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Shaping Up to Improve Health: The Strategic Leadership Role of The New Health Authority

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DISCUSSION PAPER 162

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Contents

ABSTRACT

The latest return to service planning in the NHS, while harnessing the perceived benefits of previous market approaches, nevertheless signals a radical change in the long-term role of the Health Authority. It is timely to examine the actual objectives of Health Authorities in view of their envisaged strategic leadership role. The emphasis on improving health and ironing out unacceptable local inequalities places the 'quality' agenda at the forefront of Health Authority policies. Notwithstanding the role of Regional Offices, Health Authorities will in effect become the overseer of clinical governance arrangements, including the implementation of a more evidence-based approach to service delivery and organisation. The new all-inclusive Health Improvement Programmes represent the *raison d'être* of the Health Authority of the future.

It is argued that insufficient attention has been paid to the legal framework required to support prioritisation decisions for which Health Authorities and PCGs will be held accountable. Available case law suggests that the extent to which central guidance has been followed will be critical in reviewing commissioning decisions. Given the trend towards National Service Frameworks and the development of the National Institute for Clinical Excellence, the question arises of what incentives exist for Health Authorities to pursue the evidence-based approach to its natural conclusion (ie. as one means of rationing scarce resources). Perhaps the key objective of commissioners will in fact be to avoid adverse publicity in the face of increasingly complex (and open) rationing decisions. In addition, the implication that national guidelines on clinical and cost-effectiveness will have to be adhered to sits somewhat uneasily with recent government assurances regarding clinical freedom and professional self-regulation.

Attention is given to equity considerations, the difficulty of identifying common objectives and maintaining productive relationships across organisations, and barriers to changing clinical practice. Conflicting incentives are likely in applying different dimensions of the National Performance Assessment Framework, making the Health Authority's long-term role (regulator of resource use, quality and service configuration?) a particularly difficult balancing act in ensuring administrative, clinical and political accountability in health care.

INTRODUCTION

The role of the Health Authority in the United Kingdom NHS has been the subject of debate for many years, heightened by the more recent reforms of both 1989 and 1997 [1,2]. Pre-1989 there were 192 old District Health Authorities (DHAs) in the fourteen Regional Health Authorities in England. During the 1990s there has been a trend towards reducing the number of Health Authorities: in 1995/96 there were around 110 DHAs with populations ranging from 92,000 to over 900,000 [3]. In 1997/98 there were 100 Health Authorities in the eight English Regions (with a range of 9-16 Health Authorities per Region) [4], on average covering populations of about 450,000 people [5]. Another important trend has been the merger (formally from April 1996) of DHAs and Family Health Services Authorities (FHSAs) to create unified Authorities. The boundaries of FHSAs differed for historical reasons from those of DHAs: in 1995/96 there were 90 FHSAs serving populations ranging from 120,000 to 1,600,000 people. Given that FHSAs existed to manage the services provided by general practitioners (GPs), dentists, community pharmacists and opticians, the creation of unified Authorities was intended to integrate services across primary and secondary care boundaries.

Such structural changes have resulted in fewer, larger Health Authorities with wider roles and responsibilities. The rationale for this evolution during the 1990s was partly to counter-balance the increased power of hospital Trusts in the internal market which developed following the 1989 NHS reforms. In effect the creation of unified Health Authorities would strengthen the negotiating power on the demand side of the market. Not surprisingly this has led to situations of bilateral monopoly in many geographical areas, undermining the notion (explicit in the 1989 White Paper) that competition would drive improvements in efficiency. In addition, the merger of DHAs and FHSAs was based on the rationale that integrated (or "seamless") care would only be achieved if historical boundaries between care sectors disappeared.

The objective of this paper is to examine the long-term role of the Health Authority in the light of recent major policy developments. Consideration is given initially to the nature of the Health Authority as an entity, including a brief examination of some legal and accountability issues. Given the consistency - despite the changing political scene - in the development of larger, more strategic Health Authorities, major policy developments from 1989 are considered before assessing the implications of the most recent reforms. Following this, the objectives of Health Authorities are discussed, focusing largely on the long-term role which is implicit in the development of Health Improvement Programmes (HImPs). One particular aspect - the development of clinical governance and the implementation of evidence-based health care - is considered in some detail since it is central to the new 'quality' agenda and the widening of accountability within the NHS. Before considering the nature of the Health Authority, however, it is important to place recent developments in the structure of the NHS in an economic context.

MARKET AND PLANNED APPROACHES TO HEALTH CARE

Few people would subscribe to a pure market model in health care, just as it has increasingly been accepted that some elements of a market approach can lead to dynamic efficiency. As Kornai (1971) pointed out in relation to economic systems generally: "To ask, 'Planning or market', is to ask the wrong question. Rather what we must deal with are two, complementary control sub-systems of the complicated and complex economic system" [6]. Similarly in the case of health care, a balance must be struck to reap the benefits of both market and planned approaches.

This is (arguably) borne out by the way in which the internal market in the NHS developed following the 1989 reforms. Individual initiative and enterprise from GP fundholders and some NHS Trusts led at least in some cases to a feeling of greater internal efficiency and possibly greater patient choice[1]. On the other hand, a market-orientated system raised concerns about the associated level of transaction costs. As GP fundholding developed - in particular towards total purchasing in some areas - the danger of fragmentation increased, possibly losing some of the benefits of a more co-ordinated system.

All of this suggests that the concept of a ‘planned’ (or managed) market in health care is the most relevant one for the NHS. As Arvidsson (1995) points out, a planned market differs from a regulated market in one crucial respect: the existence of a principal [8]. A planned market implies that someone plans for the system and has the authority to guide activities. In a regulated market, although there are rules governing the actions of individuals and organisations, there is no principal informing them what objectives to pursue and what activities to undertake. Instead these are governed by market forces.

In the case of health care, government policy usually states the overall objectives, as well as dealing with issues of resource allocation and financial control. In these respects, planned and regulated markets in health care are essentially the same. However:

“The crucial question concerns the government's authority and accountability. In a planned market, government can legitimately intervene by fixing prices, setting production targets or making structural changes..... These are the responsibilities of a principal. In the case of a regulated market, government responsibility concerns the operation of the market, or rather the outcome of market operations. In addition to laying down the rules for market operators, government may act as an operator itself - that is, as a buyer or a seller" [8].

[1] See, for example, Smee (1995): "there is much evidence that individual Trusts are taking advantage of their freedoms to innovate and improve services"; "Trusts are proving more effective in meeting patient expectations"; and in relation to GP fundholders: "as self-employed small businessmen, they have shown themselves highly responsive to market signals.....there is other evidence suggesting that the existence of budget constraints is encouraging efficient purchasing" [7].

Arvidsson points to the Swedish case in which planned and regulated markets co-exist. In Swedish health care, national government acts as a market regulator, whereas regional governments assume the role of the principal of regional, planned markets.

This framework is helpful in assessing where the NHS lies on the continuum between market and hierarchy. Arvidsson suggests that the NHS may provide an example of a planned market at local level, where regions and districts have typically been responsible for public health promotion and the purchasing of health care services, but the system relies upon autonomous providers for the actual provision of services. This leaves open the question of the government's role: for example, the model could involve a regulated - not planned - national market for health care. Here the government would assume the role of regulator of general conditions for local market operations, possibly also setting standards and evaluating outcomes. Conversely, if the government wished "to enforce a national policy by being directly involved in the investment and production decisions, the result would be a planned national market" [8].

Clearly the balance between markets and planning raises wider issues about the role of government, and in particular the nature and extent of regulation required. An obvious interim conclusion is that the best way forward is to secure the benefits of a planned system (predicted to be economies of scale and scope, with non-duplication of services), while still harnessing the dynamic benefits of the market approach (predicted to be greater productive efficiency and patient choice). This leaves open the exact nature of regulation of purchasers and providers, and whether this is best achieved regionally or nationally.

The 1997 reforms can essentially be viewed as a return to the spirit of service planning. They mirror in health care the general thrust of the new Labour government’s approach to the economy in general: harnessing the benefits of the market with a traditional planning model, recognising the need for regulation to minimise the effects of market failures. In this respect the latest reforms represent a clever balance: on the one hand giving the impression that local health care decisions will be placed in the hands of doctors and nurses who are perceived to be the closest agents of patients; and on the other hand strengthening considerably the hand of local Health Authorities which will have a major strategic planning role. Through the (increasingly larger and fewer) Health Authorities, and in turn through the Regional Offices of the NHS Executive, the central hand of government will exert a tight control over the commissioning and provision of health care.

This control has for some time been evident in issues of financial stewardship, whereby local Chief Executives are accountable to the NHS Executive, and ultimately, through the NHS Chief Executive, to Parliament. “In this way it is intended that vertical accountability, at least on issues of financial stewardship, should complement rather than inhibit local decision making and accountabilities” [9]. Perhaps the single most important element of the latest reforms is the complementary emphasis on accountability for issues of **quality** in health care. Chief Executives at a local level will be responsible for ensuring a high quality of care at both primary and secondary care level. The most tangible evidence of this

strengthening of accountability can be seen in the strong line of accountability from Primary Care Groups (PCGs) to Health Authorities (an issue returned to later). Clinical quality will be examined and monitored both in terms of the commissioning decisions which are made by Health Authorities and PCGs and the care which is delivered by GPs and their Primary Health Care Teams (PHCTs).

In many ways the latest reforms will perpetuate the managed (or planned) market which arose from the 1989 reforms, although the greater emphasis on equity considerations (discussed later) is an important development. Regional Offices will continue to exist in the short-term, acting in effect as regulators of Health Authorities and NHS Trusts through the performance management framework. As the structure of the 'planned market' develops, it is increasingly difficult to envisage a future role for these Regional Offices. The predicted trend will be towards a bilateral monopoly situation, with fewer and larger Health Authorities on the demand side, and increased co-operation or collaboration between providers on the supply side. In theory the emergence of PCGs is designed to increase local choice and superficially gives the appearance of competition on the demand side, but the power of the Health Authority to guide events (through the HImP) should not be under-estimated. In addition, it is not clear that GPs will demonstrate much enthusiasm or commitment to the latest reforms and their new, wider commissioning role - at least not until the incentives for their co-operation have been resolved.

If PCGs develop along the lines envisaged in the White Paper, with a natural extension to Primary Care Trusts, then the role of the Health Authority will become more naturally that of local regulator of resource use, quality and service configuration. In these circumstances the role of the regional tier will effectively disappear. Larger Health Authorities will assume this role either through formal merger or at the very least through more sharing of information and core services, for example in the area of providing an evidence base to support commissioning decisions.

After the developments of the last ten years or so, it is difficult to envisage any UK government returning to either a pure market or a pure central planning model to underpin its approach to improving health and health care. The planned or managed market is here to stay, with regulation focusing increasingly on both financial and qualitative aspects of health care delivery.

WHAT IS THE HEALTH AUTHORITY?

Writing this paper has raised the somewhat fundamental question of what type of organisation the Health Authority is likely to be in the future. The words of the White Paper give clues as to its new strategic role; service planning is back in vogue if not in name; there are some obvious parallels to the 1989 reforms, for example in the health needs assessment role; but what will the Health Authority be as an organisation?

It does not directly provide health care, and in future much of its direct purchasing role will be devolved to PCGs, which in turn have the option to apply for NHS Trust status. While Regional Offices exist, it is not clear that Health Authorities have a regulatory role, although in practice this task may indeed lie with Health Authorities locally. The process of conciliation in the NHS will remain at least in the short-term the responsibility of Regional Offices.

The Health Authority has no line management responsibility for hospitals which provide health care services. It has statutory responsibility for the development of PCGs, but many of the players in these new groupings (GPs) will remain as independent contractors in the NHS.

The Health Authority is partly the advocate of the consumer but where does that leave Community Health Councils (CHCs)?

In truth the Health Authority of the future will have many and diverse roles, but it remains difficult to describe the Health Authority in organisational terms. It will not be a provider, a purchaser (except for specialist services) or an explicit regulator - so what will it be?

A useful starting point in addressing this question is to explore some of the legal considerations[2]. The first point to make is that the National Health Service is in law part of the services of the Crown, which "is one of the most curious departments of English administrative law" [12]. Since the inception of the NHS, duties have been imposed on various NHS bodies (such as the old Regional Hospital Boards): duties which, as Wade (1971) notes, "are probably not *legal* duties at all, in the sense that they can be enforced by legal process" [12]. For example, the opening words of the National Health Service Act (1946) state that:

"It shall be the duty of the Minister of Health....to promote the establishment in England and Wales of a comprehensive health service.....".

The Health Authorities Act (1995) completed the NHS reforms which were commenced in 1989, creating the new unified Health Authorities following the

[2] For an excellent discussion of the whole issue of public law and health service accountability, see Longley (1993) [10]; in addition, Allen (1997) focuses upon the legal framework of the NHS internal market, with an informative discussion of the nature of NHS 'contracts' and the process of conciliation in the resolution of contractual disputes [11].

merger of DHAs and FHSAs. The Act placed a duty on these unified Authorities "to take the advice they need to fulfil their functions from doctors, nurses, midwives and other persons with professional expertise in and experience of health care". Although these examples of duties are imposed by statute, "it seems plain that it must be by political rather than legal means that they are to be enforced" [12, pp. 157-8].

This distinction between administrative and political accountability is reinforced in a recent paper discussing the accountability of Total Purchasing Pilots (TPPs) [13], which as formal sub-committees of Health Authorities were subject to the same accountability mechanisms (which will also be the case for the emergent PCGs). The Secretary of State is formally accountable to Parliament for the performance of Health Authorities, and in turn Health Authorities are 'downwardly accountable' to the public: for example via the need for open Health Authority meetings and the statutory responsibility for having local functioning CHCs.

Through such mechanisms, and as public bodies within the NHS, Health Authorities can therefore be viewed as the statutory 'agents'[3] of the Secretary of State for Health, and will be held to account via the political process and the usual remedies of public law [12]. Where there is an application for judicial review, it is likely that cases will hinge upon procedural issues concerning *how* a decision is made, rather than the content of the decision itself. Dixon *et al.* [13] highlight the important aspect of **clinical** accountability as an additional dimension in the NHS, since health professionals are accountable for their clinical behaviour to their respective professional bodies. This aspect of accountability is expected to assume considerably more importance with the advent and development of clinical governance arrangements in different care settings. This topic will be returned to later with reference to specific examples.

The importance of these legal and accountability considerations lies in addressing two fundamental issues. Firstly, the statutory duties (whether or not they can be legally enforced) placed upon Health Authority Boards and Chief Executives will influence the objectives which they pursue. Secondly, they will influence the relationships which develop between Health Authorities and other organisations. Before addressing these issues, it is necessary to consider the developing role of the Health Authority in view of recent government reforms to the NHS.

[3]Although not in the legal sense of the term 'agent', since there is no legally binding contract of agency between them [11].

THE DEVELOPING ROLE OF THE HEALTH AUTHORITY

The 1989 White Paper

The purpose of this section is to examine what the DHA's role was envisaged to be in the 1989 reforms, enacted in the NHS and Community Care Act of 1990. In essence DHAs, as the main purchasers of health care services, had as their primary role to secure measurable improvements in the health of their resident populations. This would be achieved through the development of a practical and workable approach to assessing health needs and purchasing services to meet those needs [14]. Directors of Public Health in Health Authorities would have responsibility for the health needs assessment process, and results from this would be incorporated within contracts directly or through the use of clinical guidelines, protocols and service specifications.

NHS Management Executive guidance issued in March 1991 [15] envisaged three separate, but linked, elements of health needs assessment to be undertaken by DHAs:

1. epidemiological assessments which collated information on prevalence, incidence, effectiveness and cost-effectiveness in particular areas;
2. comparative assessments encompassing factors such as demography, price, quality and process efficiency;
3. adoption of a corporate stance encompassing the views of different groups.

In short, the role of the Health Authority as main purchaser of health care services should be informed by valid and reliable epidemiological and economic information. Secondly, in the decision-making process, Health Authorities were expected to take into account the views of different organisations, including FHSAs, GPs and local authority social services [16] in what became known as the development of "healthy alliances". Considerable emphasis was also placed upon the principle of involving local people in the decision-making process [17], although the guidance steered carefully away from any real issues of rationing or prioritisation in situations where public and professional opinions might differ, or where there would be a significant difference between expectations and affordability. This was hardly surprising: Redmayne *et al*. (1993) noted that "the Secretary of State has made it clear that she does not want to move towards explicit rationing" [18]. An analysis by the authors of commissioning Authorities' 1993/94 purchasing plans indicated that:

"Priority setting...continues for the most part to be implicit, as does the consequent rationing. Non-decisions are as important in this respect as decisions: that is, a purchaser who decides not to spend extra money on a particular service may, in effect, be rationing availability and access just as much as one who announces that specific procedures will be excluded" [18, p.36].

The point is that explicit rationing was not perceived as part of the role of the Health Authority, even though the logic of the health needs assessment process (as described above, including taking into account cost-effectiveness evidence) suggested that this was in fact the primary role of the main purchaser.

Towards a primary care-led NHS

In January 1995 the Conservative government issued the policy document "Developing NHS Purchasing and GP Fundholding: towards a primary care-led NHS" [19]. This document envisaged three key roles of the new Health Authority, summarised as strategy, monitoring and support. Central to these roles would be the following three elements:

i. to develop and implement a local health strategy;

ii. to work in collaboration with GPs, NHS Trusts, local agencies and local people;

iii. to develop a coherent view of the health needs of the local population.

The same document also outlined an extension of GP fundholding, with new options for 'community' as well as 'standard' fundholding, designed to encourage more and more GPs to hold their own budgets for a defined range of services. In addition the notion of 'total purchasing' was introduced whereby in a number of pilot sites the Health Authority would relinquish virtually all of its direct purchasing power, thereby extending the range of services which GP groups (TPPs) could purchase. The policy document is highly significant since it continued the drive towards placing more and more purchasing decisions at primary care level, leaving the Health Authorities to take the strategic leadership role. Explicit elements of this role were: to continue to develop alliances with other organisations in meeting health and health care targets (for example in accordance with the Health of the Nation [20]); to support primary care decision-makers, for example by providing information on clinical and cost-effectiveness; and to monitor, in collaboration with GPs, the quality and standards of care of hospital providers [21].

The 1997 White Paper

The latest reforms give Health Authorities a clear strategic leadership role which is highly consistent in tone with the evolution of Government policy through the 1990s:

"Health Authorities will give strategic leadership on the ground in the new NHS. They will lead the development of local Health Improvement Programmes which will identify the health needs of local people and what needs to be done to meet them. Health Authorities will work closely with NHS Trusts, the new Primary Care Groups, Local Authorities, academic and research interests, voluntary organisations, and the local community in devising this new strategic approach to the planning and delivery of health care." [2, para.4.1, p.24].

Given that the 1997 White Paper is set within the context of the same medium-term priorities for the NHS [22] as those under the previous administration, this consistency is hardly surprising. The increased emphasis upon (for example) the underlying evidence base, quality standards, public involvement, multi-agency working, and focusing upon health not solely health care are all largely continuations of trends which were occurring anyway. What, then, is radically different about the 1997 White Paper?

Before addressing this question it is important to summarise the envisaged future role of the Health Authority from the 1997 White Paper. The over-arching 'leading and shaping' role contains a number of key tasks:

- **assessing the health needs** of the local population, drawing on the knowledge of other organisations;

- drawing up a strategy for meeting those needs, in the form of a **Health Improvement Programme**, developed in partnership with all the local interests and ensuring delivery of the NHS contribution to it;

- deciding on the **range and location of health care services** for the Health Authority's residents, which should flow from, and be part of, the Health Improvement Programme;

- determining **local targets and standards** to drive quality and efficiency in the light of national and local priorities and guidance, and ensuring their delivery;

- supporting the **development of Primary Care Groups** so that they can rapidly assume their new responsibilities;

- **allocating resources to Primary Care Groups**;

- **holding Primary Care Groups to account**.

Source: "The New NHS: modern, dependable" (1997) [page 25, para 4.3]

These tasks can be summarised into two major distinct (but not unrelated) roles:

1. to develop an all-inclusive Health Improvement Programme reflecting important health needs and addressing important health care service issues, with commonly agreed objectives, standards and targets across partnership organisations;

2. to develop PCGs and monitor their pace of change, ensuring appropriate resource allocation mechanisms are in place to facilitate this within a clear accountability framework.

The first of these represents the long-term *raison d'être* of the Health Authority: the strategic planning role aimed at improving health (involving all relevant agencies and the public) in agreed national and local priority areas. The second area, while important, is at least in theory a time-limited role, if PCGs progress quickly through the levels described in Table 1 below:

Table 1: Levels of PCG development

Level	Description
1	at minimum, act in support of the Health Authority in commissioning care for its population, acting in an advisory capacity
2	take devolved responsibility for managing the budget for health care in their area, acting as part of the Health Authority
3	become established as free-standing bodies accountable to the Health Authority for commissioning care
4	become established as free-standing bodies accountable to the Health Authority for commissioning care, and with added responsibility for the provision of community services for their population

Source: adapted from "The New NHS: modern, dependable" (1997) [page 35]

The future role of the Health Authority will continue to involve the resource allocation element, and indeed certain functions to support PCGs can be expected to remain with the Health Authority (eg. commissioning of dental services, clinical audit to support primary care), but the central rationale for the existence of Health Authorities must hinge upon the first of these major roles.

It is argued here that there are four ways in which the latest reforms signal a **radical** shift in policy emphasis with respect to the role of the Health Authority. Firstly, and perhaps least tangible, is the shift in the power base back towards Health Authorities. The 1989 reforms offered NHS Trust providers significant capital and labour market freedoms (regardless of whether these were realised) and the possibility - if not the financial incentives ultimately - to behave entrepreneurially, seeking to maximise income from different purchasers, forging alliances with private sector providers, pricing competitively, raising quality standards to attract 'business', and so on[4]. The 1997 reforms, however, place the Health Authority in a clear "leading and shaping" role, embodied in the Health Improvement Programme (HImP) which is the strategy for meeting health needs, drawn up in partnership with all relevant local interests.

The HImP signals a return to service planning, given the constituent parts which broadly cover: the most important health needs, the main health care requirements of local people, and the range, location and investment required in local health services to meet the needs of local people. The responsibility for developing this three-year planning framework lies squarely with the Health Authority which, although it must undertake this collaboratively, will ultimately be held to account for meeting targets outlined in the HImP. Additionally, it is clear that Health Authorities will be able to

[4] Note that it is not being argued here that these were benefits of the internal market, nor that NHS Trusts in general even acted in these ways. What is being argued is that this was the philosophy behind the 1989 reforms, offering providers significant freedoms to develop their organisations as if they were operating in a private sector environment (hence the frequently-used term 'quasi-market' to describe arrangements in the new purchaser / provider world). Although anecdotal, it is undoubtedly true that NHS Trusts in the early years of the reforms attracted the top NHS management to senior posts, as well as recruiting in significant numbers from the private sector. This must have been some indication of the prestige attached to working in NHS Trusts as opposed to Health Authorities.

hold others to account in ensuring delivery of the NHS contribution to the Programme.

Herein lies the second radical change in emphasis in the 1997 reforms: the statutory accountability of PCGs to Health Authorities. Figure 1 indicates this change in the statutory line of accountability, as well as the line of service accountability to secondary care Trusts. As shown in Table 1, the White Paper outlines four levels at which PCGs might operate, and it is unclear to what extent and at what pace PCGs will be expected to progress from Level 1 through to Level 4. While PCGs remain at Levels 1 and 2, they will be constituted formally as sub-committees of the Health Authority, with the Chairs of PCG Boards being directly accountable to the Chief Executive of the Health Authority [23].

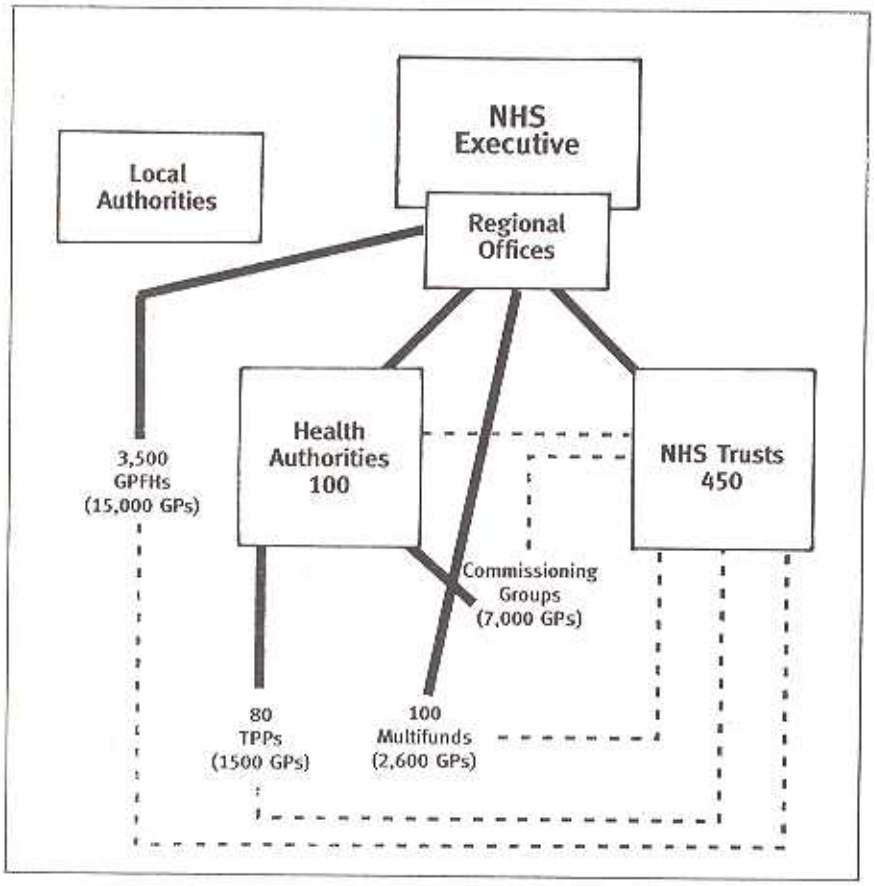
At this stage most of the evidence regarding the level at which PCGs will operate is anecdotal. Early development work has focused upon the size and configuration of PCG groupings, with more recent guidance [23] concentrating on issues of process such as the composition of PCG Boards. It is not clear what degree of enthusiasm exists amongst GPs to develop the commissioning role of PCGs beyond Levels 1/2. Similarly, it is unclear how much pressure will be exerted from central government to progress towards Primary Care Trust status.

The HImP represents the planning framework within which all of the relevant organisations, critically including Local Authorities, must operate to meet important health targets. Primary Care Groups of GPs and other health care professionals will not be able to make independent commissioning decisions *which are inconsistent with the agreed HImP*, one aim of which will be to ensure that patients on the lists of all GP practices are treated equitably, in the sense that they are part of the same commissioning framework (thereby ending the two-tier system of fundholding / non-fundholding and potentially unequal access to health care resources).

Thirdly, a major change for the Health Authority is the devolution to PCGs of direct purchasing for all primary and secondary care services. Over time it is envisaged that Health Authorities will retain the direct purchasing function for specialist services only. In practice, however, it is less clear at what pace PCGs will develop through the different levels. Experience from the evaluation of TPPs [24] suggests that PCGs will inevitably develop at different speeds: for example, large multi-practice pilots were reported as needing more time for organisational development before progress could be made. This suggests that Health Authorities will retain the direct commissioning role for longer in the case of some PCGs, although the expectation is that ultimately they will relinquish this role, except for specialist services.

Finally, Health Authorities will have reserve powers to ensure that major investment decisions - such as capital developments or new consultant medical staffing appointments - are consistent with the HImP. This is potentially a radical step, reinforcing the shift in balance of power to the Health Authority, assuming that the reserve powers are used effectively. 'Purchaser support' for major investment decisions could actually become a real lever for ensuring that change takes place when it is required, and equally for preventing changes which are not considered necessary by all parties to the HImP.

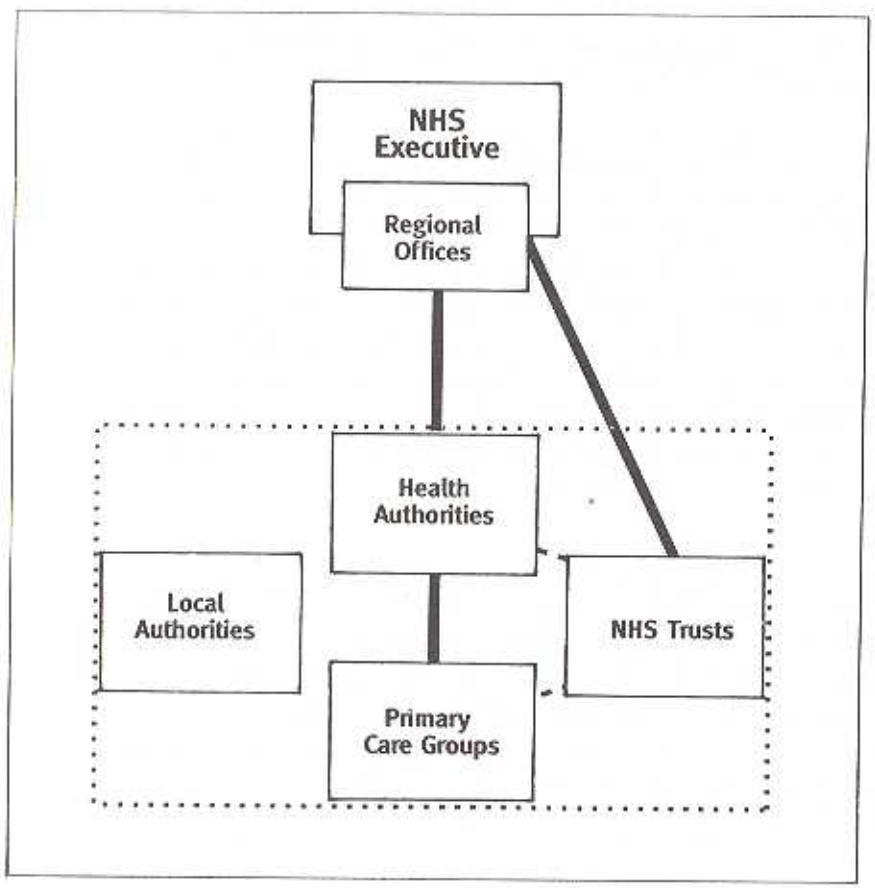
Figure 1: **Financing and accountability arrangements in the new NHS compared with the old**



The old NHS

accountability

contract



The new NHS

statutory accountability

service accountability

Health Improvement Programme

There is a fifth way in which the White Paper is radical, and although not relating directly to the Health Authority's role, is critical nevertheless. This is the "extension of corporate governance from financial to clinical matters" [25]. The White Paper contains a set of proposals for ensuring that the performance management framework gives a stronger emphasis to issues of quality, including proposals for the establishment of a National Institute for Clinical Excellence (NICE) and a Commission for Health Improvement. Ministerial statements have reinforced the new statutory duty for quality for which officers in PCGs and Trusts (both primary and secondary care) will be held accountable [26].

Through the HImP, Health Authorities will have a central role in ensuring that the outputs of NICE, including National Service Frameworks, are used to inform decision-making on the basis of the best available evidence. This issue is returned to later; for now it is sufficient to note that a key role of the Health Authority will be to ensure that appropriate frameworks exist for ensuring clinical governance in primary and secondary care. In practice the expectation is that this will be achieved through the HImP, "determining local targets and standards to drive quality and efficiency in the light of national priorities and guidance, and ensuring their delivery" [2, para.4.3, p.25].

HEALTH AUTHORITY OBJECTIVES

Remarkably little has been written about the formal objectives of Health Authorities, an understanding of which is critical to predicting behaviour arising from any set of reforms. Part of the difficulty lies in the inevitability that the objectives of any large organisation are multi-dimensional, complicated by the fact that principal-agent problems exist within organisations (eg. do all Health Authority employees work wholly, or even primarily, on the stated objectives of the organisation?). Leaving aside the problems arising through what will inevitably be imperfect agency relationships, it is worth exploring what these objectives are likely to be following the latest NHS reforms.

Health Authority objectives will reflect a combination of inputs from the non-executive members and the executive directors (officers) of the Authority. Overall goals will translate into strategic and then operational objectives which at least in theory will be reflected in the workplans and individual objectives of all Health Authority staff groups, both professional and managerial. Given this filtering of information throughout the organisation, the most accurate reflection of Health Authority objectives is likely to be contained in the personal objectives of the Chief Executive, which clearly will be influenced by the views of non-executive members, including the Chair of the Health Authority. Depending on the style of the Chief Executive, this could be caricatured by "shared responsibility", "common goals and objectives", or, more cynically, "my problem is your problem". Analogously, as Black (1998) notes with respect to the development of clinical governance: "making trust chief executives personally responsible for the clinical performance of their services might prove to be just the incentive needed" (to realise the good intentions of increasing the focus on quality) [25].

It is reasonable to postulate that a key constraint for Health Authorities will remain the need to maintain financial control [27]. Although it appears that the annual budget-setting round will move to a three-year cycle [28], Health Authorities will nevertheless be subject to a relatively tight budget constraint which in practice will require close in-year financial monitoring. Other developments such as the devolution of larger budgets to PCGs will almost certainly mean that Health Authorities exercise **more** financial control in the face of greater perceived risk. The statutory accountability of PCGs for their commissioning decisions inevitably means that Health Authorities cannot absolve themselves of responsibility for the use of resources once those resources have been allocated.

The over-riding high-level objective of Health Authorities is clearly to improve the health of their resident populations. Increasingly it is being recognised that this requires a multi-agency, intersectoral approach to tackle the root cause of health and social problems, which typically can only be affected marginally by the health care sector. Health Authority Chief Executives will be careful to ensure that they are held to account on realistic objectives and targets which will focus on delivering what the NHS can contribute to these wider health and social problems. [The White Paper makes it clear that Health Authorities, while responsible for drawing up the HImP to meet the health needs of local populations - developed in partnership with all local

interests - are responsible primarily for *ensuring delivery of the NHS contribution to the Health Improvement Programme*].

In practice, therefore, the high-level objective of improving health will involve Health Authorities focusing on what can realistically be delivered by the health care sector. The implication of the above arguments is that the economic problem of Health Authorities can be expressed formally in conventional terms:

max. H s.t. M = **p**.**x**

where H = health
M = budget constraint
p = vector of all health care prices
x = vector of all health care services (activity)

This does not, however, take us very far: the budget constraint, as already argued, can be assumed to be binding (whether over an annual or a three-year period), but the maximand 'H' has to be proxied by objectives which Health Authorities can reasonably pursue in day-to-day practice.

These objectives could include, in no particular order:

- developing and maintaining a strategic overview of health and health care
- avoiding adverse publicity
- establishing good working relationships with partnership organisations
- enhancing the regional / national prestige of the Health Authority
- assessing health needs and planning services accordingly
- allocating resources equitably
- setting and monitoring performance targets
- overseeing clinical governance arrangements
- improving the evidence base upon which commissioning decisions are made
- listening and responding to the views of the public.

These objectives are not intended to be exhaustive, nor are they mutually exclusive: for example, avoiding adverse publicity can be achieved partly by establishing good working relationships with GPs, hospitals and Local Authorities. They are largely process objectives, illustrating the difficulty in specifying measurable, tangible, outcome-based objectives. The new NHS Performance Assessment Framework [29] contains many indicators (eg. for measuring effective health care), which are aimed at providing a more 'rounded' view of performance, but in practice these will indicate direction of travel towards improved quality of care rather than health outcomes.

The political dimension should[5] not be under-estimated. The weight attached to different objectives by Health Authority Chief Executives will vary depending upon the latest Ministerial pronouncements. If the key measure of performance is announced to be a reduction in the size of the waiting list pool or average waiting times, then considerable emphasis will be placed on achieving this by Chief Executives. The political climate will change frequently and will have a direct impact on the weight placed on different process objectives. Arguably, however, the list of objectives postulated above would remain robust in terms of the long-term role of the Health Authority, since all are central to the development of the HImP and the discharge of its statutory duties.

This requires that Health Authorities fulfil their strategic role by developing relationships and co-ordinating work across a range of organisations. It also requires a careful and systematic approach to prioritisation decisions; accountability for such decisions (regardless of which organisation actually takes the decision) will have to at least be informed by the available evidence base if clinical governance is to be implemented successfully. Planning the range and location of services in partnership with other organisations, and identifying the underlying investment required, are major challenges for the new Health Authorities in meeting successfully the above objectives. In addition, the whole issue of measuring impact must be addressed through the performance assessment process, interpreted broadly to include aspects of quality as well as financial measures.

Developing financial strategy to support the HImP and ensuring equitable resource allocation to PCGs will remain central elements of the Health Authority's role. However, issues around resource allocation and financial accountability have been discussed in more detail elsewhere [31], drawing upon lessons from the evaluation of TPPs. It is the new focus - upon accountability for quality of clinical care - which is considered in more detail in the remainder of this paper. This requires a fundamental shift in thinking and culture in the NHS, recognising that: (i) long-term relationships must be developed with partner organisations based on common objectives; (ii) the evidence base can at least partially inform prioritisation decisions; (iii) equity considerations may conflict with approaches based on efficiency criteria; (iv) managing changes in (clinical) practice is inherently complex; and (v) there will be many barriers / constraints to the change process. With the aid of some examples from the application of Evidence Based Health Care (EBHC), each of these themes is explored below.

Developing relationships and co-ordinating work across organisations

[5] In relation to changing service configuration, the perspective of one Health Authority Chief Executive (Eminson, 1998) is informative: "Local political pressure is another source of challenge to existing service patterns where inadequacies are perceived. Combinations of the Community Health Council, specialist interest groups, local consultants and MPs can sometimes come together and bring about a seemingly irresistible momentum for change, usually founded on access or quality concerns or both. (Such alliances can on other occasions form an equally powerful resistance to change)" [30].

The Health Authority's new role can be characterised by taking the lead on developing health strategy. Hickson *et al*. (1986) note that strategic decisions involve numerous parties within and outside firms, whereby the more parties are involved, the greater the likelihood of serious conflicts of interest [32]. This insight is highly relevant to the NHS from even a cursory glance at the different partners which Health Authorities have to engage in developing their HImPs ("NHS Trusts, Primary Care Groups, other primary care professionals such as dentists, opticians and pharmacists, the public and other partner organisations" [2, para.4.7, page 26]).
The strength of the White Paper proposals lies in the recognition that the development of such relationships takes time and commitment from all sides. As Besanko *et al*. (1986) point out, however, commitment "presumes some stability in the firm's strategic environment, so that the firm can persist in its strategic activities long enough to recoup its investments" [33]. In the context of the NHS, the Health Authority ("the firm") can only "recoup its investments" (in time and resources to develop the necessary relationships) if a long-term view is taken of the strategies required to improve health. What is not intrinsic to the NHS is any degree of stability in the "strategic environment", which as already noted is heavily dominated by political influences. Health Authorities will have to adopt a robust position with regard to their long-term objectives and not be deflected off-course by changes in rhetoric and labels (locality commissioning to primary care groups, clinical effectiveness to clinical governance, and so on).

The experience of discussing purchaser / provider relationships with a major commercial sector company (Marks & Spencer plc) is instructive in this respect. Marks & Spencer's popular image is an association with value / quality / customer service, and the company's relationship with suppliers is based very firmly on these principles, commitment to which is ensured by establishing long-term (10-15 years) relationships between M&S purchasers and suppliers. Clearly no-one could argue that M&S does not operate in an environment involving many different organisations, nor that principal / agent problems are not likely to exist, nor that the top management of M&S does not have to satisfy a number of stakeholders - not least the demands of shareholders for a satisfactory return on their investments. In practice this does not appear to diminish the company's commitment to improving continuously the quality and value-for-money of the services it offers.

The analogy with Health Authorities is clear: improving the quality of health care delivered (with a view to improving health) can only be achieved if this is viewed as a long-term objective to which all partnership organisations are wholly committed. The danger is that Health Authorities will be deflected off-course by short-term demands arising from a number of sources, one of which is the need to balance the (often conflicting) interests of different organisations.

These potentially conflicting interests will have a direct impact on the objectives of the Health Authority, since in pursuing the high-level objective of pursuing the health of its resident population, account will have to be taken of the objectives of other organisations such as PCGs, Local Authorities and CHCs. In formal modelling terms this means that the simple maximisation problem stated earlier has even less relevance: there is a significant externality problem by which the ability of the Health Authority to pursue its objectives will be influenced heavily by the behaviour of other

organisations. Indeed, it could reasonably be argued that the Health Authority can *only* achieve its high-level objective if the interests of other organisations can be aligned with its own. Although not stated in formal economic terms, this is the rationale behind the HImP and the policy guidance that all parties must be in agreement regarding the content of the Programme.

This intended alignment of objectives can perhaps be seen most explicitly in the guidance on establishing PCGs [34]. The initial step of establishing "Level 1 and 2" PCGs will involve operating these as committees or sub-committees of the Health Authority, reinforcing the statutory accountability element stated in the White Paper. Indeed the Chief Executive of the Health Authority is the accountable officer "and must ensure that proper arrangements are in place for ensuring that the Primary Care Group operates within the authority it has been delegated" [34, para.30, page 11]. In effect the PCG will operate, at least in theory, as the agent of the Health Authority. There is not room here to enter into the arguments around conflicting objectives and incentives even *within* PCGs: suffice to say that an individual PCG is itself not a homogeneous unit, having as it does to represent the views of a wide range of practices and health care professionals. Also relevant will be the attitudes of different Health Authorities, to the extent that a 'command and control' or a *laissez-faire* approach is taken towards the development of PCGs. *A priori* it would be expected that PCGs would be constrained as sub-committees of the Health Authority (confirmed by experience from the evaluation of total purchasing [13]), although in practice this will depend on behavioural factors and the extent to which the objectives of different organisations can be aligned.

Prioritisation decisions

Perhaps the strongest evidence for supporting the argument that Health Authorities will have as a key objective the avoidance of adverse publicity lies in recent case studies. A good example of the adverse publicity which can arise is provided by the infamous case of 'Child B' [35]. This involved a decision by Cambridge Health Authority to refuse authorisation of payment for treatment of a 10 year-old girl with acute myeloid leukaemia. Public interest in the case heightened when in March 1995 the case (brought by the child's father against Cambridge Health Authority) went to the High Court. Judgement was made in favour of the child's father and Cambridge Health Authority was ordered to re-consider its decision. However, the case went immediately to the Court of Appeal; the High Court's decision was over-turned and it was found that the Health Authority had "acted rationally and fairly" in the circumstances.

Although the Health Authority was ultimately exonerated in this case, it provides a sharp reminder of both the unpopular role of the Health Authority and the difficulty of engaging a reasoned public debate on health care rationing decisions. Few would be surprised if Health Authority Chief Executives and other senior officers did as much as possible in their everyday business to avoid such cases coming to the fore.

A more recent case [36] concerns the treatment of multiple sclerosis patients with interferon beta, whereby the High Court ruled that North Derbyshire Health Authority had acted unlawfully in denying a patient drug treatment:

"Mr Justice Dyson stated that the Health Authority had knowingly imposed what was in effect a blanket ban on the use of the drug, *despite guidance in an NHS circular on making it available through hospitals*. A blanket ban was the very antithesis of national policy, whose aim was to target the drug at patients who could most benefit from the treatment." [36; emphasis added].

What this case reinforces is the point made earlier [11] that cases in which Health Authorities' decisions are called into question will hinge upon procedural issues concerning *how* a decision is made, rather than the content of the decision itself. In this particular case the judgement appears to hinge on the critical question of whether the Health Authority followed guidance contained in the relevant Health Service Circular. In other words, the imposition of what was in effect a blanket ban on the use of interferon beta[6] was viewed as being at odds with the stated national policy of targeting the drug on the basis of 'capacity to benefit'. The content of the decision: that is, whether the individual in question who was denied treatment would actually have benefited from the drug, appears to have been of secondary importance to the judgement.

The rights and wrongs of this case are not for debate here. What is interesting is the conflict of objectives faced by Health Authorities. ***If*** in the interferon beta case North Derbyshire Health Authority could have proved beyond all reasonable doubt that the patient who was denied treatment would in fact **not** have benefited from the drug (citing evidence from several hypothetical randomised controlled trials), then presumably the judge would still have found against the Health Authority, on the basis that its actions were at odds with national policy guidance. In reality, Health Authorities will inevitably compromise their high-level objective of improving health at the expense of avoiding such adverse publicity.

A third example reinforces the truism that EBHC is not an exact science. In the absence of evidence from several well-designed randomised controlled trials (RCTs), purchasing decisions are far from straightforward. This was highlighted by the recent debate on sleep apnoea in the *Lancet* and the *British Medical Journal*.

The case is instructive because it highlights the important distinction between the efficacy and effectiveness of treatment. In the *Lancet* article, Stradling (1997) frequently refers to the efficacy of continuous positive airways pressure (CPAP) in the management of patients with obstructive sleep apnoea [37].[7] In the *British Medical Journal* two months later, Wright *et al*. (1997) reported the results of a systematic review of the effectiveness of CPAP. The authors concluded that "There is a paucity of robust evidence for the clinical and cost-effectiveness of CPAP in the treatment of most patients with sleep apnoea" [38]. Despite the vigorous defence of CPAP by Stradling (who argued that North Yorkshire Health Authority had in effect "misused evidence-based medicine" by advising local GPs that there was "doubt as to

[6] The Health Authority adopted the policy that the drug would not be made available outside a clinical trial, and continued to refuse payment when informed that a proposed national trial had been postponed indefinitely.

[7] As a result, Stradling concludes that CPAP is simple and "unarguably technically effective", and that "there is abundant evidence for the efficacy of nasal CPAP" [37].

the clinical significance of sleep apnoea and of benefit from nasal CPAP"), the two positions are not irreconcilable.

One position is arguing that sleep apnoea is efficacious for some individual patients. The other position is based on a wider picture which is questioning whether the health effects of nasal CPAP for patients with obstructive sleep apnoea are sufficiently important to justify significant investment. That is, what are the clinical and cost-effectiveness arguments for giving priority to CPAP as opposed to all of the other competing priorities faced by the Health Authority? Given that the systematic review concluded that "the evidence for a causal association between sleep apnoea and other adverse health outcomes is weak", it is reasonable to question whether nasal CPAP should be funded in preference to other interventions. For example, the review proposes RCTs of CPAP versus effective weight reduction programmes. From the patient's perspective, this may be desirable given the "unpleasant aspects of this nightly treatment [nasal CPAP]", as recognised by Stradling himself.

This debate highlights one very important point: namely, **that the absence of good evidence is different from saying that a treatment does no good**. This is a common theme from many systematic reviews of research evidence. It also, however, raises the fundamental question of how far cost-effectiveness evidence should be taken into account in the commissioning decisions which Health Authorities and PCGs will have to make. The immediate policy implication of the North Derbyshire Health Authority interferon beta case was that:

"Those health authorities in a similar position to North Derbyshire will now need to review their policies. If additional money is to be spent on interferon beta, it will mean taking cash from some other sources." [36, quoting Stephen Thornton, Chief Executive of Cambridge & Huntingdon Health Authority].

In short, Health Authorities which attempt to take into account EBHC in their commissioning decisions, however rational and well-intended, run a substantial risk of adverse publicity which outweighs the possible benefits of explicit rationing. It is not surprising that the present government, while advocating strongly the use of EBHC (to be reinforced through initiatives such as NICE and the Commission for Health Improvement), has stopped short of a call for explicit rationing. This is despite a relatively recent London conference, where in open debate a multi-disciplinary audience of doctors, patients and health service managers voted overwhelmingly in favour of the motion that "the government has an obligation to take a lead in rationing" [39].

The issue will not disappear and several cases have highlighted the dilemmas faced by Health Authorities and, increasingly, PCGs. A good example is in the use of statins (lipid-lowering drugs) in the primary and secondary prevention of ischaemic heart disease. Freemantle *et al*. (1997) describe the Standing Medical Advisory Committee guidance on the use of statins as a "case of misleading priorities" [40], since it fails to link costs and benefits (effectiveness) information. Information from the latest US trials [41] suggests that the effectiveness evidence is so overwhelming that trials may have to be stopped on ethical grounds. The question for Health Authorities in the UK will be at which groups of patients statins should be targeted,

on grounds of both appropriateness and *cost*-effectiveness[8]. What is certain is that if the use of statins is informed by effectiveness information only, the prescribing budgets of Health Authorities (and hence PCGs) will quickly be over-loaded. The risk is that other areas of cost-effective prescribing are compromised in the rush to introduce newer technologies which are not informed by sufficiently sophisticated cost-effectiveness information.

The dilemma faced by the Department of Health in the absence of a systematic process for the economic evaluation of new drugs is highlighted by the indecision over how to deal with the introduction of Sildenafil (Viagra), culminating in interim guidance [42] advising Health Authorities not to support the drug's provision at NHS expense.

All of these examples highlight the same fundamental question: what incentives are there for Health Authorities to inform their own and PCGs' commissioning decisions with the best available evidence on clinical and cost-effectiveness? The answer lies potentially in the national Performance Assessment Framework and the development of initiatives on clinical guidelines, National Service Frameworks and the new emphasis on clinical governance. These provide the incentive to place quality at the heart of the health care agenda. What the above examples highlight, however, will be the need for the NHS Executive to explore in great depth the socio-legal implications of commissioning decisions **which will increasingly be based on the work of bodies such as NICE**. The implications of implementing such work sit somewhat uneasily with the government's commitment that GPs' clinical "freedom to refer and prescribe remains unchanged" (by the introduction of PCGs) [43].

Chief Executives of Health Authorities, both in their traditional role and as the accountable officers of PCGs, will need to be reassured that a consistent approach will be taken - if necessary by the courts through the process of judicial review - to reviewing commissioning decisions which are based on nationally available evidence of clinical and cost-effectiveness. The absence of much case law in the area of health care prioritisation decisions does not help in this respect, given that legal precedent will presumably be the key determinant in judging the outcome of specific cases. The position of Health Authorities is akin to that of hospital Trusts which for some time have been concerned with the question of rising patient expectations and possible litigation over individual clinical decisions: hence the incorporation of risk management activities into the wider clinical effectiveness (clinical governance) frameworks being developed by Trusts. Health Authorities and PCGs will face parallel considerations in the decisions which they take at a population level (the sleep apnoea case highlights the tension between individual and population-based decision-making).

The danger of a non-systematic approach to rationing decisions is that it perpetuates what Dr David Eddy (a senior adviser for health policy and management at Kaiser

[8] "National evidence based guidelines in which recommendations are linked explicitly with evidence on benefits and costs and which provide decision makers with the information they need to determine local priorities are necessary to support strategic change" [40].

Permanente, a large managed care organisation in the USA) has described as "dumb rationing" in the NHS. Indeed Dr Eddy has used the interferon beta example to highlight the inconsistent and somewhat arbitrary nature of the current system, whereby rationing can depend on postcode (eg. would patients in the neighbouring Health Authority to North Derbyshire have been dealt with in the same way?). Dr Eddy argues instead for "smart rationing", in which account is taken of "evidence on efficacy as well as nationally agreed priorities to allow equitable distribution of scarce resources" [44]. This is entirely consistent with what is being argued here (although 'efficacy' should be replaced with 'cost-effectiveness'), and strengthens the argument for a consistent accountability framework which supports evidence-based commissioning decisions.

Equity considerations

The unquestioning application of EBHC in the context of improving health is an unsatisfactory description of the Health Authority's role for several reasons, one of which is that equity considerations are typically ignored by such an approach. The EBHC movement is based on a belief that health will be improved (or maximised) if decisions are made on the basis of robust clinical and cost-effectiveness evidence[9]. That is, allocative efficiency in the health care sector will be enhanced. This, however, does not deal with the distribution of health benefits across different groups of society.

Harrison (1998) notes that an approach based on maximising total health gain may well produce different results from an approach which gives greater weight to the distribution of health benefits (the classic efficiency / equity trade-off) [45]. It is important to bear in mind that some notions of equity (eg. equity of access) treat health care as partly an end in itself, a principle which is in fact embodied in the founding principle of the NHS ("equal access for equal need regardless of ability to pay"). The evidence-based approach is underpinned by the criterion of (cost-) effectiveness, and would clearly be at odds with an approach based on the principle of equal access to health care being the predominant criterion for resource allocation. In a hypothetical situation in which one individual would gain five healthy years of life and a second individual one month of healthy life from the same health care intervention, and resources could not be deployed to treat both individuals, the evidence-based approach would clearly favour the individual who had more health to gain. Those favouring a pure equity approach would wish to allocate the resources differently.

A recent review [46] found "substantial recent evidence of certain inequities in access to health care in England", and pointed out that some health care sectors - notably acute inpatient care - had been the subject of considerably more research than others. One important conclusion of the review is that research should seek to redress this imbalance in sectors where existing evidence is sparse.

[9] The weight attached to cost-effectiveness information by proponents of evidence-based health care will differ according to disciplinary background.

The efficiency / equity trade-off in health care is hardly new, but it raises two important issues for Health Authorities in their new role. Firstly, if they are to take seriously the issue of patient and public involvement, the equity (or 'fairness') stand-point may have to be given more weight than would be implicit in the evidence-based approach. Policy formulation will need to consider both efficiency and equity, but the question of whose views should count as to the respective weights should be the subject of debate with local populations. Secondly, in their role as allocators of resources to PCGs, Health Authorities will clearly have to give a high weight to equity considerations. The political imperative of doing so will dominate, not least to avoid any repeat of the claims after the 1989 reforms that GP fundholding led to a two-tier system of access to waiting lists, 'cream-skimming' and so on. Health Authorities will have to be seen to be fair-minded in the process of resource allocation, and frequently this will involve a more process-orientated interpretation of equity (eg. equity of access to hospital services) than an approach based on maximising health or ensuring some notion of equitable outcome for equal need.

In passing it is also worth bearing in mind the caveat offered by Birch (1998) that "the evidence-based approach, dominated by a focus on health outcomes from health care interventions, overlooks the notion that society is not a 'level playing field'. Policies aimed at maximising health outcomes.....risk redeploying resources inefficiently and in ways which systematically favour those groups with favourable 'prospects for health'....." [47][10]. Health Authorities in their future role cannot afford to ignore this, and must balance the need for an evidence-based approach against the other criteria which decision-makers and the public consider to be important.

It is a timely reminder [47] that making health care decisions on the basis of the best available information is no more than one normative position which can be taken. If the distribution of health benefits is made more unequal by over-emphasising such an approach, then Health Authorities will be judged to have failed in delivering at least some of the wider social goals of the latest NHS reforms. The encouragement of joint strategies between health and social care, through the HImP, will probably reinforce the need to consider alternative paradigms such as 'entitlement' or the 'rescue principle' [45], which in practical decision-making terms are likely to lead to different policies than those based solely on considerations of clinical and cost-effectiveness.

Changing clinical practice

If the shifting balance of power towards purchasers is to bring about real benefits to Health Authorities' resident populations, then changes in culture have to be achieved throughout different care settings. The implementation of EBHC involves the application of important principles, but it is naïve to assume that simply collecting and disseminating scientific evidence will bring about the necessary changes in

[10] There is a direct analogy here with the growing emphasis on public access to health care information sources: it is the educated middle classes who are likely to have better access to resources such as the Internet, potentially giving rise to a parallel inverse care law in terms of access to information. Health Authorities will have to devise ways of ensuring that policies on improving access to information and involving the public do not exacerbate existing inequalities.

behaviour. Even where the evidence has been reviewed systematically, there often remain disagreements about (a) the nature of the evidence and the conclusions drawn by those undertaking the reviews, and (b) the validity of recommendations in local circumstances. The Walshe and Ham (1997) survey of the impact of selected *Effective Health Care* bulletins is instructive in this respect [48].

For example, in the case of the bulletin which recommended the use of transurethral incision of the prostate (TUIP) in the treatment of benign prostatic hyperplasia, the authors found that the vast majority of clinicians working in urology services did not agree with the bulletin's recommendations. Not surprisingly, therefore, the survey found that only 12% of Trusts planned to change their practice in accordance with the bulletin's recommendations; and "virtually no Health Authorities had incorporated this recommendation (to use TUIP as the preferred operation of choice) into their contracts with providers of urology services".

This is an important lesson. It does not necessarily mean that the conclusions of this particular bulletin were incorrect. It does illustrate, however, the near-impossible task of changing clinical practice if the evidence is insufficiently robust. A further criterion is perhaps the extent to which the evidence meets with accepted clinical practice. This is a controversial area, since there is no universal definition of what is 'accepted practice', and there is a danger that efforts to challenge accepted clinical practice on the basis of sound evidence meet with resistance for the wrong reasons. What this highlights is the conflict between the use of population-derived data from systematic reviews and the use of such information for helping clinicians make decisions with individual patients. As Health Authorities and PCGs begin to implement National Service Frameworks and the findings from NICE, this tension needs to be recognised and managed carefully in discussions with local providers.

There is no single solution to the issue of bringing about desired changes in clinical practice. A number of wider structural and process changes in the health care system are taking place, however, which may help.

Firstly, a move away from the annual contracting round will change the emphasis, with agreements increasingly based on a longer-term strategic view (3-5 years) of the shape of services in the future. Secondly, this will hopefully shift attention towards quality of care and health outcomes, and away from the 'head counts' of finished consultant episodes and client contacts. Thirdly, the process of integrating research evidence, routine information analysis, clinical guidelines, education and training, clinical audit and service specifications (and the structures in Health Authorities and Trusts to support these) should ensure that a co-ordinated approach is taken to clinical effectiveness (or clinical governance). Fourthly, co-ordination of Health Authority and PCG commissioning should help to integrate work at the interfaces between primary, secondary and community care (in particular if Health Authority and Local Authority decisions can equally be co-ordinated). Viewing care in this genuinely integrated way is not typical in the NHS, despite years of rhetoric about seamless care and integrated care packages.

Finally, and perhaps most important, basing the purchaser / provider relationship on a principle of co-operation rather than competition [49] could have far-reaching effects

in attempting to develop a jointly agreed evidence-based approach. This process would be assisted by the involvement of key clinicians in drawing up service agreements: it seems eminently sensible that local experts in particular fields should be involved in a process which is intended to bring together many diverse aspects of 'quality' (and which is likely to increasingly be underpinned by service specifications, clinical guidelines, continuous professional development and an effective audit process).

Barriers to change

Even where the research evidence is considered robust and results valid in a local context, routine information systems are often inadequate. For example, obtaining accurate and timely case-mix analyses from hospital data remains problematic. Variations in practice across hospital clinicians, an inevitable feature of practice and differing case-loads / case-mixes, remain largely 'not talked about'. The White Paper refers to the need to identify "poor clinical performance" at an early stage; doing so will require a greater sharing of information between purchaser and provider and a more open dialogue about individual clinician performance. A major barrier to making progress in this area is the paucity of existing hospital coding systems to ensure accurate diagnostic and procedure code data.

There are limits to evidence-based health care. At its worst it has been described as "cook-book medicine" [50]. Guidelines should be perceived as precisely that: guidance based on recognised best practice, but understanding that they have to be tailored to the needs of individual patients. The blind application of guidelines and protocols makes the false assumption that medicine is an exact science, for example that diagnosis is always accurate and not subject to bias or uncertainty.[11] Even where an accurate diagnosis has been made, there remain many factors influencing the individual clinician's decision: for example, the probability of particular outcomes, the valuation of possible different outcomes, and the willingness to live with a degree of risk [51]. One of the major problems is that, in advance of providing treatment to a particular patient, likely outcomes can only be expressed in terms of probabilities applicable to a defined population. The outcome for an individual patient is uncertain, and the nature of probability distributions is that there will almost certainly be one patient who will benefit from a treatment which the research evidence has 'proved' to be ineffective for a defined population.

All of these arguments are valid, but should not be used as an excuse for Health Authorities and PCGs to avoid an evidence-based approach. If specific treatments are undertaken for particular patients where the evidence base is weak, there should nevertheless be good reasons for doing so. It is also in Trusts' interests to deal with this process explicitly, with hospital risk management and clinical audit programmes seen as integral to the emerging clinical governance agenda.

The issue of patient expectations is closely related to the areas of clinical uncertainty and risk management. The 'health care information industry' runs the risk of increasing patient expectations still further. More and more people will gain access to relevant sources of information on the Internet, information which can be used to influence or challenge the clinical decision. Clinicians, and hospitals in general, will be fearful of litigation and the development of an integrated approach to clinical audit, clinical effectiveness and risk management is essential. There will be situations where individual patients demand treatments which are of uncertain, unproven

[11] There is not space here to rehearse all of the important arguments on this subject. An excellent summary is provided in McKee and Clarke (1995) "Guidelines, Enthusiasms, Uncertainty, and the Limits to Purchasing" [51].

benefit. Problems will inevitably arise if one clinician has provided such a treatment for one patient and another patient is denied similar treatment. As far as possible, there should be consistent use of guidelines and accurate recording of information (eg. diagnosis, patient characteristics and risk factors), together with an effective audit process, to minimise the degree of uncertainty in the exercise of clinical judgement.

The Health Authority will have to tread a fine line between providing the best information to patients to allow genuinely informed choice about preferred courses of treatment, and supporting providers and other purchasers in managing expectations where the evidence base is weak.

Achieving improvements in the quality of care is only one aspect of performance on which Health Authorities and Trusts will be judged. There is considerable scope for conflicting incentives in practice, as the following passage from Walshe and Ham (1997) illustrates:

"....the much criticised Efficiency Index rewards needless clinical activity and punishes watchful waiting. The *Patient's Charter* standards for surgical waiting lists encourage surgeons to perform ineffective procedures on long waiters at the expense of effective ones on other patients. The activity-based currency of contracting values all admissions and clinic visits equally, regardless of the appropriateness of the care provided. At the least, some of these perverse incentives to ineffective clinical practice need to be removed. Ideally, new measures which recognise and reward effective clinical practice should be put in their place" [48, p.34].

Where Health Authorities face clearly conflicting incentives, for example where a relatively ineffective treatment is not being reduced and finished consultant episodes in the relevant specialty are rising, this needs to be detected and recognised within the new performance assessment framework. In practice it is unclear how new indicators of NHS Trusts' financial performance, such as the National Schedule of Reference Costs [52], will be used alongside indicators of quality to produce broader measures of efficiency, and how the possibility of conflicting incentives will be addressed.

EPILOGUE: THE *PASTORAL* ROLES OF THE HEALTH AUTHORITY

The Health Authority of the future remains difficult to describe in organisational terms, despite the key tasks and roles being relatively clear. The White Paper appears to envisage some all-seeing, all-powerful, knowledgeable organisation with aims of goodness (improving health). Mr Blair's apparent conversion to Catholicism may not be a coincidence: the religious parallels are strong. The Health Authority's role lies in administering the gospel according to evidence-based health care, equity, partnership and quality. In practice it will exist to reconcile local differences and to act as the diplomatic envoy. Indeed, its role could be described as *PASTORAL* or ministerial: administering to the needs of its resident population, raising awareness and spreading the word:

P *the planner*
A *the assessor of health needs*
S *the shaper / strategist*
T *the target-setter*
O *the overseer of clinical governance arrangements*
R *the resource-allocator*
A *the (accountable) agent of the population*
L *the leader*

There is of course a dark side: like all religions, not everyone is a believer. How will the atheists (eg. the Trusts who do not practice evidence-based health care) be dealt with? How will Health Authorities be able to carry out their altruistic objective of improving health while achieving financial balance? What form will sanctions take for those Primary Care Groups who do not live by "the third way"? And what arguments will actually lie in the objective functions of Health Authorities and their senior officers?

There are many parallels between the 1997 NHS reforms and the preceding years of the internal market in the role envisaged for Health Authorities. The return to at least a limited form of service ***P***lanning is to be welcomed, and although it should not become a public health industry, the health needs ***A***ssessment role is a key one for Health Authorities to undertake with partner organisations. The White Paper envisages that Health Authorities will be the key ***S***hapers of events in improving the health of local populations according to agreed ***S***trategies. Through the implementation of evidence-based health care and the many facets of the performance assessment framework, Health Authorities (and PCGs) will have to set ***T***argets for the delivery of high-quality care in different settings.

In time the Health Authority may explicitly become the local regulator - in particular as Health Authorities increasingly share support services and if the role of Regional Offices disappears - but in the meantime it will have a fundamental role as the ***O***verseer of clinical governance arrangements as they develop in primary and secondary care. This new element of accountability is perhaps the most important aspect of the latest reforms, and continues the previous government's drive towards a more evidence-based health service.

Resource allocation is a major aspect of the Health Authority's role, not a new role but one with greater emphasis given the devolution of comprehensive budgets to Primary Care Groups. The focus on discharging this role equitably is critical and will be seen as a key indicator of success in avoiding a return to claims of a two-tier system of access to hospital care. The latest reforms give an important reminder that the Health Authority can act as the true ***A***gent for local populations, and indeed is ***A***ccountable for doing so; GPs and other primary care health professionals are in a difficult position as both purchasers and providers, and can act in a partial agency capacity only for *patients* not for the *public* at large.

Finally, the White Paper charges the new Health Authorities with a major ***L***eadership role in developing the Health Improvement Programmes which will form the cornerstone of improving the health of local populations. In doing so, co-operation and partnership are emphasised, but there is little doubt that the balance of power has swung back in favour of the planners.

Whether the Health Authority as an all-seeing, all-powerful, knowledgeable organisation can fulfil its aims of goodness (improving health) and spreading the word of equitable, evidence-based health care remains something which can only be tested empirically over time.

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