merit award (about £60,000 in 1988-89). But it is unclear whether such levels of remuneration improve health outcomes.

Pluralism in Finance

Finance of health care is obviously important to governments. What is unusual about the UK, is concern that costs may have been contained too "successfully". In most other countries, and in the US in particular, the search is still on to find ways of containing costs. John Moore, when Secretary of State for Health and Social Security, appeared to accept that there was a crisis in the NHS from underfunding, but attributed this to the comparatively low percentage of spending on health care in the UK which is privately financed. For this reason, he stated that the Review was seeking means of augmenting total funding through increased private finance. But if ability and willingness to pay is not to be a barrier to access to health care, then the health care system will be tax financed. The use of user charges or insurance will create price barriers to consumption and these effects will inhibit use of the health care system. Such reduced utilisation by some groups will make it impossible to identify patients who will benefit the most, so frustrating the efficient working of the system. In addition to these arguments, tax finance has the advantage of being cheap to collect and easy to cash limit (contain costs).

Consumer choice

What evidence do we have that giving consumers greater say would direct care to be more effective? The scope for cost-effective preventive measures nicely illustrates the mismatch between beliefs of consumers and expert knowledge. Many consumers of private health care believe that regular check-ups are effective in reducing mortality or reducing disability. It has been shown, however, that such check ups are relatively ineffective, since the individual

notices signs or symptoms for the majority of conditions which lead to death and disability, goes to see his GP and receives adequate treatment. The South East London Screening Study Group (1977) showed that the introduction of regular check-ups would do little to improve expectation of life or reduction of disability.

It is, however, possible for consumers to be well informed about preventive medicine and make rational choices. Acting as sovereign consumers when we are seriously ill, however, is hard to conceive. As Owen (1976) observed: "when ill we desperately want to believe in the power of the physician's skills, we want reassurance, we often yearn for certainty even when we know there cannot be any real certainty".

Consumers when ill thus want to believe in physicians power to heal, and it is this desire that Owen suggested is the reason for society granting status and privileges to physicians. Yet, as Owen (1976) observed:

> the honest doctor is only too well aware of the inadequacies of his skills when confronting much illness. It is a salutary fact that the vast bulk of modern illness does not respond to the doctor's skills. The majority of a doctor's time is spent in helping patients to accommodate themselves to the facts of their illness. The largest element of all illness in modern society is the ageing process itself -- a largely irreversible process. Health services and the doctors are cast in the role of providers of good health, yet at best, for the bulk of illness all they can do is alleviate symptoms. The dramatic cure is the exception rather than the rule.

There are therefore two kinds of problems here. Initially, expanding consumer choice would result in consumers believing that more resources ought to be made available for killer diseases such a coronary heart disease, despite the relative ineffectiveness of treatment. Then, frustration over the failure to buy health (as opposed to health care) could lead to escalation in malpractice suits

against physicians. Owen highlighted society's ambivalence to physicians arising from awareness of their limited capacity to heal and needing to believe otherwise. This ambivalence is illustrated by the consumer-oriented approach of the US resulting in high rates of renumeration to physicians and malpractice suits against them.

Even when methods of treatment and diagnosis have been evaluated the current organisation of health care does not facilitate change. It is always difficult to persuade those providing a service to change their practices. For example, many trials have demonstrated reduction in post-operative mortality from the use of prophylactic anti-coagulants before surgery for fractured neck of femur or abdominal surgery. But ten years after these results had been established, this practice had not been generally accepted (Morris and Mitchell, 1976a, 1976b). A different kind of example is provided by variations in treatment of breast cancer: there is no evidence to support radical mastectomy rather than lumpectomy, and women have suffered and still do suffer mutilating surgery for no proven benefit (Anonymous, 1986). Change in practice often requires external pressure, and in this respect the Royal Colleges can be influential (e.g. the Royal College of Surgery has published guidelines for day surgery by the Commission on the Provision of Surgical Services (1985)). But it is hard to see expanding the role of the consumer as a means of fostering the changes that are needed to make health care more effective, as this requires detailed knowledge of health care practice. Consumer pressure can and does make delivery of care more humane and improve patients' experience of the process of care: as in changes in obstetric practice and easier access by parents to children when in hospital. The problem is, of course, that merely focussing on consumers' immediate satisfaction does not guarantee that preferred longer-term outcomes are produced.

Acute care

If health care is reviewed from the perspective of efficacy in improving health, then the cliche gives priority to preventive and not acute care. This is forcefully illustrated by AIDS and the current epidemic of measles: it is odd to consider remedies only by

increasing allocations to acute hospitals. Unfortunately, as we explained above, the scope for prevention is limited, but the next obvious step in the sequence from preventive care is to primary rather than acute care. And thus the focus here is on primary care as a means of developing health care options for the UK. The criteria necessary for a competitive market to work in health care are discussed here and by Maynard (1989).

A PROVIDER MARKET FOR THE NHS?

A provider market

A wide range of options have been canvassed for reform of the NHS largely in terms of greater pluralism in finance or delivery, and giving the consumer greater influence. Greater pluralism in finance is either unimportant or dangerous: it is unimportant if it is restricted to topping up basic care in terms of better physical amenities; it is dangerous if it is combined with opting out of paying for the NHS, as this could easily result in Government paying for the high risk population, but having lost the power to contain costs through being the dominant buyer. Such changes are not directed at improving health outcomes. Nor is giving the ordinary consumer increased influence over the provision of care, because the consumer lacks knowledge to be anything like sovereign in demanding health services -- as Starr (1982) has observed a quack is more interested in impressing his customers than his peers. Thus, the proposed reform which remains for critical examination is whether a provider (or "internal") market could generate appropriate incentives for professionals to pursue effective health care. The reasons for advocating a provider market are based on the belief that some form of competition will lead to move cost-effective provision of health care. Given the nature of health care, this belief merits close scrutiny.

What is a provider market?

A market is a network of buyers and sellers. These actors may be based in the private or public sectors (provision) and may use

private or public funding (finance). So the first essential characteristic of the provider market for health care is that there will be a public-private mix of provision and the mix will be determined by the cost-effectiveness of competing agencies. (Following Enthoven (1985), the fashionable term for a provider market is an 'internal' market, this is misleading because it implies competition internal to the NHS. Thus the term provider market, as suggested by Culyer and Brazier (1988), is used here.)

Who holds the budget?

A fundamental assumption in arguments for provider markets is that there is a clearly identified budget holder who is responsible for the efficient delivery of health care, manages the available budget (costs), and ensures that the quality of care (health outcomes) is the best.

An objective of clear identification and unification of budgets is to end the present fragmentation which creates perverse incentives, and results in resources being used inefficiently. Sector resource managers currently seek to shift patients and costs to other parts of the system regardless of the efficiency of such behaviour. Thus GPs can shift patients to the hospital systems through referrals. Hospital managers can shift drug costs at patient discharge from hospitals (generics) to Family Practitioner Services (FPS) (branded products possibly) and shift renal failure treatment costs onto the FPS budget by acquiring, via GPs, fluids for continuous peritoneal dialysis. These and other perverse responses can be ameliorated by budget integration: Hospital and Community Health Services (HCHS) could, for example, be integrated with those of GPs in FPS, with personal social services, and even social security. Alternatively individual budgets and management roles and accountability could be clarified. What is novel about recent proposals for integrating budgets for primary and secondary care is the concept that the budget holder would not be responsible for providing these services.

Various forms of provider markets have been proposed where the budget holder receives finance by capitation according to defined

populations (as in US Health Maintenance Organisations (HMOs)). Enthoven (1985) advocated districts employing GPs, and providing and buying hospital services in a provider market. Maynard (1985) and Maynard et al (1986) advocated GPs receiving a capitation-based sum for primary and secondary care and buying secondary care in a provider market. Bevan (1987, 1989) advocated a hybrid between these whereby GPs' choices are used by districts to plan secondary care. Goldsmith and Willetts (1988) and Pirie and Butler (1985) advocated the creation of new financial intermediaries with which GPs would contract and which would be responsible for buying (but not providing) hospital care. (For a clear, short account of these proposals see Social Services Committee (1988).) In these proposals, budgets for provider markets have been defined to cover: HCHS only (Bevan); HCHS and FPS (Enthoven; Maynard; Goldsmith and Willetts; Pirie and Butler); budgets for provider markets could also, however, be extended to cover LASS and SS.

Incentives of Changing to Capitation-Based Budgets in Provider Markets

The intended effect of all forms of provider markets is to change the incentive structures: hospitals would have to compete for business and organise facilities for the convenience of customers rather than for the quiet life and for the advantage of providers. Performance, in terms of cost and process, could be compared and if outcome data were generated, efficiency standards could be set and monitored. There would be incentives for managers or GPs, acting as proxies for consumers, to seek the cheapest and most efficacious care.

But, there are also problems with budgets where payment is based on capitation: the lesson from general practice in the UK is that capitation induces the possibility of under-service. HMOs in the United States have been shown to reduce costs compared to the fee-per-item-of-service system offered by Blue Cross and Blue Shield insurers (Brook et al, 1983), but the impact of this saving on health benefits is disputed. Much of the analysis of HMOs is based on not-for-profit organisations such as Kaiser in California and the recent (1980s) emergence of for-profit HMOs may generate different

results. Ware et al (1986) showed that health outcomes for poor, ill people who joined the HMO in the Rand study were inferior to those for fee-per-item-of-service provider systems. So HMOs may constrain the demands of the inarticulate and be more responsive to the middle class. Whether such responses are cost effective is unknown: perhaps the poor can benefit less from care? Such concerns are relevant to proposed provider markets which are modelled on the US HMO.

Maynard proposed a for-profit HMO for the NHS in which GPs would gain or lose financially, according to whether the cost of the demands they made for services was less or greater than the capitation-based sum allocated to them for those services. This provides direct financial incentives for underservice, although these effects will be constrained by consumers' freedom to switch providers if they are able to detect that their care is inadequate. The other postulated reforms are for not-for-profit organisations which would manage financial allocations in ways similar to those of districts and family practitioner committees. Whilst this has the advantage of not providing financial incentives to underserve, it also fails to provide incentives for economy: all organisations will seek to use fully their financial allocations and thus there is a need to find some way of monitoring how efficiently resources are used.

What is the pricing system?

For trade to take place in a market place it is necessary to have a system of prices. There is an assumption (Bevan, 1989) or advocacy (Akehurst et al, 1988) of the use of Diagnostic Related Groups (DRGs) as a basis for prices for hospital care in provider markets. The DRG system was implemented in the USA as a (socialist) system of price control. By allocating fixed values to different categories of care, the income (cost) growth of inpatient care was curtailed. The US system of prospective payment has limitations as regards its applicablity for pricing health services in a provider market in the UK:

(i) it does not cover physicians' costs.
(ii) it does not cover out-patient care;

(iii) it induces "DRG creep", i.e. the re-categorisation of patients in order to get better reimbursement from higher DRG payment categories (this has generated a software industry in the USA as hospital managers have sought to maximise their institutions' income).

The DRG system of inpatient classification could be used as a basis for fixing prices, only after resolving a number of obvious problems What values should these prices take? Should they cover all labour, other current and capital costs? The NHS estate has been revalued at replacement and market values, so capital values could be derived from this. (Whilst it is not obvious how all these problems could be resolved, such data are required urgently to signal to users and managers the approximate opportunity cost of treatments whether or not a provider market is introduced into the NHS.)

When DRG pricing policy has been determined, will managers be able to change them or will they be centrally determined, like for pay beds, by the Department of Health? Will price competition be permitted with managers using marginal cost prices? The DRG price will guarantee the provider a given income or return on each patient. Thus the hospitals' income will be determined by volume and DRG price, and to generate surplus, managers will seek to increase volume and reduce length of stay. Will quality be measured? Will results be published? Will competition on grounds of price and quality be encouraged through advertising?

Under a system of DRG pricing, hospital managers may be able to shift costs onto community agencies and informal care systems outside the hospital/primary care budgets. The more limited the budget, the greater the scope for perverse incentives leading to inefficiency, and thus the greater the importance of ensuring that exchange rates are identified clearly and monitored rigorously.

Excess capacity

The market mechanism in the form of cross-charging, which involves buying and selling of hospital facilities, has developed most rapidly

in the South where there is excess capacity. Only managers with spare capacity (beds and doctors) will be able to bid in the competitive tender process. Thus competition at present is limited to those hospitals with the capacity and incentive to tender for contracts. Tight cash limits create incentives to tender, but also tend to reduce capacity to do so. Short term contracts would facilitate creating capacity to compete for contracts. Without such contracts, managers with spare capacity may face considerable problems. For instance a failure to get a contract raises overhead costs, and may lead to hospital closure even though some of its departments are efficient. Effective competition for "market shares" requires that managers can expand or reduce their capacity in a manner appropriate to their success, or lack of it, in the competitive tendering process and close down quickly, if necessary, redundant activities and plant.

The effects of the private sector on market competition are unclear. The private sector appears to be no more efficient than the NHS and it tends to provide, particularly in the South East where it is concentrated, a different product which is more expensive, and not more cost effective. The extent to which it attracts NHS budgets will depend on its pricing policies, quality of care offered, and its capacity. At present there is spare capacity in the private sector and hence its managers could take advantage of provider markets.

Employment contracts

With a market for health care, some institutions would lose contracts and others gain them via the process of competitive tendering. Would employing authorities have the freedom to dismiss and recruit freely all staff and buy/sell assets? If a hospital loses business due to quality failures or high costs, its overheads will be inflated by spare capacity which costs money but generates no revenue. Managers will then be faced by a competitive disadvantage when bidding for new contracts.

The private sector is not circumscribed by restrictive contracts and so, for the market mechanism to work efficiently, it is necessary to

introduce both short-term contracts and rigorous performance review. Are employers, let alone the Government, prepared to grasp this unavoidable consequence of using the market mechanism to induce greater efficiency? If they are not, then market flexibility will be severely inhibited and the gains from market innovations may be limited.

In addition to the duration of the contract of employment having to be more flexible, it will also be necessary to allow market prices to reflect local supply and demand conditions. Thus we might expect higher prices in the South East and a competitive advantage for hospital providers in the North.

Freedom of choice for consumers

The budget holder would act as the purchaser of care and patients would have highly restricted rights as consumers: they would get care where their budget holder had located their contract. This compares with the freedom of choice to be treated anywhere (in principle at least) in the NHS today. To believe that the increased use of the provider market as, for example advocated by Enthoven (1985), would enhance consumer choice is naive. Permitting managers to deploy resources requires consumer safeguards and acceptance of "enlightened paternalism".

Prioritisation

If managers go out to competitive tender and expend their full budget they will, either implicitly as now, or explicitly as it might be, prioritise care. They cannot meet all demands and thus the process of letting tenders will determine a health authority's priorities. The implication of this is that when the 200 or whatever hip replacements have been done in a particular year, no more such treatments may be offered. Thus contracting will make prioritisation explicit and subject to much more debate.

Quality of care

An essential part of any tender contract will be provisions as to the quality of patient care. Whilst process quality matters (i.e. quality of physical surroundings, reception and personal treatment). outcome in terms of enhancements in the length and quality of life, is vital. Thus to monitor tenders and enforce standards in the market place, it will be essential to develop not only a pricing system but also a system for monitoring quality of care or outcomes.

Any failure to develop such a system may create incentives for providers to reduce costs only, and with no outcome reporting system, patients' health may be impaired. For managers to survive in this market place it is essential for them to have both cost and outcome data; essential not only in terms of defence of their performance, but essential also in terms of detecting comparative advantage and winning tenders as a result.

Equity

Is the objective to have equity in access to health care, or equity in access given patients' relative ability to benefit in terms of improvements in health status? RAWPing the HCHS and FPS budgets to provide capitation-based payments to populations defined by an HMO system would mean that resources allocated would crudely reflect need, and equalise the capacity of the chosen organisational form to provide health care services. Recent analysis has shown inequity in the distribution of resources to primary care (Birch and Maynard, 1986; Bevan and Charlton, 1987). This also raises the question of the possibility of an equitable distribution of resources to social services based on similar principles. These capitation payments could also be related to the outcome objective. If that objective is benefit maximisation, and some District or GP group practice has more patients capable of benefiting from the available budget, perhaps those budget holders should get larger budgets?

Problems with Provider Markets

The present Government apparently wants to hear that the efficiency with which health care can be provided can be improved by the

introduction of a provider market. Efficiency of provision can be increased and there is no case to increase the funding of health care except to ease change in some areas (e.g. buying out consultant contracts). However, the image and the reality of provider markets in the mind of politicians seem to be significantly different: half-baked rhetoric and the political desire for change is obscuring the significant practical problems involved in such a change. That there can be problems is illustrated by an experiment of a provider market for health care for the poor in Arizona where participating Health Care Organisations (HCOs) bid competitively for providing services.

In the Arizona Health Care Cost Containment System (AHCCCS), the Arizona Physicians Independent Practice Association (APIPA) enrolled slightly more than 40 per cent of beneficiaries, but in subsequent years this and other participating HCOs encountered serious financial difficulties as a result of competition:

> In the summer of the third year of AHCCCS, APIPA went through a Chapter 11 bankruptcy and ultimately was acquired by a nonprofit hospital partnership. Health Care Providers was dissolved under a Chapter 5 bankruptcy, as was Western Sun, a rural intrepreneurial HCO. In the fourth year, Dynamic Health Services, another rural HCO, also experienced financial difficulties and was purchased by a nonprofit hospital HCO (Mercy Care Plan). Only three entrepreneurial plans survived, and their overall share of the program's total entrollment dropped to 22 percent. The largest of these plans (APC) was purchased by Lincoln National corporation and recently reported an outstanding debt of about $10.5 million. Lincoln National was required by AHCCCS officials to provide $5 million in new capital for APC to avert an immediate contract cancellation in addition to $3.5 million already supplied in response to a previous order of the Arizona Department of Insurance (Kirkman - Liff et al, 1987).

Bankruptcy of providers is just one possible problem of introducing provider markets. Questions that need to be answered in such reforms include:

(i) Who will be the budget holder, the District or the GP, i.e. are you prepared to reform the hospital system only, or take on that and the general practitioners? Who will be the patient's guardian or advocate: the District General Manager or the GP?

(ii) Who will fix the price? Will there be a central price fixing with DRGs, or discretion for managers to adopt marginal cost pricing policies?

(iii) How much excess capacity will be permitted to facilitate tendering and competition? The larger the excess, the greater the underutilisation of scarce resources, but if the excess is marginal, so will be competition. Are you prepared to close down activities and hospitals rapidly to meet market needs?

(iv) Will there be flexible employment contracts, i.e. who will determine pay levels and the duration of the contract? To use resources efficiently it may be necessary, for instance, to pay consusltants and nurses overtime to use spare night-time theatre capacity. If Districts do not win contracts in the market, can they sack consultants and other staff?

(v) There will be <u>less</u> freedom of choice for consumers in District and GP-HMOs where managers control the supply of health care. Yet the political rhetoric is the reverse from politicians who advocate the market.

(vii) Who will monitor outcome and equity and how? "Quality of care" is part of the rhetoric of market advocates yet such

> mechanisms will only perform efficiently if managers (the resource allocators) are informed about the costs and outcomes of care. Are you prepared to invest in these management systems?

The current policy debate appears to ignore these essential ingredients of the market solution for health care provision. This may be either a conspiracy, with market advocates using Fabian techniques to change slowly the policy environment, so that radical change in consultant contracts and the provision of price, cost and outcome information is engineered, or alternatively it may reflect ignorance of a most profound nature.

EXPERIMENTING WITH PROVIDER MARKETS

Objectives of experiment

Because the current policy debate has tended to highlight only the possible advantages of provider markets, it is essential to design and evaluate carefully structured experiments to discover their actual advantages and disadvantages. Such experiments will not give quick answers. But, if the conventional wisdom is wrong about provider markets, it is essential that future policy debate is informed by the facts derived from scientific evaluation of experiments. To design experiments, it is necessary to identify the objectives which a change to a provider market is expected to achieve: various types of market have been proposed, and the consensus for experiment in provider markets may only be apparent as its advocates may be pursuing different objectives. The objectives central to this paper are those of cost-effectiveness and equity. These may be realised by three kinds of redistribution of resources.

The first kind of redistribution of resources could follow from shopping around between suppliers of services for diagnosis and acute hospital care. This appears to underlie most models which have been advocated for a NHS internal market, and is intended to lead to resources being transferred from inefficient to efficient hospitals (or consultants). The second kind of redistribution could be between

different ways of organising care: as in Finland where there was a shift from secondary to primary care. The third kind of redistribution would be a more equitable allocation of resources to populations. Current policies have largely achieved equity between regions. The obvious next steps are to achieve equity between districts within regions, and, where this has been accomplished to seek equity within districts.

The scope for the first kind of redistribution may be limited in practice: Enthoven (1985) excluded emergency admissions from a competitive market; many patients may be still want to go to their local hospital; and although a recent survey (Davies, 1988) has suggested that there is willingness to travel to avoid waiting, this willingness may not extend to travelling for services because they are cheaper or the quality of care is better. Also there are difficulties in measuring efficiency as this includes outcomes as well as costs. GPs could, however, be regarded as judges of quality if it is they who decide on places of treatment in this provider market.

The second kind of redistribution could be implemented by giving GPs influence over service planning supported by information and monitoring of need for unpopular services. This could lead to Finnish-style health care driven by market choice by GPs. In an internal market, where the GP has a notional budget for the patient and acts as his guardian, each group practice could decide to increase community-based care, and possibly demand community hospitals. Where this would differ from a centrally-planned initiative, is that the pattern could vary across the UK. Thus accessibility and cost-effectiveness would lead to different kinds of services in cities and in the country. If initial experience were encouraging, then this model could provide the basis for further developments from which a fuller provider market based on GPs could emerge.

Little is known about inequity in use of HCHS within districts, although the Integrated Analysis for the Review of RAWP (Coopers and Lybrand, 1988) indicates massive variation in inpatient admission

rates by electoral ward within Regions. It is highly likely that group practices' populations make very different use of health authority services. This is not certain because, as Crombie and Fleming (1988) point out, there has been no comprehensive study of this kind. Studies of variation between GPs have been largely limited to actions for which the GP is solely responsible. Thus there have been examinations of variations in GP referrals to outpatient clinics and diagnostic services. But it is reasonable also to expect GPs' to influence rates of referral rates of use of inpatient care -- indeed their role in this respect is said to be one explanation for the UK's low use of hospital inpatient care. And one study of inpatient admissions following GP referrals for orthopaedic care found no difference between rates of admission for GPs with different rates of referral (Ross et al, 1983).

Of these three distributions in resources, as we believe that the first and most popular is of least importance, we therefore advocate experiments involving GPs in planning HCHS. These experiments would focus on examining the possible impact of shifts in resources of the second (efficiency) and third (equity) kinds. The efficiency objective would be examined by giving GPs information and the power to act upon it. GPs would have for the first time, the opportunity costs of inpatient admissions to acute hospitals in terms of using these resources for community-based care, and power to influence the pattern of service provision. Their current role is that of gatekeeper to a pattern of services over which they have little or no influence or incentive to economise. GPs currently try to optimise their demands within constraints set by others. Attempting to implement the equity objective at the level of practices' populations requires assessing what the impact would be of changes in distributions of use of resources.

Experiments with clinical budgeting

To test the impact and feasibility of involving GPs in planning HCHS would involve:

(i) Planning HCHS within a resource limit for each practice.

(ii) GPs accepting the need to try to keep to their plans, and being regularly informed of use of resources so that this may be done.

(iii) GPs having access to a choice of diagnostic services.

(iv) GPs being informed of choice between hospitals for their services in terms of waiting time, cost, accessibility to outpatient clinics, and whatever indicators of quality are available.

(v) GPs being able to choose between hospitals for outpatient and inpatient care with the cost of referral and admission being charged according to service provided and hospitals chosen.

(vi) GPs being able to choose the balance between hospital and community services: thus an increase in community care could be financed by reducing use of inpatient care.

Laying out what such an experiment entails shows how poorly placed we are to conduct it in terms of the information which is routinely available now. Only approximate cost data could be used currently and there are hardly any data on quality of care. Fortunately the most important component of health authority services in terms of resources, is inpatient care, for which there is most information on use of services, and a satisfactory means of classification (DRGs). Costs by DRG at each hospital may be estimated given knowledge of its case mix and its total costs. The only extra data necessary to be able to estimate variation in use of health authority resources by practice is the GP's name for each admission. Alternatively, where postcodes are recorded routinely, these could be used as a basis of estimates. Thus it is possible to use DRGs to examine variation in use of inpatient services by practice and to monitor this use within financial years.

The proposed experiment has two arms: one would involve detailed analysis of use of resources by a small number of practice

populations chosen for experiments in planning HCHS; the second would investigate approximate estimates of resource use and outcomes over a large number of practices. The second arm would inform the choice of practices, and provide data on these as controls for the experiments so that any changes resulting from the experiment of planning HCHS by group practices could be compared not only with previous use by each practice, but also with other practices not included in the experiments.

The experiment in planning HCHS by group practice could usefully begin with a small number of practices and consist of two stages. The practices chosen would be those with populations which had been shown by the second arm to have different levels of use of inpatient services as compared with their estimated equitable levels: above this level, at approximately the same level and below this level. The first stage of the experiment would be to estimate total use of HCHS resources over a given period, such as a year. The second stage would be an experiment in which each practice was set a notional budget for planning HCHS at the same level of resources as estimated in the previous period. Each would then be asked to plan its choice of future services within that total.

It would be premature to aim to set notional budgets at estimated equitable levels at the level of practices. Thus research needs to try to assess reasons for variation in use of HCHS. This could be done by extending the second arm to analyse resource use and outcomes across all services for a few selected diseases, for example, asthma, diabetes, hypertension/stroke. The following can be determined by practice: prevalence of each condition, expenditure on drugs prescribed by GPs, hospital admissions, and adverse outcomes in terms of mortality and emergency admissions. It may in this way be possible to see if there is any relationship between resource use and outcomes: to assess whether, for example, practices with very-high levels of resource use are securing better outcomes for their patients, or that high use of resources is due to failure within primary care to prevent and contain illness. These

are, of course, delicate issues which may not be conclusively resolved, because of the small numbers involved in analysis at the level of group practices, but without including assessment of outcomes, experiments for reforming health care are seriously deficient.

Hospital-based and clinical budgeting and GP planning of HCHS

Finally, it is necessary to consider how planning HCHS by GPs relates to various attempts to involve hospital clinicians in the budgetary process in hospitals. These attempts have been under way for ten years. Their rationale springs from recognition of inadequacies in the way financial information was structured in NHS hospitals (Williams, 1978), and that mere changes in that structure provided no incentive for change (Wickens et al, 1984). Although the rationale is apparently sound, the various initiatives have not so far demonstrated obvious improvements, rather have they illuminated difficulties with the enterprise (Perrin, 1988; Pollit et al, 1988). Given this disappointing record, why should planning of HCHS by GPs succeed where the seemingly easier hospital-based model has yet to do so?

A difficulty with hospital-based clinical budgeting is that it seeks to relate costs to work done, but the hospital's revenue is primarily based not on cases treated but on the population it serves. Clinical staff who are able to treat more cases within available fixed resources (staff, beds, theatres etc) will reduce the average costs per case, but increase total expenditure through more intensive treatment. Thus being more "efficient" increases the total costs of the hospitals, but there will be no entitlement to more revenue because of this increased efficiency.

The introduction of planning of HCHS by GPs as a means of determining hospital allocations would radically alter the context of hospital budgeting. GPs would be responsible for translating capitation-based allocations into demands for treatment, and a hospital could only treat more cases if, at the price it charged, the GP could pay for it. Thus a hospital which treated more cases would get more money.

Paradoxically therefore, difficulties with hospital-based clinical budgeting may be seen as reasons for the introduction of an anologue model for GPs. Indeed, Pollitt et al (1988) conclude their pessimistic review of prospects for successful implementation of budgetary innovation in NHS hospitals by suggesting that if radical changes which encouraged greater competition were to come about, then "workload-based budgets could become an urgent concern for both doctors and managers, almost a prerequisite for success in struggles for institutional autonomy and survival".

CONCLUSIONS

The nine main points made by this paper may be summarised as follows:

1. There is no known way of organising and financing health care which is both equitable and efficient: no country has a system obviously superior to that of the UK, nor have previous reorganisations of the NHS been wholely beneficial. Thus any change from the status quo is likely to have advantages and disadvantages.

2. For a change to be an improvement, its advantages would have to be deemed to outweigh its disadvantages in relation to the objectives of UK health care.

3. The longstanding objectives of UK health care have been that access to care ought to depend only on the need for it, and, as resources have become obviously scarce, that access should be rationed on grounds of need and effectiveness (i.e. patients' capacity to benefit). Participants in the current debate have sought to introduce new objectives of consumer choice over finance and providers of services. Consumer choice over finance can threaten the objective that access to care should not depend on willingness or ability to pay. Consumer choice over provision can lead to resources being used on ineffective care.

The prior concerns of reform must be the objectives of longstanding. This means health care will be financed from taxation and be largely free at the point of consumption. The important questions that remain are how to improve efficiency and equity.

4. The debate surrounding the current review of NHS by the Government has focussed on acute hospital services. This is understandable from a narrow financial perspective, because these services consume most of the resources available to the NHS. But, if the objective of health care policy is to enhance the health of the population to its greatest extent from a given bueget then competition between acute service providers may not be the most promising way of securing most effective use of available finance.

5. Where prevention is demonstrated to be better than cure, the necessary action is taken in the UK with two exceptions: there is scope for increasing coverage of vaccination and immunisation, and more vigorous government action against smoking and alcohol abuse. Increasing consumer choice would be likely to lead to wasting resources on funding of popular types of care or on emotive diseases regardless of the effectiveness of using resources in these ways.

6. In most other countries, access to health care which is other than preventive is via specialists. The UK is unusual in having a system of primary care which meets most of the populations' demands for health services. Little is known about the effectiveness of most of primary, secondary (or acute), or tertiary (rehabilitation) care. Thus increasing consumer choice is likely to do little to ensure that resources are used more effectively.

7. The GP by acting as the 'gatekeeper' to hospital services is accepted as an explanation for the UK's low use of these services, and there is little evidence that this lower use results in worse health outcomes. But there are wide variations

in the way GPs fulfil their 'gatekeeper' role. It is here that there is greatest scope for reforming the NHS to improve efficiency and equity in use of secondary (acute) and tertiary (rehabilitation) care.

8. We advocate experimenting with a provider market in which GPs choose between acute and other forms of care (community, community hospital, rehabilitation) with competition between the different providers of services. We propose research which would also examine the extent to which substitution for different types of care currently takes place between group practices with different levels of use of health authority services. This would illuminate scope for more efficient practice and reasons for inequity arising from variation in use of UK health care resources by different practice populations.

9. The reasons why we advocate experiment is because any move to a provider market will encounter a host of problems. There are procedural difficulties in defining and setting budgets appropriately, and developing ways of supplying information on costs. There are no comprehensive measures of outcomes on quality of care. Finally, it is unclear that there is consensus for accepting the unpleasant aspects of effective competition: uncertainty, restriction of choice, losses of jobs and hospital closures.

The 1988 Review of the NHS offers opportunities for the improvement of the UK health system in terms of efficiency and equity. Such improvements will only be secured, however, from changes which have demonstrated their potential for doing so through experiment. Reorganisations like those of 1974 and 1982 incurred high transitional costs and their benefits remain unclear. Further reorganisation based on rhetoric of the market will only lead to a further crisis in the early 1990s with even greater scepticism of Government's search either to evade or resolve the problems of health care in the UK. For these reasons we have therefore suggested an experiment which does not of itself entail radical change, but, if the experiment results in proven benefits, it does have potential for

pointing how change might proceed. Even if the experiment of involving GPs in planning of HCHS fails, much will have been learnt about the extent to which historical divisions in the provision of health care in UK result in inefficiency and inequity.

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