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“Cinderella” Services in the NHS
Internal Market: Does Contracting
Make a Difference?

This paper examines the impact of the NHS internal market reforms on an aspect of equity in the British system that features little in recent policy commentary: the allocation of resources between acute services for the entire population and non-acute services for the elderly, the mentally ill, and the disabled (the so-called “Cinderella” services). The authors’ research on health planning and contracting in the NHS in Wales suggests that patterns of services have remained largely unchanged, and that pressures in the reformed system, such as the Patient’s Charter initiative, prevent any major reallocation of resources away from the acute sector. Given the ineffectiveness of the contract mechanism in changing funding patterns, the authors consider whether the wider NHS reforms have nevertheless extended the legal remedies available to patients from the “Cinderella” groups faced with inadequate services. Recent cases suggest that, while the courts are reassessing the principles applied in reviewing administrative action affecting the allocation of health care resources, it is patients requiring acute care who are most likely to benefit. The authors conclude that, in terms of progress towards a more equitable distribution of resources between sectors, the NHS internal market is not a good model for other nations to emulate.

Les auteurs examinent l’impact des réformes touchant le système de santé du Royaume-Uni, le NHS (National Health Service), sur l’équité dans la répartition des ressources entre les services de traitement en aigu offerts à la population en général et les services de longue durée consacrés aux plus âgés, aux malades mentaux et aux handicapés (le groupe ‘Cinderella’). Suite à des recherches, les auteurs constatent que les pratiques de planification et d’engagements contractuels sous la NHS au pays de Galles n’ont pas modifié les modèles de services déjà offerts. De plus, ils constatent que des initiatives telle la ‘Charte du patient’ (Patient’s Charter) élaborée sous le nouveau système exercent des pressions empêchant l’affectation des ressources à des secteurs autres que le secteur de traitement en aigu. Le modèle contractuel étant inadéquat pour changer les modes de financement dans le secteur de la santé, les auteurs se penchent sur la proposition suivante: la réforme du NHS offrirait-elle aux malades chroniques un plus grand nombre de recours judiciaires en cas de services inadéquats? Pendant que les tribunaux révisent les pratiques administratives concernant la

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répartition des ressources allouées aux soins de la santé, il est probable que les patients recevant les services de traitement en aigu en profiteront. Les auteurs viennent à la conclusion que le modèle du NHS n'est pas un exemple à suivre pour atteindre une distribution équitable des ressources entre les différents secteurs du système de santé.

Introduction

Since the late 1980s many developed countries have implemented reforms of publicly financed health care systems,¹ mostly through the introduction of managed markets, competition and arrangements for purchaser/provider contracting.² In recent years the Canadian system, long seen as an exemplary model of universal health care insurance, has been the subject of increased criticism,³ with the result that several provinces are contemplating market-oriented reforms and reviewing the experience of other nations. There is growing interest in contracts as a means of specifying performance standards and fostering competition. Britain was one of the first European countries to embark on reform and its "health care experiment"⁴ has been followed by policy makers in many countries. In contrast to those reform efforts where change is piecemeal and incremental, the British approach has used primary legislation, in the form of the *National Health Service and Community Care Act 1990* (hereinafter *NHSCCA*), to achieve radical change in the organization and delivery of services. The National Health Service (NHS) was divided into purchaser and provider sides, with district health authorities (DHAs) and general practitioner fundholders letting contracts to buy services from hospitals and community units, now re-constituted

1. Organization for Economic Cooperation & Development (OECD), *The Reform of Health Care Systems: A Comparative Analysis of Seven OECD Countries* (OECD: Paris, 1994); J.W. Hurst, "Reforming Health Care in Seven European Nations" (1991) 10 *Health Aff.* 7; B. Abel-Smith & E. Mossialos, "Cost-Containment and Health Care Reform: a Study of the European Union" (1994) 28 *Health Policy* 89; A.C. Twaddle, "Health System Reforms: Toward a Framework for International Comparisons" (1996) 43 *Soc. Sci. & Med.* 637; W.P. van de Ven, "Market-Oriented Health Care Reforms: Trends and Future Options" (1996) 43 *Soc. Sci. & Med.* 655.

2. R. Saltman & C. von Otter, *Planned Markets and Public Competition* (Buckingham: Open University Press, 1992); R. Saltman & C. von Otter, eds., *Implementing Planned Markets in Health Care: Balancing Social and Economic Responsibility* (Buckingham: Open University Press, 1995); C.D. Collins, D.J. Hunter & A.T. Green, "The Market and Health Sector Reform" (1994) 8 *J. Mgmt. Med.* 42.

3. R. Chernomas & A. Sepehri, "An Economist's Brief Guide to the Recent Debate on the Canadian Health Care System" (1994) 24 *Int'l J. Health Serv.* 189; T. Rathwell, "Health Care in Canada: A System in Turmoil" (1994) 27 *Health Policy* 5.

4. P. Day & R. Klein, "Britain's Health Care Experiment" (1991) 10 *Health Aff.* 39.

as autonomous NHS trusts.⁵ The resultant “internal market” system has generated a large corpus of published research accessible to the international policy community.⁶

This edition of the Dalhousie Law Journal has a dual focus on “lessons from away” and vulnerable populations, and in this paper we assess the impact of the British reforms on one area largely ignored in the existing policy commentary: the allocation of resources between the acute hospital sector and non-acute services for the elderly, the mentally ill, and those with physical and learning disabilities⁷—the so-called “Cinderella” services. In the sections that follow we first discuss the model of population-based purchasing implicit in the NHS reforms, which many believed would result in a re-allocation of resources between services and thereby maximize “health gain.” We then consider findings from two studies of the NHS in Wales—one of Health Authority purchasing plans and one of contracting behaviour—and assess how far the new system of contracting actually functioned to change patterns of service provision. The studies provide no evidence of any significant transfer of expenditure from the acute sector towards primary care and community health services, and highlight certain pressures that continue to pull resources towards acute care. In light of the failure of the internal market to improve the position of the non-acute services by reallocating resources, we consider whether the wider NHS reforms have nevertheless extended the legal remedies available to patients and relatives faced with curtailed or inadequate services. We examine trends in judicial review during the 1980s and 1990s, but conclude that—to the extent that the courts are becoming more willing to intervene in cases involving NHS resource allocation—it is patients requiring acute care, rather than the “Cinderella” groups, who are most likely to benefit.

I. *Using Contracts to Reshape the NHS*

The NHS reforms emerged out of a perceived crisis of funding in the acute hospital sector, and the contemporaneous policy debate about the benefits of competition, efficiency and “money following patients” related primarily to the delivery of acute services. However, the reforms were also

5. J. Butler, *Patients, Policies and Politics: Before and After Working for Patients* (Buckingham: Open University Press, 1992).

6. R. Robinson & J. Le Grand, *Evaluating the NHS Reforms* (London: King’s Fund, 1994). R. Robinson, “The Impact of the NHS Reforms 1991-1995: A Review of Research Evidence” (1996) 18 J. Pub. Health Med. 337. R. Flynn & G. Williams, eds., *Contracting for Health: Quasi-Markets and the National Health Service* (Oxford: Oxford University Press, 1997).

7. Formerly known in Britain as mental handicap.

intended to enable DHAs to move away from historic patterns of resource allocation. The architects of the reforms argued that they "would devolve more power to the local scene . . . and would create a service structure more in tune with the needs and wishes of the people."⁸ The white paper, *Working for Patients*, identified the role of DHAs as purchasers as:

Ensuring that the health needs of the population for which they are responsible are met: that there are effective services for the prevention and control of diseases and the promotion of health; that their population has access to a range of high-quality value for money services.⁹

This new role required DHAs to assess the health needs of their resident populations and to commission services to meet those needs. Contracting would be based on assessed needs and evidence of the clinical effectiveness of the purchased services, rather than existing service patterns, or the "he who shouts loudest" pressures exerted by consultants. This would open up the possibility of real change in the balance of services. Kenneth Clarke, appearing before the House of Commons Social Services Committee, suggested that it might be possible to demonstrate a dramatic improvement in service by allocating more resources to the Cinderella services rather than "the ritzy, high-tech stuff."¹⁰

The underfunding of the Cinderella services—including non-acute services for the elderly, the disabled and the mentally ill—had been seen as a major problem in the NHS of the 1970s and 80s.¹¹ Despite the expressed commitment of successive governments to transfer resources from the acute sector into these areas, it proved difficult to achieve implementation at the health authority and hospital level. Many commentators saw this as a prime example of the ability of the medical profession to resist the implementation of strategic policies, and argued that one advantage of the purchaser-provider split and the new system of contracting for clinical services would be managers' increased ability to counter vested professional interests.¹²

8. Butler, *supra* note 5 at 49.

9. U.K., Department of Health, *Working for Patients* (London: HMSO, 1989) at 14-15.

10. J. Warden, "Letter From Westminster—Clarke Steps Out" (1989) 298 Br. Med. J. 1478.

11. The term came into wide usage during this period to refer to NHS services, such as those mentioned in the text, which (as in the original Cinderella story) did not receive the attention and resources given to more favoured siblings. For statements of priorities by Ministers that use this language see: D. Owen, *In Sickness and in Health: The Politics of Medicine* (London: Quartet, 1976); R. Moyle, *DHSS Press Release no. 78/62*, 22 February 1978. For academic comment see: S. Haywood & A. Alazewski, *Crisis in the Health Service: The Politics of Management* (London: Croom Helm, 1980); C. Ham, *Policy Making in the NHS* (London: Macmillan, 1981). Both the unflattering "Cinderella" label and the reality of service underfunding reflect the relative lack of power of these patient groups.

12. S. Harrison, "Working the Markets: Purchaser/Provider Separation in English Health Care" (1991) 21 Int'l J. Health Serv. 625.

By the early 1990s, the term Cinderella services was still associated with the traditional client groups, but usually in the context of primary and community health services.¹³ During the previous decade a major re-drawing of the boundaries of health and social care had occurred. Much of the stock of NHS long-stay beds had been lost, and replaced by beds in nursing and residential homes outside the health service.¹⁴ As local authority social services departments assumed responsibility for managing more community services, an increasingly pluralistic social care sector developed, with significant voluntary and private sector involvement.¹⁵ Parallel to the arrangements laid down for contracting in the NHS, the NHSCCA made provision for local government authorities to contract with providers for community care services. The new community care arrangements were financed partly through the Social Security benefits system and partly through a Special Transitional Grant paid by central government to the local authorities. This shift in the locus of care relieved pressure on NHS budgets, but replaced NHS care free at the point of delivery with care financed by fees or means-tested state benefits. The community health services that remained within the NHS included district nursing, health visiting, therapeutic treatment and rehabilitation, thereby encompassing traditional services for mothers and children as well as those for the management of chronic illness, disability and mental illness in the community. By 1996 there were about sixty specialized community health services trusts in England, a further twenty-three combined acute and community trusts, and sixty trusts combining community services with hospital services for mental illness and learning disabilities.¹⁶

Official policy from the 1990s onwards has emphasized the benefits of a primary care-led NHS.¹⁷ Primary care in this context is understood to include not only family doctors but other health professionals, such as community-based nurses, midwives, health visitors and therapists, and thus overlaps with the community health services. Redmayne, in her

13. N. Bosanquet, "Primary Care: Reviving the Sleeping Beauty" (1995) 105(5448) *Health Serv. J.* 20.

14. Audit Commission, *Homeward Bound: A New Course for Community Health* (London: HMSO, 1992); D. Greaves, "Changing Priorities in Residential Medical and Social Services" (1997) 23 *J. Med. Ethics* 77.

15. J. Mohan, "Privatization in the British Health Sector: A Challenge to the NHS?" in J. Gabe, M. Calnan & M. Bury, eds., *The Sociology of the Health Service* (London: Routledge, 1991).

16. R. Flynn, G. Williams & S. Pickard, *Markets and Networks: Contracting in Community Health Services* (Buckingham: Open University Press, 1996).

17. National Health Service Executive, *Developing NHS Purchasing and GP Fundholding: Towards a Primary Care-Led NHS* (Leeds: NHSE, 1994).

study of the 1994/95 purchasing plans of sixty-six English health authorities, found a striking degree of unanimity with regard to the prediction "that primary care will be the main focus of health care delivery in future," and also noted that many had plans to shift resources from the acute secondary sector into primary and community services.¹⁸ Although it was not possible on the basis of the plans to assess to what extent most had actually moved resources, "tentative" evidence from six DHAs who provided projections of future expenditure suggested at least a modest shift from the acute to the primary and community sectors.

II. *Purchasing - A Mechanism For Change?*

We present data from two studies carried out in Wales — one on purchasing plans and related documents, and one on contracting behaviour¹⁹ — which suggest that the picture may be a more static one, with cost pressures in the acute sector blunting strategic policies to reallocate resources. It is necessary to enter the caveat that our findings (like Redmayne's) relate to health authorities, and not to general practice fundholders, whose spending patterns may be different. Day and Klein²⁰ argue that the reformed NHS incorporates two contradictory models of contracting operating at these two levels. Our concern is with the health authority commissioning model that was central to early conceptions of the purchaser/provider split, and which continues to be of interest to other countries contemplating "internal-market-style" reforms.

Wales is a region of 2.9 million people occupying 20,766 square kilometers of mainland Britain. It elects representatives to the United Kingdom Parliament but enjoys some limited administrative devolution. The NHS in Wales is in many ways similar to that of England, although there are some important organizational differences. The major contrasts have been in the lack of a regional tier of management in Wales, which has meant that District Health Authorities have taken on board roles reserved until recently for Regional Health Authorities in England, and in the existence of a separate Department of State in the form of the Welsh Office. The Department of Health makes health policy for England and Wales, which, however, is modified where necessary by the Welsh Office Health Department at the all-Wales level. The Welsh Office has been

18. S. Redmayne, *Re-shaping the NHS: NAHAT Research Paper No. 16* (Birmingham: NAHAT, 1995), at p 21.

19. The first study was completed by Siobhan McLelland, the second by David Hughes and Lesley Griffiths with Jean McHale.

20. Day & Klein, *supra* note 4.

allocated both Departmental and Regional responsibilities, including a role in formulating and disseminating policy.²¹ From 1982 to 1995 there were nine DHAs, covering areas co-terminous with the existing local authorities.²² There were also nine Family Health Services Authorities (FHSAs), governing the work of general medical practitioners, dentists, pharmacists and opticians. As the NHS reforms took shape, many DHAs and FHSAs developed close working relationships and, following a major service reorganization in April 1996, five unified Health Authorities were created to replace the authorities that had previously existed.

The first of our two research projects, the study of health plans and related documents, covers the period from 1992 to 1996. Documents from the nine Welsh DHAs were analyzed together with those from the five unified Health Authorities, which existed in shadow form in 1995/96. For ease of reference, we will refer to both groups as HAs.

Documentary analysis offers the potential to explore the historical development of policy making within a developing organization such as a health authority.²³ Health authorities publish a large volume of written material, including the health plans, purchasing intentions, annual reports and accounts examined in the research. However, the documents are produced primarily to meet the requirements of the Welsh Office and must be viewed within that political context. This poses some difficulties for the researcher, since the documents are notable for both their rhetoric and a prospective focus that at times precludes analysis of actual achievements. Thus many of the documents devote much textual space to the description of planned changes together with general statements regarding priorities, vision and strategy, rather than information on outcomes in previous years. Where new developments are described, information on funding is not always provided. However, the documents do offer the researcher an opportunity to track policy making and implementation over time, and across a number of organizations. The documents provide a revealing "window" for examining national policy (including policy on disadvantaged groups) and its translation into local health plans. They also shed light on the impact of the internal market on service patterns, in terms of the formulation of purchasing intentions and the agreement of developments and disinvestments.

21. R. Levitt & A. Wall, *The Reorganized National Health Service*, 4th ed. (London: Chapman and Hall, 1992).

22. The number of DHAs was reduced to eight in 1995/96 as an interim step before the major reorganization of the following year.

23. N. Forster, "The analysis of company documentation" in C. Cassell and G. Symon, eds., *Qualitative Analysis in Organizational Research* (London: Sage, 1994); A.M. Rafferty, "Historical Research" in D. Cormack, ed., *The Research Process in Nursing*, 3rd ed. (Oxford: Blackwell Science, 1996).

As purchasing matured, and at points mutated into health care "commissioning,"²⁴ it became clear that the internal market was perceived as a mechanism by which patterns of service delivery could be changed, and that purchasing was "the engine that would drive the reforms."²⁵ It might reasonably be expected therefore that one of the tasks for purchasers would be to shift the focus of health care from the acute sector to primary and community care, and to address the issue of access to services by disadvantaged groups. This section seeks to establish the extent to which this has occurred. We discuss a number of themes emerging from the analysis of the documents which affected the allocation of resources between sectors and services, and impacted upon service development for disadvantaged groups.

One of the major influences on health policy during the period of the study was a Welsh Office Initiative launched in 1989 to develop the "Strategic Intent and Direction" (SID) for the NHS in Wales. SID was in line with the World Health Organization (WHO) strategy "Health for All by the Year 2000" and was developed before similar initiatives in other countries, including the "Health of the Nation" in England.²⁶ The initiative was formalized through a document bearing the same name which identified the aim of the "Strategic Intent" thus:

Working with others, the NHS should aim to take the people of Wales into the 21st Century with a level of health on course to compare with the best in Europe.²⁷

The document goes on to set out the means by which the intent can be secured. "Reassessment of the existing patterns of health care services should be guided by three key themes of strategic direction focusing on: health gain, people-centred services, and effective use of resources."²⁸ SID identifies ten health gain areas where health could be improved. These include cardiovascular disease and cancers (identified as the major causes of death within Wales), and also emotional health and relationships, injuries, respiratory illnesses, and healthy environments. Four additional areas—mental handicap, mental distress and illness, maternal and early child health, and physical and sensory disability and discom-

24. "Commissioning" is seen as a wider process than contracting, concerned with health needs assessment, clinical effectiveness and population-based purchasing.

25. B. Mawhinney & D. Nichol, *Purchasing for Health* (London: NHS Management Executive, 1994).

26. N. Whitehead, "Is it fair? Evaluating the Equity Implications of the NHS Reforms" in R. Robinson & J. LeGrand, eds., *Evaluating the NHS Reforms* (London: King's Fund Institute, 1994).

27. Welsh Health Planning Forum, *The Strategic Intent and Direction for the NHS in Wales* (Cardiff: Welsh Office, 1989) at 7.

28. *Ibid.* at 13.

fort—cover the Cinderella groups that are our concern in this paper. The document acknowledges that strategic planning “has tended to emphasize and be driven by provider-related issues,” with the consequence that managers and clinicians have been distracted from the underlying purpose of the NHS, which is “to secure better health for the population as a whole.”²⁹ SID proposes “a new framework for planning” in which Health Authorities will “formulate strategies which respond to these challenges taking into account the important input of those involved at community level.”³⁰

The requirements of SID had an important role in shaping the purchasing intentions of the HAs, particularly in the immediate aftermath of the initiative. In 1992/93 HAs were required to produce lengthy “Local Strategies for Health”, which translated SID into a local context. Most Local Strategies contain detailed objectives for improving health in the areas identified for investment, supplemented in some cases by estimates of resource commitments against health gain areas. However, the detail of Local Strategies was not repeated on a regular basis and the format of subsequent documents makes it difficult to establish how far these objectives were actually achieved. This is confirmed by a 1996 National Audit Office report evaluating the impact of SID which concluded that the “impact on the delivery of health services to patients has been relatively limited.”³¹ Whilst the language of “health gain” maintains a place in the documents of the mid-1990s (including those of the newly configured HAs), its influence diminishes as the impact of other initiatives, such as the *Patient's Charter*, begins to be felt.

A second important theme which gathers strength as time passes is the move towards “a primary care-led NHS.” Many of the documents set the goal of shifting the focus of the NHS in Wales from one dominated by the acute hospital sector to one in which primary care plays a prominent role. This is crystallized in the Welsh Office's 1995 document, “A Fresh Start”³² which foreshadows a major change in the role of the new unified HAs, with the main responsibility for purchasing gradually shifting to GPs.

These policies figure prominently in HA health plans, and are reflected in limited organizational changes in areas such as the creation of GP forums and the development of locality commissioning teams. However, as with SID, there is little evidence of a significant reallocation of

29. *Ibid.* at 9.

30. *Ibid.* at 11.

31. U.K. National Audit Office, *Improving Health in Wales* (London: HMSO, 1996).

32. U.K. Welsh Office, *A Fresh Start: First Report of the Changing Roles Group* (Cardiff: Welsh Office, 1995).

resources towards primary care. Analysis of investments and disinvestments suggests that the acute sector retains its position. This is explicitly recognised by some HAs in statements such as the following:

- acute services continue to consume the majority of resources;
- ... we expect to purchase broadly the same hospital services;
- ... many of the existing processes, systems and approaches will continue.

Where a shift does occur in this area it is predominantly in the provision of locally based diagnostic and ambulatory services. Some of these developments may be seen in the context of the rural population of large areas of Wales, for whom geographical access to district general hospital services is difficult.³³ Others were situated in large urban centres and the industrial areas of the South Wales valleys. The nature of developments varies from one HA to another but includes: blood pressure monitoring in a community pharmacy setting; locally provided ophthalmology, dermatology and neurology services; locally provided general surgery; locally available cardiac catheterization and foetal monitoring; and open access services for GPs in physiotherapy, pathology and radiology. Many of these developments involve the movement of traditional hospital services into non-hospital settings so as to avoid the high costs of acute hospital admission. However, it may be misleading to see these new services as exclusively concerned with strengthening primary care. A more important consideration may be that such developments will result in reduced surgical waiting lists (a major concern in this period) thus reducing pressure on acute hospitals.

The "health gain" concept directs attention to health care outcomes, as opposed to processes, and by the mid-1990s the documents contain references to clinical effectiveness and evidence-based medicine, which by then commanded increasing interest in public health medicine circles. Some HAs then moved further and introduced the concept of evidence-based purchasing, by which evidence of clinical effectiveness will be used to shape investment and disinvestment decisions. By 1994/95 seven of the nine HAs included lists of excluded or restricted treatments in their health plans, sometimes supporting these "disinvestments" by citing evidence on effectiveness. Examples of "disinvestments" made on these grounds in 1994/96 include: ear, nose and throat operations on children, assisted reproduction, varicose vein operations, prostate operations, and dilatation and curettage. The extent to which resources are released and where they are reapplied is rarely identified. What is most notable is the marginal and thus relatively uncontested nature of the treatments cur-

33. For example, the area covered by the former Powys HA does not contain a district general hospital within its boundaries.

rently affected by restrictions. It is difficult to predict which services would be most vulnerable if the principles of evidence-based purchasing were extended. Since ideas about clinical effectiveness, and the supporting methodology of randomized controlled trials and systematic reviews, have been developed mainly in the context of acute interventions, it may be difficult for some community services to establish their value in these same terms.³⁴ Yet it is also true that many mainstream acute procedures have not been supported by controlled trials.³⁵

The documents make frequent references to constraints on purchasing arising from central policies on waiting times and cost economies. These themes become more prominent towards the end of the research period, and appear to have had a major impact on the ability of the HAs to change patterns of service delivery. Waiting times “guarantees” are articulated through the *Patient's Charter*, which was originally introduced in 1991 and endeavours to articulate patient rights and to set high national standards of service.³⁶ The *Charter* includes a range of general rights regarding access to health care and individual delivery of health care. Over time these have been supplemented by specific targets primarily related to waiting times for appointments and urgent treatments in hospital, and to community appointments, which have become increasingly stringent. HAs were encouraged to produce local *Charters*, which in some areas improve on the minimum standards required nationally.

The HA documents suggest that the achievement of *Charter* guarantees affected patterns of priorities by advancing the claims of the services most affected. Some HAs acknowledged that a tension existed between the *Charter*-driven focus on wait times and the older health gain agenda:

If the service is to be responsive to the public's demands then we must direct resources to reducing waiting lists and hence waiting times. However, it must be appreciated that this is not necessarily the same as meeting health gain targets and health needs.

In addition to local *Patient's Charters*, all HAs have agreed local targets based on other recent policy documents, such as *Caring for the Future*.³⁷

34. R. Klein, “The NHS and the New Scientism: Solution or Delusion?” (1996) 89 *Quarterly J. Med.* 85.

35. See: Sir Norman Browse, “Evidence to the House of Commons Health Committee, First Report Session 1994-95” in U.K.H.C. Health Committee, *Priority Setting in the NHS: Purchasing. Vol II: Minutes of Evidence and Appendices, HC 134-II* (London: HMSO, 1995) at 72.

36. U.K. Department of Health, *The Patient's Charter and You* (London: DOH, 1995); J. Montgomery, “Patients First: the Role of Rights” in K.W.M. Fulford, S. Ersser & T. Hope, *Essential Practice in Patient-Centred Care* (Oxford: Blackwell Science, 1996).

37. U.K. Welsh Office. NHS Directorate, *Caring for the Future: The Pathfinder* (Cardiff: Welsh Office, 1992).

These relate to such matters as childhood immunization rates, use of generic prescription drugs, and cutting the percentage of overweight adults. Only a small number have a community care dimension. However, an interesting example illustrates one HA's concern with the sensitive issue of moving patients from free NHS beds to social care, the availability of which may be means-tested:

No patient is to be discharged from hospital before arrangements have been made to meet any continuing health or social care needs, having first fully consulted with the patient, and with the patient's agreement or that of his or her carers.

A predominant theme running through almost all documents was that financial constraints generated at the centre were reducing the scope for discretionary decision making at the local level. Welsh Office guidelines required that strategic developments were normally "revenue neutral," so that investments in new services had to be balanced by corresponding savings, but the scope for reallocating resources between providers and services was severely limited. Most new monies were channelled to support the achievement of *Charter* targets (mainly through waiting list initiatives) and the additional pressures placed on providers made it difficult to reduce their allocations without damaging their ability to meet the required performance targets. At the same time, Welsh Office introduced annual "cost efficiency" and "cost improvement" targets, which had the effect of increasing pressure on HA and trust budgets by requiring them to improve productivity and reduce management costs. These pressures were further compounded by rising provider costs resulting from increasing numbers of emergency admissions. The sharp upward trend of emergency admissions from the mid-1990s onwards has received much attention and continues to draw resources into the acute sector.³⁸

Some reference is made in all the documents to services or client groups that can be located within the notion of the Cinderella services. The main groups which figured in the documents are substance abusers, mothers and children, and people with mental health problems and learning disabilities. Concern with these groups derives in part from the health gain areas specified in SID but can also be traced back to a number of other policy directives. While some documents mention recent circulars on Elderly Care, there is surprisingly little emphasis overall on service

38. S. Kendrick, "Emergency Admissions: What is driving the increase?" (1995) 105(5451) *Health Serv. J.* 26; N. Edwards, "The Wrong Side of the Bed" (1997) 107(5552) *Health Serv. J.* 26.

provision for older people. Reference is also made to two major policy documents from the 1980s—the *All Wales Strategy for Mental Health* and the *All Wales Strategy for Mental Handicap*—and, in contrast to the elderly, all the HAs give significant attention to these client groups. Consistent with the contemporary trend to encourage community care, initiatives in mental illness and learning disabilities are concerned primarily with the closure of large institutions and the provision of alternative forms of care in the community. Some HAs have more specific plans than others for this transfer of resources, although this can usually be attributed to differences in the level of institutional provision in the different areas. Specific investments identified by the HAs include: increased use of community psychiatric nurses; expansion of the voluntary sector; expansion of advocacy services; developing services for the elderly mentally ill; and annual checks for all adults with learning disabilities and their carers. The concern for the re-provision of mental health and learning disabilities services does diminish somewhat over the years, reflecting perhaps a partial achievement of the objectives. However, the assurance of adequate provision for people with mental health problems emerged as an important issue for many HAs in the mid-1990s.

In reaching an overall assessment of purchasing patterns it is important to recognize that developments represent only marginal changes in service delivery, typically accounting for only a tiny percentage of HA budgets. Although the nature of developments varies widely, there is no evidence of any general movement of resources away from the acute sector. Revenue developments tend to be phrased in the language of health gain and therefore are often focused on the ten areas identified for investment within SID. Again, this results in significant attention being given to developments which aim to reduce the levels of cancers and cardiovascular disease. Investments in other areas are remarkably disparate. Specific developments that might benefit disadvantaged groups are often included under the rubric of health promotion, and include community cardiac rehabilitation, needle exchange in community pharmacies, and support for retired persons. Other developments presented in the context of health gain include a Somali advocacy project, additional community midwives and a number of community mothers and visitors schemes. In later years one trend across several HAs is the concentration on waiting times guarantees, a trend that again supports acute hospitals.

Early views of the role of HAs³⁹ emphasised the need to forge “healthy alliances” with other agencies, including social services departments and

39. U.K. Department of Health, *The New Role of Health Authorities* (London: DOH, 1990).

voluntary organizations. It was thought that this would reinforce the relationships between health and social care services and, in theory, facilitate a "seamless" interface among organizations involved in local service provision. However, while the language of "collaboration" and "seamless services" is used in many of the documents, there is little detail on the mechanisms needed to address these issues, or discussion of current problems. One area that does receive limited attention is hospital discharge, and, concomitantly, the desirability of improving communication between hospital staff and social care and primary care services. The emphasis on hospital discharge may reflect concern with the pressures touched on earlier. "Bed blocking," often by elderly patients, constrains providers' ability to achieve guaranteed waiting times and to cope with the rising number of emergency admissions. Investments in this area may be directed as much at improving the efficiency of the secondary sector as developing community services.

While the NHS reforms were intended to ensure that purchasers secured real changes in patterns of services, the analysis of purchasing documents reveals that any observable change has been predominantly at the margins of service delivery. The bulk of new funding (in the form of waiting list initiatives monies) has gone to increase the speed with which patients are treated in acute hospitals, primarily to fulfil the waiting times guarantees of the *Patient's Charter*. Visionary statements claiming a move to a primary care led NHS have not been matched by transfers of resources of services, and in any case does not give special attention to vulnerable populations. The move towards purchasing on the basis of clinical effectiveness again concentrates attention on the acute sector, and establishes standards of effectiveness evidence that are difficult to apply to community services.

III. Contracting and Resource Allocation: The "Alpha" Study

To understand why the allocation of resources between sectors and services has changed so little we need to examine the nature of NHS contracting. Here we draw on the findings of a socio-legal study of the NHS in Wales.⁴⁰ The first phase of the research involved a case study of

40. D. Hughes, J. McHale & L. Griffiths, *Contracts in the NHS: The Regulation of an Imposed Market, Final Report to ESRC* (1996) [unpublished]; D. Hughes, J. McHale & L. Griffiths, "Contracts in the NHS: Searching for a Model" in D. Campbell & P. Vincent-Jones, eds., *Contract and Economic Organization: Socio-Legal Initiatives* (Aldershot: Dartmouth, 1996); D. Hughes, L. Griffiths & J. McHale, "Do Quasi-Markets Evolve? Institutional Analysis and the NHS" (1997) 21 *Cambridge J. Econ.* 259.

one HA, which we will call "Alpha," and its relations with providers in the 1993-95 period. The researchers observed weekly meetings of the HA core contracting team, as well as its negotiation and monitoring meetings with acute hospitals and a mixed mental health/community trust (approximately 80 meetings in all). The case study was supplemented by interviews in late 1995 with contracts staff in all nine Welsh HAs and twenty-two trusts involved in the 1994/95 contracting round.

The findings from the case study correspond closely with the picture presented earlier. A *Local Strategy for Health*, prepared in 1991 as a response to SID, had set the long-term objective of shifting resources from acute to primary and community services, by such means as greater use of day surgery and more sophisticated diagnostic equipment outside hospitals. However, core performance indicator data returned to the Welsh Office reveals that Alpha's expenditures on community health services and learning disability services as a percentage of total health authority expenditure remained constant in the 1994-97 period, while the percentage spent on mental health services fell slightly.⁴¹ The pattern of new service developments also shows the acute sector holding its own. In 1994/95 secondary care took £1.9 million of the £2.8 million available for developments, including acute activity in intensive therapy units, renal analysis and medical care (as well as a modest allocation for forensic psychiatry placements). In contrast, less than £0.7 million was directed at improvements in primary and community health services, including more community nurses, support for open access radiography, physiotherapy and endoscopy, shared care in rheumatology, creating a primary care development fund for equipment in GP premises, speech therapy for special needs, and outreach stroke rehabilitation. Disinvestments affected all sectors, with savings in the acute sector (cessation of dilatation and curettage in women under forty, and deduction in length of stay in hospital for cardiac and inguinal hernia patients) balanced by reductions in hospital-based services for people with learning disabilities, less antenatal care for low-risk mothers, and fewer routine school medical examinations. Of the traditional Cinderella groups only those with learning disabilities appear to have been specifically targeted for investment, though improved generic services may well have helped to support these groups in the community.

We now turn to consider how far these issues become manifest in the contracting process. Contracting follows a cycle based on the financial

41. Unfortunately, consolidated figures for all Welsh HAs for this period are not yet available.

year, during which the focus shifts between the tasks of negotiation, drafting and monitoring. In the NHS contracts are "the subject of agreement between the purchaser and provider and . . . specify the nature and level of service which the provider is expected to give and the basis on which the cost of those services will be reimbursed."⁴² Such contracts also typically contain clauses specifying information requirements, arrangements for monitoring, dispute settlement, redress in the event of non-performance, and provision for *force majeure*.⁴³ In Alpha, contracting is the responsibility of a core contracting team, headed by the Director of Finance, but also including additional finance, planning, and professional staff. The core contract team liaises with the health authority's senior executive team, and with a subcommittee of the team known as the "disinvestments group," in order to translate the agreed contracting strategy into contracts negotiated with providers.

Recent British studies suggest that contracting in the NHS has more of the character of an administrative process than true market behaviour.⁴⁴ Arrangements for NHS contracting were super-imposed upon structures and relationships surviving from the pre-1991 system, which significantly shaped the way contracting evolved. The bureaucratic mechanisms used to manage the internal market have been well documented in the academic commentary.⁴⁵ The central departments issue guidance and directives to regulate many of the basic parameters of "market" exchange, such as contract time cycles, pricing rules, dispute settlement arrangements, and rules for capital charging and borrowing. Targets for efficiency savings which require health authorities to secure the same services for a real-terms reduction in cost have been imposed every year, and are reflected in contracts with providers. Over time the central departments have changed the framework of rules to control the evolution of the "market," and defined the conditions under which they will intervene to prevent unfair practices.⁴⁶ While purchasers and providers

42. U.K. Department of Health, *Working for Patients: Funding and Contracts for Hospital Services (Working Paper 2)* (London: HMSO, 1989) at 7.

43. T. Jost et al., "The British health service reforms, the American health care revolution and purchaser-provider contracts" (1995) 20 *J. Health Pol. Policy & Law* 885; P. Spurgeon, et al., "The Experience of Contracting in Health Care" in Flynn & Williams, eds., *supra* note 6.

44. C. Bennett & E. Ferlie, *Managing Crisis and Change in Health Care: The Organizational Response to HIV/AIDS* (Buckingham: Open University Press, 1994); D. Hughes, J. McHale & L. Griffiths, "Settling NHS Contract Disputes: Formal and Informal Pathways" in Flynn & Williams, eds., *supra* note 6.

45. D. Hughes, "Health Policy: Letting the Market Work?" (1993) 5 *Soc. Policy Rev.* 104; J. Le Grand, "Internal Market Rules OK" (1994) 309 *Br. Med. J.* 1596; J. Montgomery, *Health Care Law* (Oxford: Oxford University Press, 1997).

46. U.K. National Health Service Executive (NHSE), *The Operation of the NHS Internal Market: Local Freedoms, National Responsibilities* (London: DOH, 1994).

usually conclude contracts within the terms of official guidance and without the involvement of the central departments, there is evidence that, in extreme cases, they have intervened to safeguard the position of individual trusts.⁴⁷

Under the NHS short-term planning system, which ended in 1991, annual revenue allocations by HAs to hospitals were rolled forward from year to year, with small adjustments for inflation and new developments. Changes in clinical services depended on “development monies,” which accounted for only a tiny percentage of total expenditure. The NHS reforms were intended to allow purchasers and providers to move away from historic funding patterns by using contracts to specify what would and would not be purchased from one contract to the next. Yet critics argued that this system perpetuated unfairness by basing current budgets on the budgets allocated in past years.

Rather than funding hospitals through a block revenue allocation, the new policy required HAs to buy services at hospitals’ published tariffs (usually based on an average price per specialty). This was intended to remove anomalies arising from past over- or under-funding of particular services by ensuring that prices were close to actual costs.⁴⁸ However, it was widely acknowledged that a move to tariff-based contracting would involve significant short-term adjustments that might disadvantage some HAs and trusts, and this change was resisted by many Finance Directors. By 1994/95 seven of the nine Welsh HAs, including Alpha, still based their main contracts on the quantum of costs carried over from the previous year, with limited negotiation regarding “investments” and “disinvestments.” Trusts remained within the rules by publishing tariffs, but these were usually calculated retrospectively in the light of the available contract sum. This practice, known as “roll-over contracting,” ensured a degree of financial stability for health authorities. However, it meant that contracting was little different from the old-style revenue allocation process, so that problems remained in reallocating resources between services. A report from an advisory committee on purchasing ethics, appended to Alpha’s 1994/95 Health Plan, notes that the debate on priorities and associated investments and disinvestments, affected only around one percent of health authority resources.

47. U.K.H.C. Welsh Affairs Committee, *Morrison Hospital/Icheyd Morgannwg: A Case Study of the Working of the Internal Market* (London: House of Commons, 1997).

48. Hospitals were instructed that contract prices should equal costs, calculated on a “full-cost” basis, with no planned cross-subsidization between services, specialties or procedures. See: U.K. Department of Health, *Department of Health Circular* (Finance Directorate Letter) FDL(92)49, Annex A (1992).

Another feature of the new contracting system that militated against the reallocation of resources between services was that most clinical services were purchased in the aggregate rather than by procedure. NHS contracts take three forms: block contracts involve provision of a service for a fixed price regardless of volume;⁴⁹ cost and volume contracts provide for an adjustment of price if volume is above or below an indicative level agreed in the contract; and cost-per-case contracts specify an agreed price for each case treated. Welsh HAs use cost-per-case contracts only for occasional specialized or high-cost procedures. The pattern in Alpha, as in most other Welsh HAs, has been that contracts with main acute providers took a cost-and- volume form, while a block contract was used to buy services from the mental health/community unit. Block contracts had been the predominant contract form in the early 1990s, largely because of the administrative burden associated with launching the internal market and the limitations of existing information systems. While acute hospitals were able to develop more sophisticated contracts as time went by, providers of community health services found this more difficult. Where acute hospitals mostly used "deaths and discharges," "day cases," and "new inpatient attendances" as the units for specifying activity in contracts, community units typically used staff "contacts" as their main contract currency. Given the imprecise relationship among "contacts," clinical care and outcomes, and the consequent problems of costing "contacts" of different kinds, most health authorities continued to purchase community health services on a block basis. At face value it might be assumed that more precise information on case mix in acute hospitals contracts would enable a HA to be more explicit about what it was purchasing and not purchasing, and disinvest from services offering little benefit. In practice, however, those hospitals that had moved furthest in this direction used case-mix information to try to establish underfunding of services and push for additional revenue. Alpha resisted attempts by an acute trust to renegotiate its contract so as to reflect the complex case mix said to result from the presence of a number of subregional specialties on the site, but was forced to concede that underfunding did exist in respect of orthopaedics and ITU services.

The duty of HAs to carry out health needs assessments was considered by many commentators to be one of the major advances introduced by the purchaser/provider split, and an important mechanism for shifting resources. Alpha's work on health needs assessments centred primarily on

49. By the mid-1990s sophisticated block contracts, specifying floors and ceilings within which the fixed price applied, were becoming common in England, though less so in Wales.

a general health status survey (using Short-Form 36 Health Survey) carried out under the direction of the public health medicine department in 1993. This exercise (like SID) identified high death rates from cancer and ischaemic heart disease as the areas with greatest scope for improvement and also noted a specific deficit in oral health. However, health needs assessments received less attention than "clinical effectiveness," which was very prominent in Wales because of the emphasis placed on "health gain." In line with SID, "health gain working parties" were established in the ten designated areas. Objectives set for mental illness and learning disabilities included a reduction in institutional care, open access to community mental health teams, development of community services for challenging behaviours and reduction of preventable illness in people with learning disabilities.

The research found that these initiatives were having only a limited impact on the contracting process. The activities of the core contracting team were not closely coordinated with discussions taking place in the "disinvestments group," which centred more explicitly on clinical effectiveness and health gain issues, and it was not until late in the research period that the HA identified this problem and took steps to improve liaison.

These issues fed through into weekly contract team meetings mainly in the form of occasional discussions of clinical effectiveness evidence in respect of service developments originating from providers, mostly in the acute sector. From time to time the team found itself needing to decide whether to buy new services offered by a trust by authorizing a contract variation. Certain of these developments had not been anticipated by the HA and involved additional costs which officers sought to resist. For example, there were protracted discussions regarding the purchase of dexta scans. Although Alpha's public health medicine physicians were sceptical about the benefits of this new technology for assessing bone density, a number of GP fundholders were already purchasing it for their patients. This made the health authority vulnerable to the charge that it was perpetuating a two-tier service in which non-fundholder patients were disadvantaged. Alpha received a letter from the Welsh Office Health Department requiring it to avoid a position where services purchased by fundholders were not available to patients covered by health authority contracts. The HA decided to extend its contract to buy dexta scans, but also opened discussions with GPs to attempt to obtain district-wide agreement on purchasing new procedures.

Health needs assessments and clinical effectiveness were overshadowed by pressures coming through from providers and from the Welsh Office Health Department. The magnitude of the administrative burden

associated with the implementation of contracting is hard to overstate. The core team had to cope not only with the work of negotiating and monitoring contracts, but also with the steady stream of official guidance on contracting policy, and problems arising from the financial instability of some providers. Consequently the team found itself constantly pulled towards "fire-fighting," rather than the development work needed to improve its purchasing role.

The main pressures from providers involved demands to fund increased activity in certain acute specialties, particularly activity associated with emergency medical admissions. Emergency admissions in Alpha's contracts rose by more than thirty percent in 1993/95, reflecting a trend affecting the NHS nationally. Alpha included additional emergency admissions as a designated service development in 1994/95, and was forced to allocate additional monies from its contingency reserve to address this need.

The strongest pressures coming from the Welsh Office centred on achieving targets set out in the national *Patient's Charter*, as well as centrally-imposed management economies implemented through a reduction in the HA's revenue allocation. At this time the *Patient's Charter* had a very high political profile, with the Government seeing reduced waiting lists as evidence of the success of the (still controversial) NHS reforms. The *Charter* tended to displace other strategic and contracting policy initiatives to the extent that it became the focal point for Welsh Office monitoring of HA activities. The Welsh Office insisted that *Charter* guarantees, particularly guarantees affecting surgical waiting times, must be strictly enforced. Substantial non-recurring monies were allocated to enable hospitals to control waiting lists, and HAs came under heavy pressure to ensure that the additional funding had the desired result.

Alpha responded by writing maximum waiting times into its contracts, together with substantial financial penalties for non-performance. Providers were required to provide monthly information returns which gave details of patients nearing wait times limits, and were subject to additional financial penalties for missing information returns. These penalty clauses were deeply unpopular with providers, and proved difficult to enforce with two specialist hospitals who threatened to treat Alpha's patients on an "ECR-only" basis.⁵⁰ Nevertheless, Alpha was able to insist that penalties remain in its contracts with main providers, and levied them on

50. While HAs purchase most activity through negotiated contracts, they buy certain additional procedures as extra-contractual referrals (ECRs) at providers' published ECR tariffs.

a number of occasions during the research period. One major acute provider complained that the emphasis on *Charter* standards was forcing doctors to treat patients who had been on the waiting lists for extended periods ahead of more clinically urgent cases, and was successful in getting extra money to deal with urgent orthopaedic cases not covered by the *Charter*. The overall effect of the *Patient's Charter*, with its emphasis on surgical wait times, was undoubtedly to channel additional monies to acute providers. They benefited not only from non-recurring waiting list initiative monies, but also from extra activity purchased under Alpha's main contracts in mid-year to deal with waiting list hot spots.

One secondary effect of the pressures coming through from acute hospitals is that almost all serious contract disputes involve acute providers. During the research period Alpha was embroiled in a long-running dispute with a newly formed acute trust, which clearly illustrates the difficulties that HAs face in reducing the value of their contracts with acute hospitals. Early in the financial year money is deducted from the base budgets of HAs according to a calculation carried out by the Welsh Office so as to provide separate budgets for newly created GP fundholders. Alpha and the trust had signed a contract which specified that the final contract sum would be agreed in a contract variation when the amount of the allocation to "new wave" fundholders was confirmed. It had been assumed that the new fundholders would enter contracts with the trust which reflected patient flows in previous years, and that this would leave its financial position largely unaffected. However, the Welsh Office, with HA advice, allocated a larger sum to fundholders than expected, and the trust found that the fundholders were electing to spend some of this money elsewhere, so that it faced a substantial reduction in contract income. The trust responded by reallocating its fixed costs to enable it to claim a higher proportion of overheads from Alpha, as well as seeking payment for the clinical activity not now covered by contracts. The two organizations were unable to agree upon a contract variation and the dispute went to conciliation. Alpha was criticized by the conciliators for not advising the trust of the change in the basis of the fundholder allocation and for poor communication as the problem developed, and was required to make good a large proportion of the trust's lost revenue. It is unclear how much of the shortfall in fundholder contracts reflected a reallocation of monies to non-acute services as opposed to other acute hospitals, but the trust was able to use conciliation to force the HA to maintain its contract income near the expected level. As a result of these events, the trust ended the 1994/95 financial year with a small surplus, leaving the HA with a deficit.

While Alpha's two largest acute providers both achieved NHS trust status during the research period, the main community mental health provider was still "directly managed" by the HA. The relationship between the two bodies was less adversarial than that between Alpha and the acute trusts, and there were suggestions that the HA was manoeuvring to secure the financial viability of the unit and prepare it for trust status. Plans were announced for a merger with a smaller acute hospital, which would be restructured to provide a limited range of acute and community health services at a new site, with transfer of other acute specialties to the two existing acute trusts. This accorded with the long-term strategy of moving resources from secondary to community care, though the building of the new hospital would depend on securing Private Finance Initiative funding from outside the NHS.⁵¹ The planned development was still some years ahead, but a number of other service changes were canvassed to ensure that the new trust had a viable portfolio of services. There was a proposal to consolidate child health services in the new trust by amalgamating acute paediatrics with community child health services. However, this resulted in intense opposition from paediatricians, who were unwilling to leave the acute trust. As a compromise the health authority devised an unusual arrangement whereby the new trust would contract for all child health services, but then sub-contract the acute component of this work to the acute trust. Consequently, the paper value of the new trust's contract tended to overstate its actual income. Again these events illustrate the problems in moving services out of powerful acute hospitals, specifically the ability of professionals to water down changes to the point where the scale of actual resource shifts is much reduced.

The Alpha case study suggests that early hopes that contracting would transform patterns of resource allocation in the NHS were overly optimistic. The reformed service has needed to cope with many of the same pressing administrative and resource issues that affected the old system. While policy analysts have been preoccupied with the changed incentive structures and responsibilities created by the purchaser/provider split, we maintain that, in this context, contracting is not simply an economic or technical planning mechanism. Inevitably it becomes a tool in the political process of managing the NHS, something which was of crucial importance to Government in a period when the internal market could not be allowed to fail. Although contracting had been linked to activities such as health needs assessments and evidence-based purchasing, which

51. The PFI aims to encourage private enterprises to finance new developments in the NHS and other public services for which they receive a normal commercial return.

might more closely match services to the needs of local populations, this decentralizing agenda was displaced by pressures from the centre to increase efficiency and demonstrate measurable performance improvements. The *Patient's Charter*, in particular, undoubtedly reduced surgical waiting lists, but also skewed clinical priority towards a subset of targeted patients and ensured that resources remained concentrated in the acute sector.

IV. *Patients' Rights to Resources After the NHS Reforms*

Although the new system of contracting has not diverted resources away from the acute sector, there remains the possibility that the NHS reforms have made it easier for patients disadvantaged by the underfunding of services, including Cinderella services, to seek redress in the courts. In this section we change tack and consider the wider legal context. The question of patient rights after the NHS reforms has occasioned considerable scholarly commentary, and our brief discussion focuses primarily on a small number of recent cases in which the established judicial approach to NHS resource allocation cases has come under scrutiny. We argue that a comparison of cases from the 1980s and 1990s reveals some evidence of a shift in judicial attitudes, though not one that has so far produced tangible benefits for patients in terms of remedies.

There are, of course, important differences between the U.K. and Canadian contexts. The U.K. does not have a written constitution, or anything comparable to s. 7 of the *Canadian Charter of Rights and Freedoms*.⁵² Moreover the scope for litigation alleging failure to carry out statutory duties appears more restricted, largely because of the absence of a clear statutory basis for a right to treatment and the relative restraint of British judges in cases involving the allocation of health care resources. Despite the fundamental changes introduced by the *NHSCCA*, it left the legal framework affecting rights to health care services largely untouched. While ss. 1-3 of the *National Health Service Act 1977*⁵³

52. See: D. Longley, *Health Care Constitutions* (London: Cavendish, 1996); E. Colvin, "Section Seven of the Canadian Charter of Rights and Freedoms" (1989) 68 Can. Bar Rev. 560; M. Jackson, "The protection of welfare rights under the Charter" (1988) 20 Ottawa L. Rev. 257. However, as this paper was in preparation the U.K. Labour Government, elected in May 1997, announced its intention to incorporate the European Convention on Human Rights into domestic law via a Bill of Rights. There is some debate among legal commentators as to whether this will be based on a Canadian or New Zealand model, in terms of the relative roles of the judiciary and Parliament. See: F. Gibbs, "First Bill of Rights since 1689 will give courts new powers" *The Times* (15 May 1997).

53. 1977, c. 49.

require the Secretary of State for Health to provide or secure the provision of comprehensive health care, these duties are limited by the proviso in s. 3(1) that the Secretary of State is bound to provide services only "to such extent as he considers necessary to meet all reasonable requirements." NHS contracts have no direct effect on the legal position of patients, since s. 4(3) of the *NHSCCA* prevents their enforcement as contracts in law and, even if this were not the case, considerations of privity of contract would further restrict the accessibility of a remedy. Nor do the standards and guarantees provided under the *Patient's Charter*, so prominent in our empirical studies, create legally enforceable rights.⁵⁴ Section 47 of the *NHSCCA* requires local authorities to assess the needs of persons who may need community care services, but leaves considerable discretion regarding the provision of services. Local authorities are required only to decide what services to provide in the light of the assessment. As emerged in one case considered below, any stricter duty to provide services would depend on the provisions of earlier enactments incorporated in the statutory regime created by the 1990 Act.

The British Secretary of State for Health, Kenneth Clarke, was concerned that an Act with contracting as its centrepiece should not become "a lawyer's charter and paradise."⁵⁵ Consequently the Government made provision in the *NHSCCA* to prevent NHS contracts from being enforced in law.⁵⁶ However, many commentators predicted that the reforms would lead to more cases in the courts, including actions regarding patient rights to care.⁵⁷ It was argued that the separation of purchasers and providers would make conflicts of interests between the parties more visible, and the basis of decisions more amenable to scrutiny. Agreements for the provision of clinical services would become more formal and explicit, so that procedural aspects of purchasing might come more to the fore. Beyond this, greater organizational decentralization would mean that resource allocation decisions would often be taken by managers in health authorities and trusts rather than by Ministers making policy for the NHS as a whole.

Patients or relatives harmed by such decisions might seek redress through either public law or private law actions. Academic lawyers speculated a good deal about the form litigation might take. One route

54. See Montgomery, *supra* note 36.

55. U.K., H.C., *Parliamentary Debates*, Standing Committee E on the National Health Service and Community Care Bill, col. 349 (23 January 1990).

56. *NHSCCA*, s. 4.3.

57. D. Longley, "Diagnostic Dilemmas: Accountability in the National Health Service" [1990] *Pub. L.* 527; J. M. Jacob, "Lawyers go to Hospital" [1991] *Pub. L.* 255; C. Newdick, "Rights to NHS Resources After the 1990 Act" (1993) 1 *Med. L. Rev.* 53.

open to plaintiffs, the tort of breach of statutory duty, appears to be ruled out in the NHS context because of the unwillingness of the British courts to permit actions for breach of duty to provide statutory welfare services.⁵⁸ Interest among commentators centred more on the prospects of negligence actions brought under general tort law principles. Such an action would need to establish that a patient had suffered harm because a health authority or NHS trust carried out its functions with insufficient care. In two cases involving hospitalized patients in the pre-1991 NHS, it was held that lack of resources was not a sufficient defence against allegations that treatment practices were unsafe.⁵⁹ Some legal commentators believed that, following the reforms, a health authority might be vulnerable to allegations of negligence if the level of its contracts failed to meet the needs of its resident population, particularly in the extreme case in which no contract was let for an entire service.⁶⁰ If this were not so, NHS contracts might, in a situation where a trust cut costs and clinical standards, compromise the standard of care required by the law of negligence.⁶¹ To date, however, these arguments have not been tested in the courts, and we suspect that many of the scenarios discussed are too unlikely to be of much concern to practising lawyers.

While many commentators predicted that private law actions would offer the best prospect of success for patients, the most significant decisions of the 1990s have undoubtedly been in the public law arena, though the benefits they offer plaintiffs may ultimately be severely limited. The principles applied by the courts in dealing with allegations that the NHS has failed to perform its statutory duty by not providing adequate resources were established in *R. v. Secretary of State for Social Services, West Midlands RHA and Birmingham AHA (Teaching), ex p. Hincks*.⁶² This case involved four Staffordshire patients who had been on the waiting list for orthopaedic surgery for some years, and who were facing further delays in treatment because a scheme to improve orthopaedic services, previously approved by the Department of Health, had been shelved as an economy measure. The applicants sought a declaration that the Secretary of State was failing to fulfil his duty under s. 3(1) of the *National Health Services Act 1977* to provide comprehensive health services. The Court of Appeal held that the duty was not absolute;

58. See Montgomery, *supra* note 45 at 71.

59. *Bull v. Devon Health Authority* (1989) 1 *Lancet* 738, text of judgment unreported; *Knight v. Home Office*, [1990] 3 All E.R. 237.

60. Jacob, *supra* note 57.

61. Newdick, *supra* note 57.

62. [1980] 1 B.M.L.R. 93 [hereinafter *Hincks*].

it was necessarily limited by the implied qualification "within the resources available." Lord Denning M.R. stated that the funds for the NHS were voted by Parliament and that the service had to do the best it could within the total allocation set: "The Secretary of State says that he is doing the best he can with the financial resources available to him, and I do not think he can be faulted in the matter."⁶³

Similar issues were raised in two further cases precipitated by long cardiac surgery waiting lists in a Central Birmingham Health Authority in 1987. The cases came to have wider significance because, according to many commentators, the media attention they engendered precipitated Prime Minister Margaret Thatcher's decision to authorize the major review of the NHS that culminated in the 1991 reforms. In *R. v. Central Birmingham Health Authority, ex p. Walker*,⁶⁴ the applicants again argued that the decision not to offer surgery to correct a congenital heart defect in an infant ran counter to the duty to provide comprehensive health care. However, Macpherson J. held that the case "was not truly an attack on the actual decision made . . . [but] a general criticism of the decisions as to the staffing and financing of the health service . . . Those of course are questions which are of enormous public interest and concern, but they are questions to be raised, answered and dealt with outside the court."⁶⁵ The judge's comment that the patient's life was not presently in danger led some commentators to infer that he might have granted an order if a life-threatening emergency had been involved. In *R. v. Central Birmingham Health Authority, ex p. Collier*,⁶⁶ a case involving a neonate whose condition was more serious, it became clear that this was not so. On appeal Brown L.J. held that, even where there is immediate danger to life, the legal principles are the same.

One difficulty for the applicants in these cases was that their complaints could be construed as being in essence that a HA faced with severe resource constraints had decided to withhold treatment from one patient rather than another. In both cases the judges followed the established principle that a reviewing court must not substitute its own view of the way discretion should have been exercised for that of the original authority. Thus in *ex parte Walker*, Sir John Donaldson M.R. emphasised that it was not for the court "to substitute its own judgment for the judgment of those who are responsible for the allocation of resources,"

63. *Ibid.* at 95, per Denning M.R.

64. [1987] 3 B.M.L.R. 32 [hereinafter *Walker*].

65. *Ibid.* at 34, per Macpherson J.

66. C.A. [1988] [unreported] [hereinafter *Collier*].

since this might simply have the consequence of diverting resources from one patient to another.⁶⁷

While these cases suggest that judicial review on the statutory duty under section 3 alone will not succeed, they leave some uncertainty about the prospects of an action alleging unreasonableness. An important facet of *ex parte Walker* was Sir John Donaldson's acknowledgment that: "[i]f other circumstances arose in this case or another case it might be different, because the jurisdiction does exist . . . [b]ut it has to be used extremely sparingly."⁶⁸ The Master of the Rolls stated that the court "could only intervene where it was satisfied that there was a *prima facie* case, not only of failing to allocate resources in the way which others would think that resources should be allocated, but of a failure to allocate resources to an extent that was *Wednesbury* . . . unreasonable."⁶⁹ This reaffirmed the orthodox position that an authority breaches its public law duty only if in making a decision it fails to take account of matters that should have been considered, or it takes account of matters that it should not have considered, or it acts unreasonably to the point of irrationality.

In the NHS of the 1980s few cases involved circumstances that met these conditions and the public law route was widely perceived to offer little chance of success. Longley, in a review of the position following the *NHSCCA*, drew unfavourable comparisons with the 'hard look' doctrine of American administrative law.⁷⁰ In the U.S. courts, judges have been willing to infer remedies consistent with the general intention of legislation, and to insist that health providers furnish information on the procedural basis of decisions. Longley argued that the 1991 NHS reforms, by making resource allocation more transparent, might open the way for movement in this direction.

Seven years on, there are indications that judges have become more willing to investigate reasons for decisions. *R. v. Cambridge Health Authority, ex p. B*⁷¹ was a landmark case because it demonstrated that the courts might yet overturn resource allocation decisions on "unreason-

67. *Walker*, *supra* note 63 at 35, per Donaldson M.R. For a similar decision see *Re J (a minor) (wardship: medical treatment)*, [1992] 4 All E.R. 614.

68. *Walker*, *supra* note 63 at 35, per Donaldson M.R.

69. *Ibid.* at 35. The *Wednesbury* principles, the usual starting point for the review of administrative discretion in the British courts, originate in Lord Greene's judgment in *Associated Provincial Picture Houses v. Wednesbury Corporation*, [1948] K.B. 223. They set out the circumstances in which a court may intervene to quash an administrative decision as unlawful. A decision may be deemed unreasonable on the grounds of (a) disregard of relevancies, (b) consideration of irrelevancies, or (c) irrationality or perverseness. See M. Fordham, *Judicial Review Handbook* (Chichester: Wiley, 1995) at 267.

70. Longley, *supra* note 57.

71. [1995] 1 F.L.R. 1055 [hereinafter *B*].

ableness" grounds. The case involved B, a ten year-old girl with lymphoblastic leukaemia who had had an unsuccessful bone marrow transplant.⁷² Doctors in Cambridge and London considered that further treatment would be ineffective, but B's father found other experts who believed that another course of chemotherapy might bring benefits. If B's condition improved, a second bone marrow transplant might be possible, though at a total cost of approximately £75,000. The Cambridge Health Authority was asked to purchase the treatment, which could have been funded from its extra-contractual referral budget, but declined to do so. The Authority wrote to the father stating that the decision had been made after taking account of available clinical information, the content of Department of Health guidance on experimental and unproven treatments, and the child's best interests.

In the subsequent High Court proceedings, counsel for the HA stated that these considerations, and particularly the medical advice, had led the HA to conclude that the "substantial expenditure on treatment with such a small prospect of success would not be an effective use of resources." Laws J. granted an application for *certiorari* and quashed the decision, asking the HA to reconsider the case. He criticized the HA for accepting the medical view of what constituted B's best interests without separately consulting the family, and for not explaining the priorities that led them to refuse funding. Laws J. held that: "The ordinary *Wednesbury* principle produces the result, on the facts here, that the respondents have at least failed to have regard to a relevant consideration, namely B's family's views—which are the legitimate surrogate of her own—as to whether the proposed treatment would be in her best interests."⁷³ More fundamentally, he questioned whether a different test of reasonableness might not be required in cases which concerned the right to life: "I entertained the greatest doubt whether the decisive touchstone for the legality of the respondents' decision was the crude *Wednesbury* bludgeon. It seemed to me that the fundamental right, the right to life, was engaged in this case."⁷⁴ Laws J. referred to recent decisions, arising from the European Convention on Human Rights, which established the principle that a public body could not infringe fundamental rights unless it could show "a substantial objective justification on public interest grounds."⁷⁵ Laws J.

72. "B" was subsequently named as Jaymee Bowen.

73. *B*, *supra* note 71 at 12, per Laws J.

74. *Ibid.* at 12.

75. *Ibid.* Laws J. made reference to *Bugdaycay v. Secretary of State for the Home Dept.*, [1987] 1 All E.R. 940 [hereinafter *Bugdaycay*]; and to *Brind v. Secretary of State for the Home Dept.*, [1991] 1 All E.R. 720 [hereinafter *Brind*].

held that this principle required the HA to put forward reasons for the decision, including an explanation of the priorities that led it to decline to fund treatment, the authority having done no more here than “toll the bell of tight resources.”⁷⁶ The decision was quickly overturned by the Court of Appeal, which reasserted the public law orthodoxy. Bingham M.R. said that it would be unrealistic to expect the HA to provide accounts relating to its financial priorities for scrutiny by the court. He did not explicitly address the requirement for “substantial objective justification,” but, on the narrower question of *Wednesbury* reasonableness, found on the facts that the health authority had taken the wishes of the family into account.

Despite this ruling, the High Court judgment provides an important indication of trends in judicial review that may yet affect health care allocation. The issue may be set in the context of a series of recent decisions in which the courts have explored the standard for *Wednesbury* review. In *Bugdaycay* and *Brind*, Lord Bridge said that the more substantial the interference with human rights, the more the court will require by way of justification before it is satisfied that the decision is reasonable. Sir John Laws’ decision reflected the approach that he had advocated in his earlier publications,⁷⁷ specifically his argument that it is open to the courts to apply the principles of the European Convention on Human Rights incrementally through the development of case law, on the grounds that these principles embody values inherent in English jurisprudence.⁷⁸ While such an approach has been supported in a number of first instance judgments, all have been overturned on appeal. In a further recent case where the standard for *Wednesbury* unreasonableness was a central issue, Bingham M.R. re-stated the traditional position:

The greater the policy context of a decision, and the more remote the subject matter of a decision from ordinary judicial experience, the more hesitant the court must necessarily be in holding a decision to be irrational Where decisions of a policy-laden, esoteric or security-based nature are in issue even greater caution than normal must be shown in applying the test, but the test itself is sufficiently flexible to cover all situations.⁷⁹

76. *Ibid.*

77. Sir John Laws, “Is the High Court the Guardian of Fundamental Human Rights?” [1993] *Pub. L.* 59.

78. Recent plans to incorporate the European Convention on Human Rights into domestic law are likely to have a similar effect. It has been claimed that this will transform English public law from a sovereignty-derived system of rules to a more rights-based constitutionalism, and obligate the courts to interpret domestic law to conform with international human rights norms. See M. Hunt, *Using Human Rights Law in English Courts* (Oxford: Hart Publishing, 1997).

79. *R. v. Ministry of Defence, ex p. Smith* (1995), 145 N.L.J. Rep. 1689 (C.A.).

The argument for a more stringent test of reasonableness in the context of decisions affecting the "right to life" intersects with the issue of reasons for decisions in administrative law. At present there is only a limited statutory duty to provide reasons, coupled with common law authority requiring reasons in certain defined situations.⁸⁰ However, in some recent cases judges have decided that reasons should be given on the general principles of natural justice and fairness. Thus in *Doody*, Lord Mustill noted the trend towards greater "transparency" in administrative decisions, and suggested that refusal to give reasons raised questions about fairness which needed to be resolved on the facts of the case.⁸¹ While there is still no general duty to provide reasons, this principle may be gradually undermined as fairness considerations are acknowledged in more judgments. From this perspective, the *B* case may be the starting point for a wider debate on the rights-based arguments and the limits of *Wednesbury* reasonableness in the health service context.⁸²

While *B*, like *Hincks*, *Walker* and *Collier*, involved issues of access to hospital services, an important case from the 1990s related to community care. A group action was brought on behalf of clients affected by the decisions of a number of Social Services Departments to cease providing home care services they could no longer afford.⁸³ The Government had introduced a Special Transitional Grant to meet the increased financial burden falling on Local Authorities, but in 1994/95 the basis of the allocation was changed, leaving many authorities with large shortfalls against planned expenditure. Section 47 of the *NHSCCA* confers a right to have needs assessed, but does not guarantee that services will be provided. However, a person assessed as disabled falls into a special category, since the Act triggers the duty to decide on the services to be provided under s. 4 of the *Disabled Persons (Services, Consultation and Representation) Act 1986*,⁸⁴ which in turn requires the provision of services under s. 2 of the *Chronically Sick and Disabled Persons Act 1970*

80. For a discussion see P.P. Craig, *Administrative Law*, 3rd ed. (London: Sweet & Maxwell, 1994) at 310-15.

81. *R. v. Secretary of State for Home Dept., ex p. Doody*, [1993] 3 All E.R. 92.

82. See R. James & D. Longley, "Judicial Review and Tragic Choices: *Ex Parte B*" [1995] *Pub. L.* 367; A. Parkin, "Allocating Health Care Resources in an Imperfect World" (1995) 58 *Mod. L. Rev.* 867; P. Wilson, "Casenote, Court of Appeal: *R v. Cambridge Health Authority, ex parte B*" (1995) 17 *J. Soc. Welfare & Fam. L.* 359.

83. *R. v. Gloucester CC, ex p. Mayfood*; *R. v. Islington, ex p. McMillan*, *The Times* (21 June 1995); *R. v. Gloucester CC, ex p. Barry*; *R. v. Lancashire CC ex p. RADAR*, [1996] 4 All E.R. 421 (C.A.) [hereinafter *Barry*]. For a discussion see B. Schwehr, "Rational Rationing of Community Care Resources" [1995] *Pub. L.* 374.

84. 1986, c. 33.

(*CSDPA*).⁸⁵ The applicants contended that this placed disabled persons in a different category from other clients, and that the Council was required to provide services in line with assessed needs.

The Divisional Court held that the Council could take its resources into account in assessing needs and deciding what services to provide, but the applicants won a declaration that the council had acted unlawfully on the narrow procedural point that it had ceased providing services without reassessing their personal circumstances. The Court of Appeal went further and found that, under s. 2 of the *CSDPA*, the local authority was not entitled to take account of resources in deciding whether to provide services to meet the needs of a disabled person. Swinton Thomas L.J. said that it would otherwise be possible for an authority to make a “judgment that a disabled person has a need which it is necessary to meet applying objective criteria but they are not required to meet it because of shortage of funds, resulting in an unmet need.”⁸⁶ This would “fly in the face” of the plain language of the 1970 Act.

In the House of Lords this judgment was overturned by a majority of three to two. Lord Nicholls held that needs could not be sensibly assessed without reference to the cost of providing services. He said that the judgment of needs must necessarily proceed against some standards or criteria, which in practice could be set only by the relevant local authority. This would involve balancing the relative costs and benefits, so that “in deciding how much weight is to be attached to cost some evaluation or assumption has to be made about the impact the cost will have on the authority.”⁸⁷ This might have the consequence that eligibility criteria would become more or less stringent depending on the authority’s financial position.

The Lords clarified how the duty to assess needs under the *CSDPA* related to duties arising from other legislation. Lord Clyde noted that s. 2(1) of the *CSDPA* must be read with s. 29 of the *National Assistance Act 1948*, and s. 7 of the *Local Authority Social Services Act 1970*. He said that these statutes required local authorities to exercise their social services functions in accordance with the instructions of the Secretary of State. On this basis s. 2 of the *CSDPA* was “not marked out as anything special or unique in the general regime of social welfare.”⁸⁸ Since a local authority might take costs into account under s. 29 of the 1948 Act, it

85. 1970, c. 44.

86. *Barry*, *supra* note 83 at 439, per Swinton Thomas L.J.

87. *R. v. Gloucestershire CC and Another, ex p. Barry*, [1997] 2 W.L.R. 459 (H.L.), per Lord Nicholls at 470.

88. *Ibid.* at 473, per Lord Clyde.

might be expected that costs would remain a proper consideration under the *CSDPA*, even though s. 2 is “silent” on this matter. Lord Clyde (like McCowan J. in the High Court) drew a distinction between the duty to provide services under s. 2, and the earlier stage of assessment when the local authority satisfies itself as to what resources are necessary to meet the need:

The duty only arises if and when the local authority is so satisfied. But when it does arise it is clear that a shortage of resources will not excuse a failure in the performance of the duty. However neither the fact that the section imposes a duty towards the individual . . . nor the fact that consideration of resources is not relevant to the question of whether the duty is to be performed or not, means that a consideration of resources may not be relevant to the earlier stages of the implementation of the section which lead up to the stage when satisfaction is achieved. The earlier stages envisaged by the section require it to be distinguished from the emergence of the duty.⁸⁹

The effect of the judgment was to set s. 2 of the *CSDPA* firmly within the general community care regime created by the 1990 Act. The view that s. 47(1) of the *NHSCCA* allowed resources to be considered in making assessments of need and providing services, while s. 47(2) of that Act and s. 2 of the 1970 Act did not, was rejected. Lord Clyde held that “section 2(1) is clearly embodied in the whole of the community care regime, distinct only in its particular procedure and the importing of an express duty of performance once the local authority has been satisfied regarding the necessity to make the arrangements.”⁹⁰ The judgment established that local authorities could take resources into account in making assessment decisions, whether or not a disabled person was involved, subject to the usual requirement that they act with *Wednesbury* reasonableness.

Although the legal principles at issue in *B* and *Barry* were not crucially affected by the provisions of the 1990 Act, both cases arose from circumstances closely bound up with the NHS and community care reforms. Indeed, the cases may be formulated in the language of health policy rather than law, as a dispute over whether treatments can be legitimately funded from a finite extra-contractual referral budget, and whether services can be properly withdrawn from clients assessed as needing them as a result of cuts in the central government grant to local authorities. Considered from this perspective, the cases have an obvious contemporary dimension. Counsel in both cases made extensive reference to Departmental guidance on the provision of services after the 1990

89. *Ibid.* at 474.

90. *Ibid.* at 476.

Act. Arguably, the health and social care reforms (which made rationing dilemmas more transparent) provided an important context for the decisions, and may well have influenced those judges who departed from the orthodox approach. The *Barry* case, though turning on the straightforward point of the construction of the statute as containing an absolute duty to provide services assessed as necessary, was notable for the minority's willingness to support such an interpretation, even though it marked a departure from the judiciary's traditional tendency towards restraint in cases with a strong political dimension. *Ex parte B* illustrates that reasonableness is a relative concept, reflecting changing values in society, and that in the 1990s the orthodox *Wednesbury* position has become more difficult to sustain. Although unsuccessful, an attempt was made to articulate principles to deal with the consequences of unreasonable health care allocation decisions comparable to those applied in other areas of administrative decision making. Arguments based upon these principles are likely to re-surface in future cases.

The critical weakness of the British system of judicial review in the health resources arena is that even where the applicants' arguments are accepted by the court, it is unlikely that a remedy will be forthcoming. Thus, in another well-known case from the 1990s where a bone marrow treatment unit was closed without consultation, leaving a child on the waiting list untreated, the court accepted that the closure was invalid but refused to grant a declaration or order.⁹¹ We have suggested that the climate may be changing, and some judges may be prepared to erect boundaries beyond which health authorities pleading lack of resources cannot go. However, it must be emphasized that, even where a decision is found to be unlawful, it is likely that the court would require the authority merely to reconsider the case, rather than forcing a re-allocation of resources.

More directive measures would take the courts into difficult waters of political accountability and expert medical opinion that they have always sought to avoid. One well-established argument against a more active role for the courts is that litigation may favour the patient groups with the strongest voices. McK. Norrie has commented on the problems that might arise if "decisions were made to favour patients on the basis of which patient is likely to go to court, or who is likely to make a fuss in public if

91. *R. v. NW Thames RHA, ex p. Daniels*, [1993] 4 Med. L.R. 364.

there is an adverse decision."⁹² Although the *Barry* case did give one Cinderella group its day in court, the major health resource allocation cases from the 1980s onwards have tended to involve patients with acute, often life-threatening, conditions. Vulnerable groups face formidable obstacles in arguing their case. Moreover, cultural values shape the media reporting and political impact of cutbacks in different services. In this regard the law reflects society and perhaps society is as yet unable to recognize the needs of vulnerable segments of the community.

Conclusion

In summary, British Health Authorities have found it difficult to develop commissioning on the basis of clinical effectiveness and the health needs of their local populations, in the way envisaged in early policy documents, and have done little to achieve a more equitable distribution of resources. Nor have the courts shown themselves willing to provide redress to patients who suffer because services are curtailed or withdrawn, although it is possible that judges' attitudes to such cases may be changing. Given these limitations, the British experience is not an especially attractive model for others to follow. The implications for vulnerable populations must be weighed against any economic advantages that internal market reforms might bring.

Before turning to any more specific lessons for Canada it is important to recall the uncertainties that apply to all attempts to learn from other countries' experiences. There has been a growing realization that the importation of health service reforms from other states is more problematic than many supposed.⁹³ Before emulating the British example, questions should be asked about whether the NHS experience can be replicated (even partially) in other countries, how far elements of that system can be transplanted elsewhere, whether the alleged benefits of the NHS system are based on research evidence, and whether positive features of the indigenous system will be sacrificed.

One of the recurrent themes of the recent *ESRC Contracts and Competition Research Programme* is that the NHS reforms were shaped to a greater extent than is commonly acknowledged by the system that pre-dated them.⁹⁴ The nature of contracting, in particular, is influenced

92. K. McK. Norrie, "Resource Allocation in Health Care: The Role of the Courts" in U.J. Jensen & G. Mooney, eds., *Changing Values in Medical and Health Care Decision Making* (Chichester: Wiley, 1990) at 176.

93. C.D. Collins, A.T. Green & D.J. Hunter, "International Transfers of Health Care Reforms: Problems and Issues" (1994) 344 *Lancet* 248.

94. Flynn & Williams, *supra* note 6.

by relational networks and organizational cultures that are highly resistant to change. Contracting operates in parallel with established processes of planning and strategic management, and is not necessarily the dominant influence on the production of health care. Arguably, the achievements of the 1990s, including the significantly increased volumes of treated patients and the remarkable ability of the workforce to implement fundamental organizational change within planned timescales, had less to do with new incentive structures (the market could not bootstrap itself into existence) than with long-established service networks and systems of administrative regulation—things that, paradoxically, the reforms were intended to sweep away.

At a time when international health reform is adopting a common language and a standardized repertoire of market-driven change, we need to recognize that when the orthodox reform package is overlaid on systems which have different cultural and organizational frameworks, it may produce strikingly different results. The organization of Canadian health care is decentralized and complex, less a federal system than a collection of provincial systems with different histories and priorities. No single reform template would be appropriate, and even selective attempts to import market “elements” would play out in different and somewhat unpredictable ways in different provinces when they encountered a variety of local requirements.

Against this backdrop any apparent lessons from Britain for the Canadian system should be advanced with caution. The benefits of the internal market have been contested on a number of grounds, not least in relation to rising transactions costs, duplication of facilities by competing trusts and equity of access. On the central topic of this paper—the balance between the acute sector and primary and community health services—the reforms appear to have made little difference, although it is possible to discern a subtle tilting of the balance towards the acute sector. Given the problems that have arisen in changing the status quo under the different systems of the 1980s and 1990s, it is questionable whether NHS reforms at the structural or organizational levels make a real difference to resource allocation behaviour. Arguably, existing resource allocation patterns are shaped by a range of social and cultural influences, including professional power, medical and nursing socialization, institutional histories, media reportage and public attitudes. These forces operate at a more fundamental level and change relatively slowly.

The British experience shows that the period of reform associated with the efforts to create an internal market has not been a propitious time to attempt to reallocate resources more equitably between sectors, and may actually have had unanticipated negative effects. The launching of the

new system involved the largest accountancy exercise ever undertaken in the NHS and put considerable strain on the system. Such activities as health needs assessment and purchasing for "health gain" were inevitably given a lower priority than the basic work of financial management and development of contracting systems. Beyond this, the reforms accentuated cost pressures from acute hospitals by casting them in a "flagship" role, and selecting waiting times as a test of success. When the viability of these hospitals was threatened by rising admissions, partly through increasing numbers of emergency cases, extra resources were consumed. Similar activity trends have been reported in some Swedish county council areas which have implemented internal market arrangements, and where (as in Britain) hospital revenue is dependent on patient throughput.⁹⁵ Arguably, more attention needs to be given to changing the structure of incentives for referring doctors and hospitals.

Countries determined to push ahead with market-oriented reforms might also be well advised to ensure that arrangements to safeguard primary and community health care are in place from the beginning. Market systems are not inherently supportive of decentralized primary care based services, which may find it more difficult than secondary services to develop contract currencies and information systems.⁹⁶ Although British policy makers recognized the importance of primary and community care (not least by the support given to fundholding), there were problems of organizational coordination and it became necessary to take remedial action to give new direction to the reforms. The *Health Authorities Act 1995*⁹⁷ is seen by many commentators as a necessary corrective step, which reflected the rushed timescale of the 1990 legislation and the belated recognition of the need to bring primary and secondary care into a single management framework.

A final point is that it sometimes helps to see the endpoint before embarking on a course of action, and in the case of Britain's "health care experiment" the endpoint is not yet clear. By the time the studies reported above were completed, the HA commissioning model was being cast into doubt by moves to augment the purchasing role of general practitioners. The British Labour Party's victory in the May 1997 election has intro-

95. A. Bruce & E. Jonsson, *Competition in the Provision of Health Care: The Experience of the U.S., Sweden and Britain* (Aldershot: Arena, 1996).

96. Collins, Green & Hunter, *supra* note 90, discuss the damaging effects market reforms have had in some developing countries where primary health care strategies had led to advances in areas like community participation, decentralization and multi-sectoral approaches to health.

97. 1995, c. 17.

duced further uncertainty about the future shape of the NHS. Although the Labour Party had pledged to abolish the internal market, no bill for this purpose was included in the new Government's first Queen's speech. At the time of writing, some limited steps have been taken to curtail the GP fundholder scheme and reduce the administrative costs of contracting.⁹⁸ Many commentators consider that the purchaser-provider split will remain, but that annual contracts will be replaced by multi-year service agreements within a planning rather than a competition framework. There are some indications that the emphasis on a primary care-led NHS will continue, although the fundholding scheme is likely to give way to some version of locality purchasing led by general practitioners. It may be that policy makers presently enamoured with the British model will want to await future developments before replicating aspects of a system that now seems set to be dismantled. If health care reforms are introduced precipitately, there is a real danger that vulnerable populations will suffer.

98. For recent guidance see: U.K. NHS, *Changing the Internal Market*, NHS Executive Circular (Executive Letter) EL(97)33, (London: DOH, 1997).