



# **The development of the U.K NHS in the last decade of the 20<sup>th</sup> century**

**A reference toolkit for understanding the NHS management reforms**

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## Foreword

Since its inception in 1948, the U.K. NHS has undergone continual change. The last decade has seen substantial organisational change but remarkably little shift in overall health policy. The focus of government has, therefore, tended to be on the way things are done - achieving greater efficiency and better management – rather than on making major shifts of health policy.

It is easy to see how this pre-occupation with organisation rather than health policy comes about. The founding principles of the NHS in the UK still hold good; that the service is national, universal in being open to all, comprehensive in its range of services, based on need funded out of taxes, and free at the point of delivery. These principles are, however, under constant strain as the population grows older, medical science continues to make new treatments and therapies available, and the expectations of the public continue to rise. Governments throughout the world are facing similar pressures.

Against this setting the 1979-1997 Conservative government was committed to constrain public expenditure. Although affirming priority for the public funding of health services, the 1997 Labour government ('new' Labour) has been equally zealous in ensuring that the funds made available for public expenditure are managed efficiently.

Politicians of all persuasions, recognising the value placed on the health service by the general public, have therefore faced a policy dilemma. By rejecting the notion of limiting the coverage of the publicly funded health service, they have been forced to exact more and more efficiency out of it, hence the focus on the way the service is managed.

This document identifies the most significant changes that have taken place in the U.K., sets them in the context of previous change in the NHS, and, in particular, points the interested reader to key reference material should he or she wish to learn more about the reforms by studying source documentation.

It has been compiled by IHSD which is a resource centre set up by the UK Department for International Development to support changes in health systems internationally. Please note that IHSD is not involved in the actual procurement of documents; however, addresses and supplier numbers are listed when available. Any document out of print can be obtained from the Library or from the publishers for a fee.

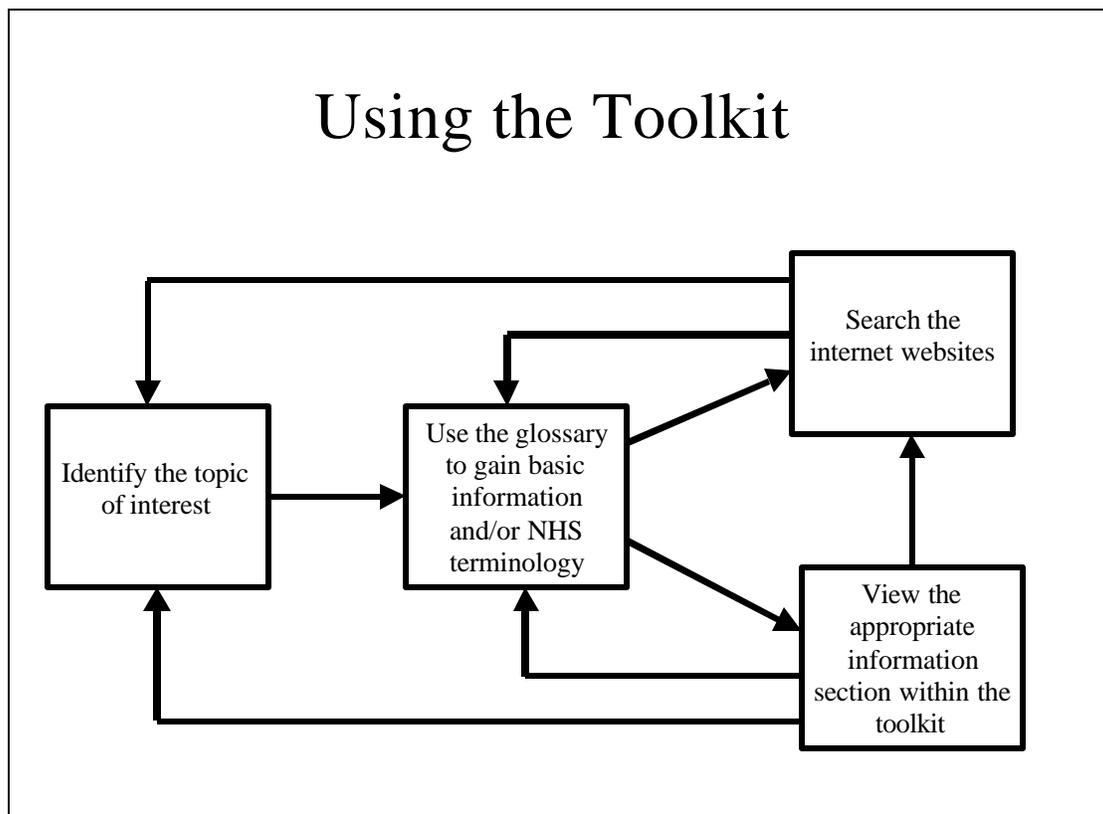
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## How to use this toolkit

This booklet is designed as a toolkit providing a comprehensive review of recent documents addressing reform in the UK's National Health Service (NHS). It is not intended to be read as a book, rather it is to be used as a **source** of reference material.

The flowchart below describes how the toolkit can be used.



## Glossary

The glossary contains an extensive list of terms and topics. As well as containing brief information, it is designed to enable the reader to identify the **NHS terminology** for a particular topic/subject.

## **Internet references**

A number of key internet references have been used in compiling the toolkit and these are given in Section 4. By using the glossary and the internet addresses, users will be able to make their own inquiries and pursue their own particular lines of interest.

## **Information sections**

The toolkit contains three major information sections, based on a hierarchy of levels of policy and practice:

- recent **white papers** which have set the policy overview for major reform.
- seven **areas of strategic importance**, where policy objectives have remained constant throughout ministerial and party political changes.
- a larger number of sections covering **detailed managerial responses** to the strategic objectives, where changes in the approach to delivering a strategic objective may be seen over time.

At the end of each section, key words and references are given.

## **References**

**A full list of references is given at the end of document.** After each title a **supplier number** has been given, corresponding to an address where the document can be procured. It is strongly suggested that you request the document by **mail**, rather than by telephone, as, during the preparation of the toolkit, it was found that telephone numbers often change.

## Glossary

**accountability** - a commonly used term in the NHS since the introduction of general management in the mid 1980s, whereby clarity has always been sought about the individual manager who is accountable in a given situation. In the formal sense some senior managers within the NHS are accountable officers which means they may be asked to account directly to Parliament for their actions.

**accountable officer** - see accountability.

**annual workforce plan** - part of the new human resources strategy that requires each local employer to produce a plan each year.

**Audit Commission** – was set up in 1983 to appoint and regulate the external auditors of local authorities in England and Wales. In 1990, its role was extended to include the NHS. It aims to be a driving force in the improvement of public services by promoting proper stewardship of public finances and by helping those responsible for public services to achieve economy, efficiency and effectiveness.

**autonomous hospitals** – The term autonomous hospitals is not used in the NHS. The establishment of NHS Trusts (see separate entry) marked the introduction of some degree of autonomy within the NHS. The recent Labour Government has made it quite clear though that NHS Trusts are part of the NHS.

**benchmarking** - a term used for comparing the performance of one organisation with a similar organisation.

**British Medical Association** – the professional association of doctors, which acts as trade union, scientific and educational body and publishing house. More than 80 per cent of British doctors are members.

**Calman Hine Report** – a strategic framework to help commissioners and providers of cancer services in England and Wales make well informed decisions. It aims to create a network of care for cancer patients in order to make sure that care received is of a uniformly high standard.

**Calman Report** - report by the Chief Medical Officer of the time entitled Hospital doctors: training for the future published in 1993. It recommended that a higher training grade should replace the registrar and senior registrar grades for hospital doctors and that the whole period of specialist training should not exceed seven years.

**cancer** - the reduction of cancer is a key part of the strategy for improving health in Scotland and England. As part of the modernisation programme, the Government intends to improve the quality and effectiveness of, and speed of access to, cancer services. Cancer rates will be monitored as part of the national performance framework. In particular, age and sex standardised registration rates for cancers of

the stomach, small intestine, colon, rectum, trachea, bronchus, skin, breast and cervix will be monitored. Also to be tracked is the percentage of the target populations screened for breast and cervical cancer to assess the effectiveness of the NHS, the survival rate for breast and cervical cancer- will be monitored.

**capacity building** – the development of the NHS from an administered to a managed service has taken place over the last 20 or so years. The NHS is unusual in that the majority of senior managers are career NHS managers, and often do not have a professional clinical background although many will be educated to masters level.

**capital** - capital expenditure is spending on the acquisition of land and premises, on the provision, adaptation, renewal, replacement and demolition of buildings, items or groups of equipment and vehicles etc. where the expenditure exceeds £5000.

**capital charges** – a financial mechanism for including the cost of capital (see entry) assets in costing and decision making.

**capitation funding** - a system which allocates funds in proportion to the resident population of the area covered, but makes adjustments to take account of demography morbidity and social deprivation. A review of the formula is underway in England, but will not be implemented until 2001-02 at the earliest.

**care in the community** - policy whereby patients with continuing medical and social care needs are cared for in a community or domestic, rather than institutional, setting. Care in the community is part of the government agenda to give patients and clients more rights to choose and to be involved with their care.

**cash limit** - a limit imposed by the government on the amount of cash which a public body may spend during a given financial year.

**CHC** – community health council (see entry).

**clinical audit** – a cyclical evaluation and measurement by health professionals of the clinical standards they are achieving.

**clinical governance** - a framework through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish.

**clinical indicators** - statistics used to assess aspects of clinical care that may raise issues for further investigation, for example of quality, but which do not, of themselves, measure quality or outcome attributable to care in individual hospitals.

**Cochrane collaboration** – an international network of nine centres, of which the UK Cochrane Centre is one. Its role is to build, maintain and disseminate up-to-date information from the systematic review of healthcare trials.

**code of practice on openness** - came into force in 1995, setting out the basic principals underlying public access to information about the NHS. The code states that trusts and health authorities should make available:

- information about what set-vices are provided.
- details of important proposals on health policies.
- details of important decisions on public health policies.
- information on the way in which health set-vices are managed.
- information about bow the NHS communicates with the public
- information on how to contact community health councils and the health services commissioner.
- information about bow people can have access to their own personal records.

**Commission for Health Improvement (CHIM)** – will have five main roles:

- provide national leadership to develop and disseminate clinical governance principals.
- independently scrutinise local clinical governance arrangements.
- carry out a programme of service reviews.
- help the NHS identify and tackle serious or persistent clinical problems.
- take an increasing responsibility for overseeing and assisting with external incident enquiries.

The commission will concentrate on clinical issues but will also have scope to deal with management issues where these lie behind clinical problems.

**commissioning** - the process by which the health needs of the population are defined, priorities determined and appropriate services purchased and evaluated.

**community care** - social care and treatments to patients/clients outside hospital with an identified physical or mental illness or disability.

**community health councils (CHCs)** - the health service's watchdogs that act on behalf of patients to recommend improvements in local health services. Their main role is to:

- monitor the effectiveness of NHS planning.
- evaluate the quality of services provided.
- ensure that the views of patients and members of the public are fully represented in any important decision making.

**community health services** - a complex set of services, usually managed by a web of NHS trusts and delivered outside the hospital setting. Core elements are those services provided by district nurses (see entry), health visitors (see entry), and therapists such as physiotherapy and speech therapists.

**Comprehensive Spending Review (CSR)** - fundamental review of public sector spending carried out in England, Scotland and Wales. The CSR resulted in a White Paper 'Modern public services for Britain: investing in reform'. The NHS will receive £21 billion over the next three years as a result of the CSR.

**contract** - term used as part of the internal market for a non-legally binding agreement between NHS purchasers and providers setting out agreed activity, cost and quality (now superseded by long-term service agreements).

**contracting out** – the term usually used to refer to the process of competitive tendering for hospital support services such as laundry and catering.

**corporate governance** - the term used to cover the best practices that should be followed to ensure probity and avoid corruption.

**costing for contracts** – common the methodology used throughout the NHS for allocating costs to treatments and services.

**CVD** – cardiovascular disease (see Our Healthier Nation).

**delegation** – over the last decade, there has been a trend to enable managerial decisions to be taken at lower levels of management. Hence the establishment of NHS Trusts as self-governing (semi-autonomous) hospitals and the development of GP fundholding and more recently PCGs are examples of this trend.

**DfID** – Department for International Development.

**districts** - predecessors to health authorities, combining both provision and purchasing/planning until the separation of functions in 1990.

**DoH** – Department of Health.

**efficiency index** – the ratio of activity over cost which is used to assess efficiency of an organisation.

**EL** – Executive Letter (see entry).

**electronic patient record** - part of the NHS Information Strategy is to enable every NHS body to invest in electronic patient records.

**equity** – The NHS is freely available at the point of delivery. To ensure that an equal distribution of funds across the country according to need, a formula based approach is used; see capitation funding, Resource Allocation Working Party (RAWP). The term equity is also increasingly being used to mean equity of outcome as well as access.

**evidence-based healthcare** - a systematic analysis of information on the effectiveness and use of treatments in providing the best health outcomes.

**Executive Letter (EL)** – Instruction or guidance issued by the NHS Management Executive to NHS management.

**external financing limit** - a cash limit set by the NHS Executive on net external financing for an NHS trust.

**extra-contractual referral** - referral of a patient for secondary care by a GP to a provider unit which has not formally negotiated a contract with the health authority or health board of residence of the patient. Abolished from April 1999, when new arrangements for Out of Area Treatments (OATs) were put in place.

**Family Health Service Authority** - predecessor organisations to health authorities, that administered primary care services. Formerly called Family Practitioner Committees.

**finished consultant episode** - an episode where the patient has completed a period of care under a consultant and is either discharged or transferred to another consultant.

**gatekeeper** - the term often used to describe the role the general practitioner plays since access to secondary and tertiary care is through referral by the general practitioner.

**general management** - introduced into the NHS in 1985 following the Griffiths Report.

**general practitioner (GP)** - a doctor providing primary care services. A GP is usually the first point of contact for a patient with the NHS. Over 90 per cent of episodes of illness are managed wholly within general practice, GPs work in healthcare teams with practice nurses, district nurses, community midwives, practice receptionists and managers. Increasingly, other health professionals such as physiotherapists and social workers are associated with GP practices.

**GP fundholder** – a now obsolete term for a GP practice that had a budget which includes the purchase of a range of hospital in-patient, out-patient and certain nursing and paramedical services.

**HA** – health authority (see entry).

**health action zones (HAZs)** – ten pilot schemes to provide a framework for the NHS and partners working together to reduce health inequalities. HAZs have three strategic aims:

- identifying and addressing the public health needs of the local area.
- increasing the effectiveness, efficiency, and responsiveness of services.
- developing partnerships for improving health and services adding value through creating synergy between the work of the different agencies.

**health authorities** - in England and Wales, formed in 1996 from the merger of district health authorities and family health services authorities. Their role is to:

- evaluate the health and healthcare needs of the population.
- set up health improvement plans.
- monitor and evaluate local changes in health and the delivery of health services to ensure objectives are achieved.
- discharge other corporate and statutory responsibilities.

**health boards** - Scottish bodies responsible for the protection and improvement of the health of their resident populations. They are expected to: involve local trusts, GPs, local authorities, community organisations and others in developing the health improvement programme developing partnerships for improving health and services, adding value through creating synergy between the work of different agencies.

**health gain** - the improvement in the health status of a population.

**health improvement programme (HIMP)** - drawn up by a health authority or board, it will set out a clear agenda for three years and indicate broad intentions for years four and five. It will include:

- a framework for primary care.
- a pattern of local service configuration.
- action plans to improve the health of local people.

**health related group (HRG)** - a grouping of similar disease categories to enable aggregation of information and for costing purposes.

**Health of the Nation** - the 1991 Department of Health report which for the first time set national targets for- improving the health status of the population.

**HSG** – health service guidance.

**Health service guidance (HSG)** guidance issued by the Department of Health to the NHS.

**internal market** - working environment created by the 1990 NHS reforms separating the NHS into Purchasers (those buying care on behalf of patients) and providers (those delivering the care), The internal market operated to some degree through financial incentives and penalties - it was considered that this would lead to greater efficiency The internal market was abolished by the current Government.

**joint investment plans** - strategies to improve inter-agency working to:

- improve the ability of people to live independently through better co-ordinated local services.
- improve partnership working between agencies, with greater transparency about current and future spending and the development of health and social care services.
- acknowledge issues of service quality and effectiveness to inform agreed strategic objectives and service development priorities.
- produce the information necessary to support the reshaping of services across the local health and social care economy.
- contribute to the preparation and delivery of HImPs by putting into operation strategies that span the health/social care interface.

**local authority** - local government organisations that do not have direct responsibilities for NHS services but that manage services such as social services, education and the environment at local level.

**long-term service agreements** – Agreements between health authorities or primary care groups, and NHS Trusts on the service to be provided for the local population. These replaced the annual contracts of the internal market and cover a minimum of three years to offer stability.

**medical audit** – see clinical audit.

**Modern Public Services for Britain: investing in Reform** – White Paper issued in 1998 as a result of the comprehensive public spending review undertaken by Government. It introduces longer term financial planning into the public service, thus giving greater certainty to resource availability within the NHS.

**'money following the patient'** - introduced as part of the 1991 reforms, 'money following the patient' means that health authorities pay for the care their resident population receives wherever this care is given.

**National Health Service Act 1946** - established the NHS. The main features of this act were that:

- the service was to be run on a national basis and paid for out of general taxation.
- all citizens could register with a family doctor of their choice, receive free treatment for simple ailments and be referred to hospitals for those conditions a GP could not treat.
- GPs remained private professional people.
- attendance at hospital was free.
- medicines prescribed by GPs could be picked up from the chemist free. Eye tests, spectacles and visits to the dentist were also free.

**National Institute for Clinical Excellence (NICE)** - a special health authority giving new coherence and prominence to information about clinical and cost effectiveness, It will provide and disseminate clinical guidelines based on the relevant evidence, clinical audit methodologies, and information on good practice. It will also identify gaps in evidence, which will be addressed through the NHS research and development programme.

**national service frameworks** - these will set national standards and define service models for a specific service or care group; set up programmes to support the implementation of those standards and models and establish performance measures against which progress within an agreed time scale will be measured. National service frameworks will be developed at the rate of two per year starting with mental health and coronary heart disease, followed by older people and accidents.

**needs assessment** - the process of assessing the health care needs of the population.

**NHS Direct** - a 24 hour telephone helpline service for patients require immediate advice and providing access to nurses and other professionals.

**NHS Executive** - management body for the NHS in England. Its responsibilities are to:

- set a strategic framework for the NHS in accordance with ministerial policy.
- improve the knowledge base of the service by disseminating information and good practice.

- manage the NHS to ensure that the policy is implemented throughout the service; that the NHS offers good quality services, sound financial control, and high standards of probity and value for money.

**NHS trusts** – public bodies providing NHS hospital and community health care. Trusts are self-governing (autonomous) bodies with their own board of directors and with freedom to organise their affairs. This is subject only to the legal framework within which they work and to the contracts that they have negotiated with purchasers.

**NICE** - see National Institute for Clinical Excellence.

**Our healthier nation - a contract for health** - government green paper on the future of the NHS in England. It states that the aims of the health service are twofold:

- to improve the health of the population as a whole by.
- increasing the length of people's lives and the number of years people spend free of illness.
- to improve the health of those worst off in society and to narrow the health gap.

**patients charter** - a set of standards and targets concerning service to patients for the NHS to meet. Charters are set at national levels (i.e. in England, Scotland, Wales and Northern Ireland) and at health authority or board level. At local level, patients' charters are expected to pay more attention to the quality and success of treatment.

**pay review bodies** - the independent panels, which recommend pay awards for NHS staff. Appointments to the pay review bodies are the responsibility of the Prime Minister. The recommendations of these bodies are submitted to the Secretary of State for Health who has the ability to authorise pay rises.

**PCG** – primary care group (see entry).

**performance indicators** - measures of achievement in particular clinical and managerial areas used to assess the performance of the trust. The new set of indicators, set by the Government under their national.

**performance framework** – a set of NHS performance indicators which together are used to assess the performance of an NHS body such as a health authority or Trust.

**performance management** – the processes used to manage the performance of Trusts and health authorities.

**planning** – in the 1980s the term 'planning' had become discredited and it was believed that the market would replace bureaucratic planning processes. More recently planning has been seen as legitimate and necessary activity. The NHS

Executive annual issue Planning and Priority Guidance that identifies the most important issues that health authorities, trusts and PCGs need to address. HAs have the lead responsibility for the health improvement programme which is the local plan to implement national priorities.

**planning and priority guidance** - see planning.

**primary care group** - responsible for the provision of primary care for their resident population. Their role includes: improving health and addressing health inequalities developing primary care and community health services advising on or commissioning of hospital services for patients contributing and implementing health improvement programmes.

**primary care team** - the team of professionals working at general practice level, usually comprising the G.P., nursing, social services, and community mental health staff.

**primary care trust** - a high level primary care group that has semi-autonomous status.

**priority setting** - the decision that particular client groups or types of service are a higher priority than others and can get a greater share of NHS resources. Priority setting differs from rationing in that rationing decisions tend to focus on effectiveness whereas priority setting focuses on value judgements.

**private finance initiative (PFI)** - a government system of encouraging private capital to be employed in public sector projects so as not to add to the total public sector borrowing requirement.

**provider (organisation)** - any organisation providing health care services.

**PSA** – public service agreement (see entry).

**public service agreement (PSA)** – agreement reached between the Treasury and the Department of Health to provide a context for stable, longer-term planning of services.

**purchaser (commissioner)** - a health care body such as a health authority that assesses the health needs of a population and buys services to meet those needs.

**purchaser/provider split** - the phrase used to describe the separation of the purchasing role and the providing role in the internal market.

**unified structure** – when the NHS was set up in 1948, it was administered by three separate bodies, primary care services (general practitioners, dentists etc.) were covered by Family Practitioner Committees, community health services were administered by local government, and hospital services were administered by Regional Health Boards, and below them hospital management committees, or

boards of governors. In 1974 the unification of hospital and community health services was achieved, and it was only in 1996 that the management of all parts fell into one unified approach.

**value for money** - the term used to get the best value for the amount of money expended.

**Resource Allocation Working Party (RAWP)** – A national working party which produced a report in 1976 'Sharing Resources for Health in England. RAWP introduced a funding formula based upon population numbers modified for age, sex and standardised mortality ratios, as crude indicators of relative health need. The RAWP formula has been modified over the years but still provides the basis of the weighted capitation funding formula used today (see capitation funding).

**rights** - under the patient's charter, those services to which every citizen is entitled.

**service agreement** - see long term service agreement.

**Smoking kills** - government white paper aimed at reducing the number of smokers in the UK. The key features are:

- no outright ban on smoking in public places. or at work .
- a focus on children, deprived adults and pregnant women.
- £100 million of new money for anti -smoking initiatives in the next three years.
- NHS smoking cessation programme to help smokers give up.
- measures to reduce the amount of smoking in public places.
- new code of practice to protect people from passive smoking at work.
- Europe-wide ban on tobacco advertising and sponsorship.
- major publicity campaign to shift attitudes and change behaviour.

**standardised mortality ratios (SMRs)** - measure of mortality per age/sex grouping used in capitation funding (see separate entry).

**SMR** - see standardised mortality ratio.

**statutory duty of partnership** - the legal requirement placed upon NHS bodies and others to work in partnership.

**teaching hospitals** - hospitals that provide a range of secondary and tertiary services and that have associated undergraduate medical schools. There is a large concentration of teaching hospitals in London.

**The New NHS: Modern and Dependable** – White Paper issued by the Labour Government in 1997. The thrust of the proposals were to build on what had worked well and discard from the policies of the previous administration what was perceived to be failing (see section 5 for more details).

**Trusts** - see NHS Trust.

**waiting time** - the time which elapses between the request by a GP for an appointment and the attendance of the patient at the outpatient department; or the date a patients name is put on an in-patient list and the date of admission. It does not include the time people are suspended from the list or time lost by people being put back on the list after being deleted from it.

**weighted capitation** – see capitation funding.

**White Paper** – a policy statement by government and are often followed by legislation that enacts the policy.

**Working for Patients** – White Paper published by the Conservative Government in 1989 (See Section 5 for more details). The Paper introduced the internal market; contracts between purchasers (see entry) and NHS Trusts (see entry); GP fundholding (see entry); medical audit (see clinical audit); capitation funding (see entry); and capital charges (see entry).

## **Internet References**

Major changes in the organisational and operational structure of the NHS have led to changes in the way documents and official publications are distributed a large number of the documents that have been referred to in this document can be obtained via the Internet.

It is important to realise that some organisations such as the NHS Executive and Department of Health almost exclusively provide files and documents for downloading via this method.

These files are in a variety of formats for example: Adobe Acrobat files that have a .pdf extension and require the software Adobe Acrobat Reader to enable you to read them. This software can be obtained from the website <http://www.adobe.com>. Alternatively, files can be provided in HTML format and simply require to be printed out directly from the Browser that you are using.

### **Department of Health**

The organisation of the main Department of Health website includes a number of online electronic databases that can be individually searched and documents retrieved by Title, Series or Keyword these databases are known as COIN (circulars on the Internet and POINT(publications on the internet).

The main Department of Health website is located at <http://www.doh.gov.uk> from there links can be made to publications, press releases and different areas of the department of Health that deal with specific enquiries.

### **DETR Department of the Environment Transport and the Regions**

<http://www.detr.gov.uk>

This is an excellent site that deals with the areas where the NHS works in partnership with Local Authorities and other government departments. It also hosts key areas that provide full text reports and abstracts of relevant legislation.

### **BMJ British Medical Journal**

A number of key documents are referred to in the British Medical Journal web-site at <http://www.bmj.com>. This site provides a six year archive of BMJ articles in full text and in (Adobe Acrobat ).pdf format. Articles can be downloaded directly from the site and links made to related texts or articles by the same author. The site provides free access to Medline the largest collected abstracts database held online. The British Medical Journal also provides a customised alerts area and this is recommended as

an important resource to enable users to receive regular updates of articles and contents lists directly to their e-mail system wherever they are in the world.

### **UK Cochrane Library**

The Cochrane Library is an electronic publication designed to supply high quality evidence to inform people providing and receiving care, and those responsible for research, teaching, funding and administration at all levels.

<http://www.cochrane.co.uk>

### **Health Services Management Centre, University of Birmingham**

The Director of the Centre is Professor Chris Ham, it publishes articles research and analysis on the management of the NHS.

<http://www.bham.ac.uk/HSMC/>

### **York University Health Economics Consortium**

The York Health Economics Consortium was established in 1986 and provides independent consultancy, applied research and training to the NHS and health care industry.

<http://www.york.ac.uk/inst/yhec/>

### **York University Centre for Health Economics**

The Centre specialises in health economics research and is well known for its work on health outcomes.

<http://www.york.ac.uk/inst/che/>

### **The Institute of Healthcare Management**

The Institute of Healthcare Management exists to enhance and promote the highest standards of professional healthcare management.

<http://www.ihm.org.uk/home.cfm>

### **Health Service Journal**

The HSJ is a weekly journal that contains news and articles about current issues in the NHS.

<http://www.hsj.co.uk>

### **Additional Web Sites are listed below.**

Essential Archives and British Government Legislation

- *About UK Legislation*
- *Acts of the UK Parliament*
- *Explanatory Notes to Acts of the UK Parliament*
- *Statutory Instruments*
- *Draft Statutory Instruments*

<http://www.legislation.hmsso.gov.uk/>

For NHS Press Releases and Announcements, and older Press Releases Archives

<http://www.coi.gov.uk/coi/depts/GDH/GDH.html>

For essential publications and access to the NHS Executive Web Pages and Green and White Papers

<http://www.doh.gov.uk/outlook.htm>

Her Majesties Stationery Office - Acts and legislation

<http://www.hmsso.gov.uk/acts/acts1997/97046--o.htm>

## Major Health Service White Papers and Acts

Organisational change in the decade has been driven by three major policy statements in the form of White Papers. (White Papers are policy statements by government and are often followed by legislation that enacts the policy).

The first of the three health White Papers, '**Working for Patients**', was published in 1989 by the Conservative Government. *Working for Patients* was based on the premise of an internal market within the state funded health sector and introduced the fundamental purchaser /provider split. The proposals in the White Paper were the subject of subsequent legislation – The **NHS and Community Care Act of 1990**.

Following the election of the Labour government in 1997, the new government published its own blueprint for the NHS, again as a White Paper; '**The New NHS: Modern and Dependable**'. The thrust of the proposals was to build on what had worked well and discard from the policies of the previous administration what was perceived as failing. The Labour policy (which prevails at the time of writing) is to retain the purchaser/provider split with quasi-autonomous trusts, and to remove elements of the internal market which reduce provider co-operation, fragment the healthcare system, or generate high transaction costs. The key organisational change is the binding together of local health care systems through Primary Care Groups. Competition is replaced by enhanced processes for performance management, and contracts by longer-term service agreements. The previous government's promotion of evidence-based medicine is reinforced, and there are new approaches to public health medicine.

The third significant White Paper '**Modern Public Services for Britain: investing in Reform**', was published in 1998 as a result of the comprehensive spending review of all public sector expenditure undertaken by the government. It introduces longer term financial planning into the public service, thus giving greater certainty to resource availability within the NHS.

The following sections describe the three most significant White papers in more detail.

### **Working for Patients (1989)**

The six ostensible innovations of the 1989 reforms were contracts; hospital and community care stand-alone Trusts; **GP fund-holders; medical audit, capitation funding, and capital charges**. However, the really radical changes could be found in the underlying principles, which separated the provision of healthcare from its planning (purchasing) and which moved away from an historical basis for the funding of services to one based on the health needs of the populations of the geographical areas covered by health authorities. The reform package was driven by a belief that large public sector organisations were inherently inefficient and that this could be tackled in two ways; by greater delegation of powers to local level, and by

competition between providers. Fundholding also added an element of purchaser competition.

The existing district health authorities (later HAs) took on the role of the **purchaser**. A number of self-selected general practices were granted fundholding status (in which general practitioners could opt out to buy basic elective hospital services for their patients). Hospitals, and subsequently community health services, were encouraged to put themselves forward as **self-governing trusts** (semi-autonomous organisations with new financial and organisational freedoms). The trust model gained rapid momentum and all units moved from directly managed to trust status within a period of some four years. **Contracts** defined relations between purchaser and provider, stating cost, volume, quality and timing. **Medical audit** was included as a way of protecting the quality of services. Other than through fundholding, the organisation of primary care (general practice) remained largely outside these changes (although fundholding became extremely influential in the subsequent reshaping of services).

The **purchaser/provider split** promoted purchasing as the means to a more rational, consumer-led design of services. Although it received much less publicity than fundholding and trusts, the separation of the purchaser from the provider was if anything a more radical transformation. Contractual funding meant that all providers – not only trusts – were involved with the internal market, whether by choice or not. All managers became engaged in the design of local contracting systems, using skeletal central guidance and the basic financial and activity data available at the time. Contracts also became a vehicle for accountability, helping define new relationships and ways of working which were tested and refined over time to meet the needs of a publicly funded system, always in the public eye.

The introduction of reforms was followed by a dynamic learning process. Purchasers and providers alike had to learn as they went along. Little guidance on implementing the details of the reforms had been provided by central government.

*Working for Patients* was a general document. It was quickly followed by a series of working papers about specific aspects of the plans, although even these were not particularly detailed. The first 11 working papers were numbered, after that their publication was less systematic. The subsequent legislation – the **National Health Service and Community Care Act** of 1990 – was more explicit and was followed by a number of specific recommendations and guidelines.

*Figure 1* below outlines the six main innovations.

Innovation	Objectives
<p>1. The introduction of an internal market through <b>contracts between purchasers and providers</b></p>	<ul style="list-style-type: none"> <li>• To reward efficient, good quality and popular providers.</li> <li>• To enable purchasers to make clear choices between providers.</li> <li>• To create competition to improve the standards of service.</li> <li>• To establish clarity about the volume and standards of services to be provided.</li> </ul>
<p>2. The <b>establishment of stand-alone Trusts</b> to manage the provision of hospital and community services. Trusts directly accountable to central government.</p>	<ul style="list-style-type: none"> <li>• To delegate responsibility for decisions about services to as near the patient as possible.</li> <li>• To remove from service providers the need to consult higher levels, particularly in management of finance and staff conditions.</li> </ul>
<p>3. The voluntary <b>creation of “fund-holding” GPs</b> who could buy some hospital services directly – mainly outpatients services, elective operations and diagnostic procedures.</p>	<ul style="list-style-type: none"> <li>• To improve standards in hospitals through competition.</li> <li>• To make GPs more influential in decisions about hospital care.</li> </ul>
<p>4. The promotion of <b>medical audit and job plans for consultants.</b></p>	<ul style="list-style-type: none"> <li>• To increase the accountability of hospital doctors, including their clinical performance.</li> </ul>
<p>5. The change to a <b>capitation (weighted population) basis</b> for purchasing services for a given population.</p>	<ul style="list-style-type: none"> <li>• To promote resource equity between different parts of the country</li> <li>• To encourage services to be tailored to meet local needs.</li> </ul>
<p>6. Introduction of <b>capital charges</b> for buildings/equipment and other capital assets.</p>	<ul style="list-style-type: none"> <li>• To encourage efficient use of land.</li> </ul>

## **The New NHS: Modern and Dependable**

Six months after election in May 1997, the new Labour Government published its own White Paper reflecting manifesto commitments to end the internal market. As well as introducing new policy, the White paper consolidated strands of existing policy carried over from the previous government. It reaffirmed government's commitment to long-standing features of the NHS: national, universal in being open to all, comprehensive in its range of services, based on need, largely funded out of taxes, largely free at the point of delivery. In doing so, it specifically rejected the hypothesis that the NHS cannot accommodate growing pressures without 'huge increases in taxation, a move to a charge-based service, or radical restrictions in patient care'. It argued that the 'cost-effectiveness of the NHS helps to reduce the tax burden to well below the European Union average', and that 'rationing or a charge-based system would dissipate these advantages'. The White Paper sets the basis for the current set of changes to the NHS.

A central theme is the replacement of the internal market with a system of integrated care, founded on principles of partnership. The sometimes divisive and isolationist tendencies fostered by competition are discouraged in favour of collaboration and integration. The separation of planning and provision is retained, but GP fundholding has been discontinued. Instead, each Health Authority now divides its population between geographically-based **primary care groups, or PCGs**, (covering populations of around 100,000). PCG Boards have representation from community and social services. They commission primary, community and secondary services, and work closely with Local Authority-run social services within the framework of a **Health Improvement Programme** (HImP) agreed for the locality. Secondary care specialists are to be involved in the HImP process. The HImP is both a planning and accountability tool, incorporating priorities for action, based on local health need, improvement of standards, and the management of change.

In place of competition, enhanced **performance management** processes will drive standards up, with the twin objectives of improving the quality of service provision and the efficiency (and, by implication, effectiveness) of its delivery. The concept of clinical governance is introduced for PCGs as well as hospitals. Contracts are replaced by **long-term service agreements**, which in turn are based on **national service frameworks** spanning both primary and secondary care (although few of these are available yet). These will give allow performance to be monitored across local health systems rather than in separate primary, community and hospital care boxes.

## **Public Service Agreements**

On coming into office, the Labour government undertook a comprehensive spending review of all public sector expenditure. The results were announced in its White Paper "**Modern Public Services for Britain: investing in Reform**". The three-year

allocation to health and personal social services has been tied to specific aims, objectives and personal targets set out in a **Public Service Agreement (PSA)** between the Treasury and the Department of Health.

The aim of the PSA is to provide the context for stable, longer-term planning of services with a greater degree of certainty than has previously been possible. Features of the health PSA for 1999-2002 include:

- a firm 3 year settlement to allow proper advance planning
- average annual increases of 4.7% in real terms
- within that, a ring-fenced NHS Modernization Fund of £5bn over the 3 years
- an efficiency target of 3% pa to yield £1bn pa
- no new NHS patient charges in the lifetime of this Parliament
- any increases in public sector pay to be paid for out of existing resources, not the additional investment.

Key words from glossary	capital charges, capitation funding, contract, G.P. fundholder, health improvement programme, internal market, long-term service agreement, medical audit, national service frameworks, NHS Trust, primary care groups, public service agreement, purchaser, purchaser/provider split
References for further reading	1,14,15,21,29

## Strategic Intent

Before the Conservative reforms of the early 1990s, significant themes were beginning to emerge which have remained constant. Other, new themes have taken root. We have identified seven of these, which are permanent features in the management of the NHS, even to the extent that they cut across political party ideology. They are described here as **strategic intents**, in no particular order:

- improving health status
- resource allocation and equity
- strengthening the role of primary care
- developing the role of community care
- involving the user
- efficiency
- delivering high quality care.

There is clearly a large degree of **overlap** between the areas (e.g. the rationale for strengthening the role of primary care is the delivery of efficient and high quality care; the rationale for high quality care is to improve health status through efficient service delivery). Each is outlined in the sub-sections that follow, in terms of the major policy implications.

## Resource Allocation and Equity

On establishment in 1948, the NHS was broadly funded on an historical basis derived from spending on equivalent services pre-1948. There has never been a serious attempt to 'zero-base' NHS funding; broadly most people's healthcare needs are met in a timely fashion most of the time. However, the historical funding base of the NHS built an inequitable distribution of funds into its fabric from the outset. Naturally an historical approach favoured those who were already well-funded and supplied with services. Despite an awareness that populations, their needs, utilisation levels, and access were not always best matched, the political difficulties of redistributing resources were not tackled head on until the 1970s through the RAWP process.

The **Resource Allocation Working Party (RAWP)** published its report, ***Sharing Resources for Health in England*** in 1976, acknowledging that there was inertia in the system. Supply influenced the demand for services. RAWP introduced a new funding formula covering the (then) 14 regions, based on population numbers modified for age, sex and **SMRs**, as crude indicators of relative health needs. RAWP addressed allocative inequity at regional level, with regions extrapolating the formula down to their constituent district HAs. Instead of moving directly to capitation-based allocations, the RAWP formula allowed regions and districts (then managers of provider services) to move gradually towards fair shares targets through positive or negative growth to their allocations year on year.

The **1991 reforms** speeded up the process with the introduction of **capitation** shares for districts, and with new rules for capital charging. Along side capitation funding, the **'money following the patient'** concept was introduced. On this basis health authorities pay for the care their resident population receives wherever this care is given. Again, the potential for unmanageable gains or losses in resources was mitigated centrally through manipulation of the new contractual system. Thus health authorities came close to their recalculated target allocations almost overnight, with modifications to ensure that established patterns of usage by the local population were not disturbed in at least the short term. In turn, providers stood to gain or lose funds depending on the decisions of their purchasers about where to place contracts, and the terms of those contracts, on the basis that purchasers stayed within budget.

Key words from glossary	equity, capitation funding, money following the patient, Resource Allocation Working Party, standardised mortality ratios
References for further reading	16,17

### Improving Health Status

The new government puts great emphasis on **health** (i.e. not just health services), and on **equity** of both access and outcomes, themes pursued in more detail in the public health White Paper, "**Saving Lives: Our Healthier Nation**". This stresses the need for concerted action by government, local organisations and individuals, who also bear a responsibility for their own health. Action on **smoking**, as the single biggest preventable cause of poor health, is covered in a separate White Paper, "**Smoking Kills**"

**Current priorities** include the following:

- targets for reduction in deaths by 2010 in 4 priority areas: cancer, coronary heart disease and stroke, accidents and mental illness (suicide and undetermined injury)
- a commitment to improve the health of the worst off and narrow the health gap ( no targets specified)
- a new Health Development Agency
- measures to reduce smoking in public places but no outright ban
- specific targets to reduce smoking in 3 priority groups, children, deprived adults and pregnant women
- a Europe-wide ban on tobacco advertising and sponsorship by 2006

These initiatives have flowed naturally from the previous administration's *The Health of the Nation*, a 1991 White Paper that concentrated on the responsibilities of health authorities to be accountable for the health of their resident population – rather than simply purchasing treatment for them. It specifically encouraged purchasers to concentrate on cost-effective strategies for dealing with major causes of ill health. The Paper set **national objectives and targets in key areas** over a 4 year period, indicated the action needed to achieve the targets, outlined initiatives to help implement the strategy and, finally, set the framework for monitoring, development and review. Five target areas were presented together as a coherent health (as opposed to illness) strategy.

Key words from glossary	Cochrane Collaboration, evidenced based health care, health gain, health improvement programme, Health of the Nation, Our Healthier Nation, Smoking Kills
References for further reading	2,4,8,42

### Strengthening the role of Primary Care

In the context of this document '**primary care**' is used to refer to services based within general practice (as opposed to other community-based services run by community health trusts, but which may technically also provide primary care). It also encompasses dentists, opticians and high street pharmacists, although these are not covered in any detail here.

At the time of writing, the traditional boundaries between primary care and other health services are blurring, to the benefit of the patient, and will become even less distinct if the government's vision for integrated health services is to become a reality.

General practice in the UK is regarded by many as one of the NHS's greatest assets. **General Practitioners** provide a general family medicine service and act as **gatekeepers** to secondary care. An understanding of the historical context of general practice is helpful in order to appreciate the scale of change currently underway. This section outlines some of its unique features, and the organisational issues they bring with them.

The NHS was created in 1948 with three separate administrative branches;

- hospital services (run by hospital boards)
- community health services (run by the Local authorities)
- general practice (administered by a network of Family Practitioner Committees).

Whilst the first two branches merged managerially in 1974, general practice was managed as a separate arm of the healthcare system until 1996 when HAs took on the role of administering primary care locally, alongside their purchasing functions for secondary care.

Because GPs are independent contractors, the management, as opposed to administration, of general practice has evolved more slowly than in other areas of the service. The standard model of general practice has been as a small independent business, paid for by taxation, in order and offering a service to the public free at the point of use on the basis of a common, nationally agreed contract. The HAs (and predecessor FPCs) acted as payments and registration agencies, and ensured that basic standards were met.

A rather laissez-faire attitude by governments to general practice came to an end in the mid-1980s with the publication of Green and White Papers proposing revisions to GP remuneration. These were designed to improve service coverage and quality, and to impose compulsory retirement at 70 (a good example of earlier laissez-faire!). New regulations were agreed to support the development of **primary care teams**, to improve premises and to provide incentives to work in unpopular areas, to care for the elderly, and to undertake health promotion activities. The subsequent national contract was negotiated with some difficulty, but heralded a new interest in the role of primary care.

The 1991 reforms affected primary care in three significant ways. First, the introduction of **fundholding** offered a bridge between primary and secondary care organisations, made concrete by the transfer of real money between the two. Secondly, all GPs were to be involved in the choice of HA **contracts** to ensure that the referral system between primary and secondary care continued to function effectively. For many GPs this was the first opportunity they had had to understand the work of non-primary care NHS organisations at first hand, and vice-versa. Thirdly, a formal system of **medical audit** in primary care was introduced.

The impact of **G.P. fundholding**, which was voluntary, was variable. Behind the superficial contractual and financial terminology of the contractual relationship between fundholders and other providers, new themes were developing which have been influential in shaping the current raft of PCG-based changes:

- fundholding practices were either already large practices, or smaller ones which banded together to form a fund. Local GPs in different practices began to group themselves in new ways to explore their common interest in local services – and to make real changes
- GPs could offer services within the practice which had previously only been available in hospitals and community clinics e.g. physiotherapy
- GPs became more interested in management and financial information,
- alternative and complementary models to fundholding were developed (e.g. locality purchasing, multi-funds) which usually sought to reduce transaction costs and share administration across a larger base
- some GPs believed that fundholding, and multi-funds in particular, encouraged informal peer scrutiny, which in turn led to higher standards within general practice.

It is not the place of this paper to explore some of the negative aspects of fundholding, more to point to its significance as a pointer to the role of primary care in current thinking about integrated care.

The Labour model of Primary Care Groups extends the logical crossover of fundholders as both **purchasers** and **providers**, and builds on the potential for peer review of standards. This is a long way from the 1940s and 50s model of the single-handed GP working in isolation, often over a career of some 40 years. Ideally, the emphasis on local health systems spanning several providers should help to break down traditional rivalries between GPs and consultant specialists. The PCG model also raises the profile of nurses within primary care, and foresees primary and community services being run within single trusts. It specifically avoids the issue of salaried GPs, although some commentators see a logical expansion of this option in the future.

Key words from glossary	contracts, gatekeeper, general practitioner, G.P. fundholding, medical audit, primary care, primary care groups, primary care team
References for further reading	1,19,29,41,44

## **Developing the role of Community Care**

There has been a long history of patchy co-ordination between Social Services and the National Health Service in the United Kingdom, with the potential for undesirable gaps in services for vulnerable individuals. The state (via central social security) was picking up the costs of every new entrant to residential and nursing care; changes in regulations during the early 1980s were leading to exponential growth in this area. Health Authorities were accused of cost shifting, by closing beds to rake advantage of these changes.

The Conservative White Paper '*Caring for People*' was intended to address the mounting confusion over responsibility for those patients with continuing needs, such as the elderly, people with a physical or learning disability, and those people with mental illness where responsibility was shared across health and social services. The proposals promoted individually designed care packages of hospital and community services, overseen by a care manager nominated for an individual patient.

In addition to promoting the centrality of the needs of individuals, the proposals were intended to promote rational planning and the funding of services across organizations. Relevant expenditure was frozen and transferred to local authorities. Particular responsibility was allocated to Social Services departments of local authorities whose primary role was to change from provider to facilitator, ensuring that the right mix of care was provided, if necessary through contracting in from other sources. Local authorities were to support the development of services that allowed people to stay in their own homes. The independent sector would be stimulated to provide care. In the longer term there would be incentives for local authorities to maintain some patients in their own homes, possibly at higher dependency levels than previously, requiring nursing care on a continuing basis.

It is fair to say that whilst the NHS has a lead role in services for mental health and local authorities for those with a learning disability, the greatest difficulties have persisted regarding care for the elderly, where health and social care needs can be equally pressing. Eligibility criteria for NHS long stay care (free at the point of use) are not always clear to users, who, if ineligible, may have to pay or contribute towards nursing home or residential care.

Recent initiatives emphasising a **partnership** approach and geared to improve joint planning across health and social services are being introduced, including the potential to pool funding.

Key words from glossary	care in the community, community care, joint investment plans, partnership
References for further reading	1,8,9,20,21

## Involving the User

User involvement operates at a number of levels:

- populations, in relation to population-based health issues and to the supply of local services
- individuals, in relation to their own health status and to the treatment they receive as patients
- interest groups with a focus on a particular condition, service, or service change.

For many years, the focus of user involvement in the NHS was through the rather negative channel of **complaints** mechanisms. The tensions between the views of the consumer, the defensiveness of the professional organisations, and the ever-present threat of expensive litigation have confounded repeated attempts to simplify the system. To the patient, the NHS can be a very complex bureaucracy, with responsibilities split between a number of its constituent organisations. The system is now more user-friendly than before.

Formal user involvement in the NHS has been through **Community Health Councils**, local bodies set up in 1974, to act as watchdogs over services and to act as the patient's 'friend' in making serious complaints. Both the old and the new government have considered it expedient to maintain these organisations, despite an overlap between the responsibilities of the HA and the CHC on the patient's behalf.

Unlike Local Authorities, Health Authorities, Community Health Councils and trust boards are not directly elected bodies. Some commentators refer to a 'democratic deficit' left by the system of appointments to NHS statutory bodies. The Conservative NHS reforms sought to increase consumer interest in health care, making the service more responsive to different communities, through devolution and improvement of professional listening skills. While such participation at the local level was an ideal iterated from the beginning of the reforms, it was slow to come about. However, a body of information has been produced promoting listening and responding to local voices in addition to the general duty on HAs to consult and to be more open about their activities.

Two recent shifts in policy have been significant. First, the development of clinical and non-clinical **performance indicators**, published in the form of national league tables, has sharpened consumer interest in the quality of services on offer locally. (The Patients Charter, described below introduced these concepts into the NHS.)

Secondly, **primary care groups and trusts** will be working at a very local level and their focus on the overall performance of local health systems through the health improvement programme should better reflect the patient's experience in planning for service improvements on PCGs reinforces this.

The **Patient's Charter** was introduced in 1991. It outlined ten basic existing **rights** about treatment and access to it in both primary and secondary care. Rights covered, for example, registration with a GP and changing GP, and what you should expect to happen on arrival in Accident and emergency Departments. As performance improved, new standards were added and existing standards raised. In 1995, for example, these included an 18 month guarantee of maximum waiting times for all inpatient treatment, a 12 month standard for coronary artery bypass grafts and a 26 week maximum standard for a patient to be seen by a hospital consultant after referral by their GP. Whilst many criticised these standards for concentrating on process issues – not clinical outcome – others welcomed the explicitness of the standards and the impact of league tables, which generated considerable press interest. The Charter's definition of national standards has been mirrored at local level by GPs and HAs.

The extension of the model to **clinical indicators** is again naturally arousing significant press interest. The underlying belief is that, for all their flaws (e.g. is like being compared with like in terms of case-mix?), the culture of open review of comparative clinical performance will raise legitimate questions about standards, challenge inertia, and stimulate the consumers of NHS services.

Key words from glossary	complaints, clinical indicators, community health councils, patient's charter, performance indicators, primary care group, primary care trust, rights
References for further reading	11,22,23,24

## Efficiency

A **cash limit** on the NHS was not imposed until the 1970s, along with a cap on automatic growth from expansion in supply when new facilities were opened or new consultant staff appointed. Not only did managers have a new duty to stay within budget, but explicit **priorities** for services were set which had to be met from within that budget rather than with new funds. The climate therefore changed dramatically. The response of managers quickly changed from making crude cuts in services to one driven by the potential of efficiency gains, for example, by the contracting out of ancillary support services such as cleaning and catering.

The concept of efficiency through competition was at the heart of the Conservative 1991 reforms. The reform package worked in symbiosis with two other significant developments that would help the quest for efficiency;

- the revolution in information technology and the impact of more readily available data within the NHS.
- growing interest in the concept of clinical budgeting, with services subdivided into cost and activity centres headed where appropriate by a clinician.

The purchaser/provider split immediately led to the generation of comparative data on price and activity. Whilst the NHS as a whole continued to grow in real terms, the application of formulae for fair shares capitation funding squeezed some HAs more than others who consequently had to find ways to make their budget stretch without making service cuts.

The pursuit of efficiency gains became an explicit national priority with the purchaser **efficiency index**. The government expected a demonstrable growth in activity when measured against a real terms baseline budget. For example, a HA could contract with a provider for either more activity with the same baseline budget, or the same activity with a smaller budget. Logically this trend led to questioning of methods of service delivery, not only 'could this be done differently?', but 'should it be done at all?'

Dire predictions of exponential growth in demand and need for health services have been made since the 1950s. It is the present government's belief that the service can continue to be funded out of direct taxation as long as growth in demand can be met by efficiency gains, through programmes of modernisation where necessary. Thus all those working in the NHS are involved in continuous evaluation of what they do and whether it can be done differently. A rapid dissemination of **evidence-based practice** and outcome data will lead to hard decisions, whereby established procedures and treatments found to have no benefit are discontinued to make way for new ones which are of proven benefit. The government expects to avoid explicit service rationing through this process of constant evaluation.

Key words from glossary	cash limit, priorities, efficiency index, evidenced based practice, performance indicators
References for further reading	32,37

## Delivering High Quality Care

Professional organisations had for years been the self-appointed guardians of the quality of service within the NHS. Whilst interest in total quality management (as practised in some sectors of industry) was gaining ground before the 1991 reforms, meaningful contracting required greater precision in definitions of standards of care being purchased. The reforms therefore provided the catalyst for new thinking.

Quality of care is another area composed of many strands of activity, where underlying principles may be consistent but where fashions in the prevailing management techniques change rapidly to match a growing knowledge base. There has been a steady move from process measures towards patient-oriented measures of clinical outcome and overall wellbeing; 'do you feel better', and 'how was your experience?'. The discipline of **clinical audit** has also developed over the last decade, spanning concepts of efficiency, effectiveness and peer review.

Quality of care in all its different guises is a current government preoccupation in the belief the previous government's policies were too financially driven. A number of activities are converging to help build the picture in the round:

- new national bodies have been established, one to promulgate good practice and set standards (**National Institute for Clinical Excellence or NICE**) and the other to monitor and troubleshoot areas of concern (**Commission for Health Improvement**)
- trust boards and PCGs now have an explicit duty of **clinical governance**
- a structured programme to review and disseminate evidence-based guidelines via NICE is in action
- detailed **National Service Frameworks**, for approximately three service areas each year, are being generated; these will respond to government priorities e.g. chronic heart disease, and will span primary, community and hospital care.

Key words from glossary	Commission for Health Improvement, clinical audit, clinical governance, National Institute for Clinical Excellence, National Service Frameworks
References for further reading	1,10,46

## Managerial Responses to Delivering the Strategic Intent

This section reviews executive guidance and other supporting literature issued to implement the strategic goals.

Whilst the overall goals have remained broadly constant, the means of implementing them are constantly changing. Management reforms within the NHS have reflected not only political ideologies, but also fashions in organisational theory and the social, economic and epidemiological context in which the service is operating at any one time.

The sub-sections that follow do not exactly mirror the seven strategic themes as executive action to achieve a particular goal may be directed at a number of different areas of NHS management simultaneously. For example, the strategic goal of improving health status may be implemented through allocating funds fairly to meet need, through improving the quality of care, through stronger partnerships, and so on.

### Purchaser/Provider Split

“**Internal market**” describes the separation of purchaser from provider within the NHS and was probably the biggest change to the NHS since its creation in 1948. An important belief of the 1979 – 1997 Conservative government was that competition would bring about greater efficiency. Inefficient organisations would be squeezed out by the successful ones. The 1990 **NHS and Community Care Act** separated purchasers from providers. Hospitals and other providers were to compete for (non-legally binding) **contracts** from HA purchasers. Competition would expand choice and drive up levels of efficiency and quality. The private sector would be able to bid for work through the contracting system.

**Purchasers** were to commission services for their populations, using intelligence about local need and with fair-shares funds derived from the capitation formula. By these means the historical, supply-driven basis of the NHS was to be challenged and innovation encouraged.

In practice the internal market was heavily managed by the centre through its regional offices in order to protect the public from unexpected or undesirable consequences. Where providers had a natural monopoly, competition was more a threat than a reality (contestability), achieving some of the desired consequences nonetheless. It was also biased towards the acute sector and incentives for elective work, with less obvious impacts on hospital emergency services (the exception being ambulance services).

Among the areas where competition had a real impact were:

- waiting lists, where purchasers used the contracting process to speed up treatment for certain groups of elective patients.
- fundholding, where the movement of even marginal amounts of elective work from one provider to another could be highly significant.
- shifts between different modalities of care, for example, community trusts might bid to provide services previously only provided in hospital settings, or hospitals stimulated to speed up the substitution of day care in favour of in-patient episodes.

The early days of the market were characterised first, by an emphasis on the establishment of trusts and fundholders, with the relatively complex role and functions of purchasing taking slightly longer to develop, and secondly, by the impact of one-year contracting. At best, the process highlighted inefficiencies, exposing strengths and weaknesses in cost, volumes and quality, and giving ample notice to enable providers to take corrective action. At worst, the process became an expensive paper-chase, sometimes with inappropriately aggressive behaviour between the parties (imitating what was understood to be commercial practice), and with service duplication driven by the aspirations of doctors rather than the needs of purchasers.

It has been the intention of the new Labour government to exploit the benefits and discard the disadvantages through reshaping the relationships and processes. Present policy, as described in Section 6, moves away from the one-year contract as the defining vehicle for purchaser/provider relationships, with longer-term service agreements taking their place, and the encouragement of collaborative over competitive relationships. It is expected that this will free up management capacity to develop service standards for particular areas of care. In practice, annual number-crunching for activity and cost will continue to be a necessary control. Performance management using a variety of indicators will replace competition as the spur to improved quality and efficiency.

It is not clear whether the internal market has driven the current trend towards trust mergers (rather than closures) or whether this would have happened anyway because of other factors such as shorter lengths of stay in the acute sector and closures of long stay institutions for the mentally ill.

A mass of explanatory literature about the internal market was produced in the early 1990s. In addition to the general contracting literature, some areas received particular attention as operational complexities emerged.

Key words from glossary	contracts, internal market, purchasers, purchaser/provider split
References for further reading	1,21

### **Provider Autonomy**

**NHS Trusts** were introduced by the Conservative 1991 reforms semi-**autonomous hospitals**, run by boards and accountable directly to the Secretary of State. Trust status was voluntary. In fact trusts may also include community as well as hospitals services. New powers and freedoms were delegated to allow trusts to act as stand alone organisations, controlling their own affairs within the broad framework of public accountability. They remained public organisations. The rationale was to enable providers to respond more quickly to changing local circumstances, and to be more locally accountable through self-government. New freedoms would equip them to operate effectively within the internal market environment. The major advantages of trust status were in terms of the employment of staff and the management of assets. However, trusts were heavily restricted with regard to capital spending and were subject to external financing limits set by the Department of Health.

When the reform process began it was not envisaged that many or all providers would become trusts, at least in the early stages. Some were expected to remain as directly managed units (DMUs), under the authority and management of districts. DMUs were expected to have something close to a contractual relationship with the purchasers, with management budgets structured as contracts, but enforced through the normal management process. However, while trusts proliferated, DMUs rapidly disappeared.

Also, the Conservative Government envisioned that only hospitals would acquire Trust status; however Trust status quickly became the model of choice for all providers, including community care and mental health providers. (Some of the earlier documentation only addresses hospitals acquiring Trust status). The practicalities of direct accountability to the Minister also became untenable, and special NHS Management Executive outposts were set up within the regional structure. (NB general practice remained outside this model)

Under the Labour Government, the role and status of trusts remains broadly similar. Whilst remaining as quasi-autonomous bodies, the stand-alone ethos of trusts is replaced by collaboration with other organisations - including those who might otherwise have been competitors. Trusts will be party to local Health Improvement Programmes. They will work with Primary Care Groups using long term service agreements, linked to the new National Service frameworks. In this way, trust clinicians will be encouraged to use their knowledge to make a more direct

contribution to service planning. The statutory financial duties of trusts, a specific focus of the conservative reforms, are now complemented by those for clinical quality under clinical governance.

Trusts are run by boards comprising executive and non-executive members, with a non-executive chair.

Key words from glossary	NHS Trusts, autonomous hospitals
References for further reading	1,21,25,26

### **Purchasing - principles**

The establishment of the **purchaser/provider split** divided the predecessor Districts into two camps; those interested in the providing side identified quickly with trusts and DMUs. At first, Health Authority purchasing teams tended to include representatives from planning, public health and finance (most district general managers elected for provider management). **Purchasing** (sometimes referred to as **commissioning**) skills were newer, suiting those with interests in service planning. At first some purchasing teams were unequally pitched against powerful providers, particularly if most of the previous district team had elected to manage provider services. The government made purchaser development a priority, and teams soon began to strengthen, acquiring new skills and experience. Hindsight has shown that managers should be encouraged to work as both purchasers and providers at different stages of their careers, as knowledge of provider management is a valuable asset in the purchasing function and vice-versa.

Like trust boards, HAs are composed of both executive and non-executive members headed by a non-executive chair. In 1996 the Family Health Service Authority (formerly the Family Practitioner Committee), became part of the team, representing the views of general practitioners. A desire for closer integration of primary and secondary care services and closer working with users soon led many HAs to divide themselves into smaller sub-localities. This reflected the government's policy for a 'primary care- led' NHS, which in turn became the cornerstone of the new Labour government's policy on election in 1997.

Under the latest round of reforms, HAs now delegate a substantial part of their functions to their constituent **Primary Care Groups** (PCGs). Over time, the HAs will relinquish direct commissioning responsibility and will concentrate on a strategic role in partnership with local authorities, NHS Trusts and PCGs. They will lead the process of drawing up three year Health Improvement Programmes, providing the framework within which all local NHS bodies will operate. Health Authorities will allocate funds to PCGs and hold them to account. As a result of reforms, it is likely

that there will be fewer health authorities covering larger areas. Purchasing will be carried out by the new PCGs.

All GPs are now part of Primary Care Groups, which replace **GP fundholding**, total purchasing, multi-funds and locality commissioning. PCGs cover populations of around 100,000 and will bring together GPs and community nurses in a given area. They take responsibility for commissioning services for that community, working closely with social services and with local service users. To reflect the different stages of development currently found in primary care, there is a spectrum of PCG models from simply advising their Health Authority to commissioning health services directly to becoming **Primary Care Trusts** accountable for commissioning care and providing community services. There will be major organisational implications for other NHS bodies, particularly Health Authorities and Community Trusts.

Eventually it is expected that these organisations will control unified primary care group budgets, bringing Hospital and Community Health Services, prescribing and GMS infrastructure budgets together “within a single cash-limited envelope”. This will allow PCGs to deploy almost the total local health budget in the most cost-effective way (for example, by substituting drug treatments for hospital referrals) and, if desired, switch more resources from hospital to community and primary care. For the first time, the majority of primary care expenditure, including GPs’ prescribing costs, will be within the cash limits which have applied for many years to the NHS’ hospital and community health services.

Key words from glossary	Commissioning, G.P. fundholding, health improvement programme, purchaser/provider split, purchasing, primary care groups, primary care trusts
References for further reading	21,43,45

**Purchasing – Needs assessment.**

Reform under the Conservatives initially brought strong enthusiasm for the new strategic role of the purchaser, with its consumerist and public health orientation. Health Authorities voiced aspirations to change their health care **priorities** in line with the **needs assessment** process and consumer research, and assumed they would be shifting resources in favour of community health services, the priority services and health promotion. HAs, however, faced the same difficulties they have always faced in shifting a service, shaped by powerful providers, to one led by needs. Progress on needs assessment was slow and fitful. Nevertheless, by the second year, there were several examples of innovatory forms of consumer research and more permanent consultative mechanisms, plus pilot projects in locality needs-assessment and commissioning.

This emphasis on needs assessment shows the genuine desire to tackle the inertia within the system by moving from the maintenance of existing service patterns services to a mechanism of allocating resources based on effectiveness and value for money.

Key words from glossary	needs assessment, priority setting
References for further reading	6,7

### Delegation

The Conservative government believed that the NHS was a monolithic and unresponsive organisation, inefficient and slow to change. The 1991 reforms were strong on devolution, the rationale being:

- to move the point of decision-making as near to the patient as possible in order to improve local responsiveness to need (at both population and individual patient level)
- to provide in-built incentives to manage efficiently; where problems are locally-owned, solutions can be locally generated if the organisation has the powers to act

**Delegation** needs to be matched by **accountability** in order to safeguard the public interest: typically greater freedom delegated to act independently is counter-balanced by a more stringent monitoring process.

Delegation took its most obvious form in the creation of trusts and fundholding practices. Trusts were initially to report direct to the Secretary of State (whilst HA's accountability ran through the regions). In practice the reality fell short of the rhetoric, as trusts proliferated their monitoring was through regional outposts, and a centrally driven system of performance management took hold. Despite this, the nature of the service is markedly different from that of the 1980s and beyond. Managers undoubtedly have greater freedom of action, particularly at trust level, but within the constraints of a performance management framework. Devolution does not stop at board level, but has cascaded down within organisations to lower tiers of management.

The implications for primary care are more subtle, and ambiguities persist. GPs are independent contractors, so have theoretically enjoyed a history of self-management within the constraints of a national contract. New powers and responsibilities are now being devolved to the new primary care groups (and, eventually, primary care trusts) which introduce concepts of **corporate governance** largely new to general practice. Thus there is delegation in the sense of moving commissioning decisions closer to

the patient, but a shift in the opposite direction for the individual GP, who will be providing services as part of a local system of health care rather than simply for the patients on his or her list. The local health improvement plan (HImP) will also sharpen up the role GPs have to play in meeting national and HA priorities and will hold them to account more explicitly for standards of clinical care.

Key words from glossary	accountability, corporate governance, delegation
References for further reading	1,21

### Partnerships

Joint working between the NHS and corresponding local authorities has long been recognised as essential to achieve common goals. The imperative runs to other public, private and voluntary sector organisations, for example, the police, the pharmaceutical industry and the charity sector. There has been a patchy history, sometimes obscured by the question of ‘who pays’? The Labour reforms are taking a new look at this issue and have put upon organisations a statutory duty to work in partnership.

The Government recognises that “tackling poor health and health inequality needs the NHS and local government to take joint responsibility.” They have introduced a battery of initiatives to support partnership working and the integration of services to respond to the needs of the individual user. The key initiatives include:

- a **statutory duty of partnership**, (Health Act 1999)
  - a) between NHS bodies
  - b) between NHS bodies and **local authorities**
- joint national priorities guidance for health and social services.
- 3 yearly **Health Improvement Programmes** (HImPs) involving the NHS, LAs, and the community in local strategies to improve both health and healthcare services, and improved integration with social care, and including **Joint Investment Plans**.
- new operational flexibilities, like pooled budgets, lead commissioning and integrated provision.
- joint inspection and monitoring e.g. by NHS and Social Care Regional Offices
- **Health Action Zones** (HAZ) – trailblazing partnerships between the NHS, LAs, community groups, and the voluntary and business sectors to develop and implement a total health strategy for their area. 26 HAZs have so far been announced.

Key words from glossary	health improvement programmes, health action zones, joint investment plans, local authority, statutory duty of partnership
References for further reading	5,6,7,8,9

### Value for Money and Efficiency

Whilst value for money initiatives had been embedded in the management of facilities and support services since the 1970s, until recently a systematic review of clinical performance was missing from the NHS. Medical audit, for a long time regarded as a management tool, has only received general support from doctors since the White Paper, *Working for Patients*, in 1989 insisted on its importance. Managerial and financial audit have been taking place for some years, but their interface with **clinical audit** has been rare.

In 1990 responsibility for the government's audit was transferred from the Department of Health's audit staff to the **Audit Commission**, which must report to the Secretary of State any unlawful expenditure or financial loss. Their remit in fact is much larger than this, and they undertake various surveys to assess value for money.

Due to the difficulties of measuring health outcomes, "detailed control of expenditure requires more than periodic and retrospective scrutiny. Only by understanding the cost and outcome of the main components of each health service activity can real benefits be assessed. One of the obligations of the NHS is to obtain the maximum benefit from the resources that it uses in order to maximise the health of the community".

Key words from glossary	Audit Commission, clinical audit
References for further reading	1,47

### Performance Management

In designing its new start, the government has consciously built on the foundations of earlier approaches to performance management. The abolition of the internal market, with contracts replaced by service agreements and competition by collaboration, has of itself had little impact on the emergence of performance management processes. Good, easily accessible comparative information (within the public domain) and

**benchmarking** are essential prerequisites. There is a strong emphasis on central targets and rigorous performance management, clearly linked to the achievement of national strategic priorities.

The new government spelt out its approach in March 1999 in ***The NHS Performance Assessment Framework***. The framework aspires to assess NHS performance 'in the round' through the use of high level indicators. The Performance Management Framework aims to make public accountability more concrete and visible. It reflects new initiatives to improve service quality, through the setting and monitoring of explicit service standards.

Key words from glossary	Benchmarking, performance framework
References for further reading	37,47

### **Capital and PFI**

The government's broad strategy for capital investment in the public sector is to encourage public/private partnerships. Within the NHS, some **capital** is distributed centrally, either direct to trusts as part of their external financing limit (which is used by trusts to fund small capital developments) or, occasionally, to fund major rebuilding programmes. The more common route for major schemes is now through PFI. Since the current government took power in May 1997, 18 major hospital construction projects have been approved, of which 4 have been publicly funded and 14 developed through the **Private Finance Initiative (PFI)** – now more of an institution than an initiative. The value of the NHS PFI schemes currently totals over £1 billion.

The government hails the PFI as a necessary and appropriate component of its major hospital building programme. The approach remains controversial. A key concern is the extent to which the long term PFI contracts for services, covering 20-30 years, will mortgage future revenue allocations, locking NHS purchasers into outmoded models of service delivery and depressing service innovation. There are other concerns about the PFI's preference for large (perhaps inappropriately large) structures, the difficulty of securing PFI deals for smaller mental health, community and primary care schemes, the bias to newbuild rather than renovation, and the challenging throughput assumptions underpinning some of the new hospitals' reductions in bed numbers.

Processes for the approval of capital schemes differ between small (less than a £10m threshold) and major. Small schemes can be approved locally. Major schemes fall within a centrally managed process, not given in full here. In outline, business cases are required which demonstrate the full service, activity and financial

implications of the proposal and which have explicit purchaser support. All realistic options must be considered to produce a single viable option. Cases must predict substantial efficiency gains.

Key words from glossary	capital, private finance initiative
References for further reading	38

### Capital Charging

Until 1991, capital had been treated as a free good by the NHS. The conservative reforms introduced a system of **capital charging** in 1991, highlighting the value of provider assets and providing incentives for their efficient use. The system did not depend on new money coming into the NHS, but a recycling of funds within a closed system. Adjustments have been made to the formula over time to ensure that it is fair, and that providers operating in areas where land values are high are compensated via market forces adjustments to HA allocations. Capital charges are built into the **costing for contracts** of services by provider trusts.

Key words from glossary	capital, capital charges, costing for contracts
References for further reading	38,39

## Managerial Capacity Building

A consistent process of change from the 1950s triumvirate of nurse, doctor and administrator can be observed over the decades. The executive model is now based on **general management**, introduced in the mid-1980s, with multidisciplinary teams in support. Doctors, nurses and other clinical staff are not only involved in management in their professional capacity, but sometimes as general managers too. Significant shifts in management thinking occurred in the late 1980s with complementary experiments in clinical management and budgeting; these are now standard practice and almost all secondary and community services have clinical directorates. The rationale behind clinical directorates is to move budgetary control nearer to the point of clinical decision-making. All senior staff are expected to have a broad range of management skills.

The management focus is now on the development of **primary care groups**. Until the advent of fundholding (now discontinued), few GPs had been involved in management of health care above practice level other than in a representative capacity (although many have natural management flair). Whilst remaining independent contractors, GPs are working within a clearer corporate structure, requiring new skills and knowledge or the extension of existing skills (a good example is health needs assessment). Recent organisational development in all areas of NHS activity has concentrated on teambuilding, whether at HA, trust, or individual practice or service level. The new PCGs will be no exception.

Key words from glossary	general management, primary care groups
References for further reading	1,21,29,43

## Human Resources

The NHS today is a staff-intensive organisation. Success in realizing the government's vision for the NHS will depend heavily on sufficient numbers of well-motivated, appropriately trained staff. A new Human Resources strategy was launched in 1998: "**Working Together – Securing a quality workforce for the NHS**".

Key features of the current HR strategy include:

- action on recruitment and retention for each local NHS employer to include an **annual workforce plan**, year on year improvement in retention rates for all staff, in representation of the local community and in sickness absence rates.
- training and development plans for the majority of health professional staff.
- policies and procedures to tackle harassment and promote equal opportunities.

- staff involvement in planning and delivering healthcare.
- an annual staff attitude survey to measure progress on improving the quality of working life for staff.
- a new NHS Social Partnership Forum with representation from all the national NHS management, union and employer bodies.

Other current HR issues include:

- pay, including a review of salary structures to explore the introduction of a common pay spine for all professional, managerial and other NHS staff.
- staff shortages in many professions, including doctors, nurses, pharmacists and physiotherapists. Nurse shortages have led some Trusts to seek to recruit overseas, leading to complaints e.g. from South Africa; the UK DOH is currently preparing guidance for Trusts on this issue. The government has promised up to 7000 extra doctors and at least 15,000 more nurses over 3 years, plus increases in medical and nurse training places. It has also announced a new, higher paid grade of nurse consultant..

Key words from glossary	annual workforce plan
References for further reading	12

### Information

The NHS' track record in information and IT has been unimpressive. The capital cost and rapid technological change inherent in the world of IT are problematic for the NHS, large, complex and with expenditure constrained by cash limits. The 1991 reforms gave new significance to data capture in order to make the contracting system work. However, the ability of NHS systems to deliver strategic goals remains patchy, and the systems – in terms of hardware, software and human resources - struggle to keep pace with desirable change (e.g. costing on the basis of **health related groups** HRGs). Definitions for counting (and costing) patient activity vary from place to place. Progress in linking different parts of the NHS together has been slow, despite obvious benefits to the patient.

The government nevertheless sees scope for major efficiency and quality gains from harnessing the information revolution, and its “**Information for Health: an information strategy for the modern NHS 1998-2005**” sets some challenging targets.

Current information strategy aims include;

- to enable every local NHS body to invest in **electronic patient records** (EPR) to support their own organisational requirements, including exchanging information with others.
- the ultimate incorporation of this EPR into lifelong electronic health records for everyone in the country.
- round the clock on-line access to patient records and information about best clinical practice for all NHS clinicians.
- genuinely seamless care for patients through GPs, hospitals and community services sharing information.
- fast and convenient public access to information and care through on-line information services and tele-medicine.

Much of this remains aspirational, not least because a good deal of the NHS IM and T expertise has been engaged in tackling Year 2000 problems. More generally concerns have been expressed about costs, the complexity and time needed for the procurement and installation of such major systems, and above all the challenge of persuading NHS staff, particularly clinicians, of the benefits of IT solutions. Immediately there are some specific goals, with all GPs and hospitals to be on the NHS net by 2002, on-line booking of appointments, and quicker test results.

One concrete success is **NHS Direct**, a 24-hour nurse helpline, offering health advice (0845-4647). It will cover the whole country during 2000 and go on-line in autumn 1999.

Key words from glossary	electronic patient record, health related groups, NHS Direct
References for further reading	13

## Teaching

Training and research were potentially vulnerable in the 1991 NHS internal market. A number of protective mechanisms for subsidising costs were retained in the first years of the reforms; these were then replaced with new mechanisms which encouraged the attribution of true costs in order that they were not borne by local purchasers alone, but met through central allocations direct to providers.

The new mechanisms encouraged a quasi market in undergraduate training. Medical Colleges were given the budget for placing their students with provider trusts (thus enabling a greater diversity of providers of undergraduate training). Arrangements for postgraduate training have also changed recently as a result of the **Calman Report** that has introduced shorter but more intensive training periods for doctors.

Specialists will qualify younger, leading to an increase in numbers, with consultants undertaking more of the work previously undertaken by juniors.

Training schools for nurses and other clinical staff were absorbed into the further education structure with similar arrangements for the placing of staff in training. Concerns about new entrants to training have stimulated initiatives to attract returnees to nursing.

Key words from glossary	Calman Report
References for further reading	31

## Planning

The term 'planning' had become discredited in the 1980s and it was believed that the market would replace bureaucratic planning processes. However, the practical and political imperatives of market management reinvented the planning process through a number of devices, such as the annual publication of purchasing intentions, health needs assessment, and HA corporate contracts. Although, the rigid planning mechanisms of the pre 1991 reform era have gone, planning is now firmly back in NHS terminology.

**Planning and priority guidance** is published annually by the NHS Executive that consolidates national priorities and the executive action required to implement them. The guidance is based on a three year planning cycle, consistent with the new public service agreements. Guidance is now joint with social services, thereby covering action care groups where there are joint responsibilities and identifying the lead organisation.

Health Authorities have the lead responsibility for the **Health Improvement Programmes** (HImPs) which plan for local implementation of national priorities. HImPs

are agreed between the HA and its matching local authority, with the express input of trusts and PCGs. The framework is cascaded to PCGs who have their own plans. NHS Trusts produce three year strategic plans and annual business plans, which will also reflect HImP priorities.

All parties use this framework to translate national and local priorities into specific service agreements, the successors to the contracting system used in the internal market.

Key words from glossary	health improvement programme, planning and priority guidance
References for further reading	7,32

### Urban Care

The role of the hospital world-wide is changing, with an increase in day surgery accompanied by shorter lengths of stay and new technologies. In the early days of the internal market, the expected impact on large clusters of prestigious **teaching hospitals**, was soon felt, in London and in other major cities. Problems arise from a combination of duplicated, often highly specialised services geographically close in expensive buildings. Firstly, reforms had exposed the high costs of services, including the value of assets. Secondly, **capitation funding** generally moved funds away from big cities. Finally, problems remained for rare distant purchasers referring perhaps only one or two patients a year and for consultant to consultant referrals.

A pragmatic approach to change has occurred. Closures and mergers of large institutions are rarely popular with voters. The pace of change has been slow but steady, with incremental change usually paving the way for major steps. For example, trust management may first be merged across two institutions, followed by a rationalisation of services and occasionally the eventual closure of one of the sites. The nature of staff and public interest in such changes is such that they are most likely to be accepted if there is major capital investment attached.

It is evident that patterns of care differ between rural, urban and suburban areas and what works in one may not work in another. The prevailing patterns of primary care and community health services, and their susceptibility to change, are key determinants of success in the reorganisation of hospital services.

In Scotland, Wales and Northern Ireland, hospital reorganisation programmes have been centrally driven. This has not been the case in England, which may account in part for the slow pace of change.

Key words from glossary	capitation funding, teaching hospitals
References for further reading	33,36

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