The funding

What are the likely management implications for teaching and research hospitals? The real consequences of a new financial arrangement are driven by specific details of the mechanism: how the new mechanism interacts with a web of existing financial mechanisms and, as a consequence, what new rewards and penalties will be handed on to different players. The NHS reforms have created a general financial framework which is more complex, more dynamic and less predictable in its effects than the 1974 arrangements. How purchaser/provider quasi-market funding systems behave is something that is still at the early stages of understanding; so, anticipating the effects of these new R&D funding arrangements is not at all straightforward. To make the attempt, practical managers will look carefully at the details of the mechanism and try to guess what its effects will be in the light of our growing understanding of how the NHS quasi-market behaves.

The financial mechanisms

At the centre of the new arrangements is ‘a radical new “single stream” funding mechanism’ [1]. In the classic tradition of British administration, the R&D funding stream preempts various historic expenditures, whose different origins and reasons nobody quite remembers. An elegant and cogent rationale is ascribed to these expenditures which may have little to do with how they evolved but gives good reason why they should be continued.

The new R&D funding stream preempts five existing streams of expenditures; two of them are very large.

One is the R&D contracts of the hospitals that until last year were managed by special health authorities (SHAs). These R&D contracts are themselves a rationalisation and systematisation of the fact that SHAs had exceptionally high expenditures which, when challenged, were justified as supporting the national contribution of the SHA hospitals to clinical research. Today, the allocation of these funds is based on a peer-reviewed assessment of the scientific standing of research work carried out in the institution, and of the relevance of that research to the needs of the NHS. The funding is only available to former SHA hospitals.

The second is the research (R) element of the service increment for teaching and research (SIFTR), which is said to be 25% of the total sum. SIFTR was derived many years ago to explain and support the high expenditures of undergraduate teaching hospitals. Originally expressed only as a teaching allowance, it was extended in the 1980s to include support for research in undergraduate hospitals. Today, hospitals receive the monies as a single sum, calculated mainly on the basis of student numbers. SIFTR is principally available to main undergraduate teaching hospitals, although it is allocated wherever medical students receive clinical training in significant numbers.

Both R&D contracts and SIFTR are mainly used to offset the service costs of hospitals which receive these funds. This removes the higher service costs incurred by teaching and research requirements from service prices for purchasers. Some former SHA managers argue that ministers intended the contract to meet the full costs of services which were essential to critical research programmes, as happens at NIH in America. That interpretation, however, is not reflected in the Secretary of State’s announcement which talks quite clearly about ‘excess service costs’.

Shifting the distribution of R&D funds

When the NHS reforms were introduced there was great concern that the ‘market’ would cut off the flow of patients to teaching and research hospitals which is essential for teaching and research programmes. R&D contracts and SIFTR allow teaching and research hospitals to price their services very competitively in the hope that this will allow such hospitals to keep essential patient flows. The NHS market does threaten the survival of those teaching and research hospitals that are costly and not well located for service. In these cases R&D contracts and SIFTR may sustain whole institutions and patterns of service that are important for teaching and research but would not otherwise survive.

These principles are carried over into the new single R&D funding stream, which will begin to be introduced in 1996/97. R&D funding will have five components, two of which will offset substantial elements of the general costs of teaching and research hospitals. One of these two is the funding of excess service costs of peer-reviewed non-commercial research in the same way as R&D contracts and SIFTR now operate; the other is infrastructure funding of research facilities and staff which cannot be attributed to individual projects. The other three components will fund research projects, the dissemination of research results and development of research capability.

The new arrangements are being introduced gradually, but over a period they may have far reaching effects.

The R&D funding enjoyed by the former SHAs is likely, over a period, to be distributed more widely. The claim of undergraduate centres that enjoy an international research reputation to participate in R&D funding will be irresistible. In England, examples of strong claimants to R&D funding will include the John Radcliffe in Oxford, Addenbrooke’s in Cambridge and UCL Hospitals in London; no doubt there will be several others. Assuming the total sum available remains more or less the same, in aggregate
the former SHA hospitals must be losers in this process while some of the research oriented undergraduate hospitals may be substantial gainers.

Two elements of the proposed funding arrangement may tend to focus large-scale research funding on a few research hospitals.

One is the proposal for an infrastructure component. We do not yet know how this component will be calculated. Nevertheless it is reasonable to expect that hospitals which are the site for major medical research institutes and/or research oriented medical schools, are most likely to attract infrastructure funding.

Second is the separation of R funding from SIFTR. The effects of this are potentially far-reaching. Research programmes that attract the equivalent of a Higher Education Funding Council for England (HEFCE) rating of 5, will be powerful magnets pulling funding away from hospitals with less highly rated research programmes.

These two factors working together could result, over time, in substantial losses of funding for some of the former SHAs and for the majority of undergraduate teaching hospitals, as research funding is consolidated on a relatively small number of internationally significant medical research centres.

Finally, the funding arrangements are likely to emphasise relevance to the NHS. This could be unfavourable to laboratory based research centres with a focus on the long-term potential of genetics and molecular biology. NHS research funding may favour research projects with early prospects of clinical application and approaches which are epidemiologically based and may tend to favour health services research over classical clinical research. However, an important aim of the policies implied by the Secretary of State’s press release is to sustain the long-term prosperity of the UK pharmaceutical industry: the long-term interests of that industry may favour laboratory approaches.

Effects of shifting funds

For managers the next question is: what will be the effects on hospitals of losing or winning as research funding is redistributed?

Existing R&D and SIFTR contracts mainly offset costs which otherwise must be incorporated in service prices, unless those costs can be eliminated: it is not ‘new money’ which can be committed to new activities; it is simply a rationalisation of historic patterns of expenditure. If a hospital loses R&D or SIFTR funding, in the first instance prices to purchasers will rise unless sufficient cost reductions can be made within the year to offset the loss. Experience in the quasi-market to date suggests three kinds of response to increasing prices.

For a distant purchaser, where there are alternatives for that purchaser’s residents, patients will be diverted over one or two years to hospitals that are less costly and/or closer. The local purchaser, however, will often need to ensure that the hospital remains viable to provide local services, and will not therefore divert patients in response to price rises. Instead, the local purchaser, supported by the NHS Executive regional office, will demand a cost reduction programme to bring prices back into line with other hospitals. Where purchasers from a distance have no real alternative for a particular service, the extra contractual referral (ECR) mechanism may force them to absorb price rises.

There may be cases where the combination of a radical cost reduction programme and forcing price rises on purchasers for very specialised services is not sufficient to offset the loss of R&D or SIFTR funding, particularly if the hospital is already financially challenged. This may precipitate strategic change: ie, the hospital may need to be closed because the costs of keeping it open cannot be sustained by purchasers from service funding. This is most likely to be the case where patterns of service provision dictated by research and teaching investments would not otherwise have been sustained by the NHS during all the changes over the past 20 years. Inner city and single specialty research and teaching hospitals are the most obviously vulnerable. Also vulnerable may be ‘second site’ undergraduate teaching hospitals of the large provincial medical schools that were developed in the sixties. Some of them may be too close to the city centre hospitals for service, yet may not have the concentration of medical school investment necessary to retain R funding.

For the winners, the picture is very different. They will receive additional funding which is not already committed to existing expenditures. In theory, the money should be used to lower prices for purchasers, so maintaining patient flows for research. However, as time goes by, this may not always happen. Some of the hospitals which may gain from research funding are now in deficit, supported by the London Implementation Group (LIG) or regional market management funding. A persistent deficit which is supported by regional or LIG funds is already reflected in artificially low prices. Additional research funding is likely to be applied to resolve the deficit, making hospitals viable which today are not.

Still more interesting is to guess what will happen where additional research funding is won by financially viable hospitals that have no need to lower prices to meet financial targets or retain patient referrals. In trusts where there is no need to lower prices, research funding may well become available for specifically research-related developments. Nationally, this will be an interesting phenomenon. The final effect of all these financial manoeuvres may be to remove funding that now supports services for patients in inner cities to promote academic endeavours in the more pleasant university towns.

There are some important qualifications to be made
Supporting R&D in the NHS

about the apparent logic of the arrangements so far described.

The arrangements focus on manipulating service prices to influence the behaviour of the quasi-market. They were formulated in large part to satisfy the concerns of academic medicine that the flow of patients needed for research should be maintained. But experience suggests that the quasi-market is not, in fact, very price-sensitive. Local interests of health authority members have had much more influence on purchasers when changing extant referral patterns than differences in prices. Essentially every health authority tries to concentrate its contracts on local hospitals, whether that saves or costs money for a particular service. Low prices because of R&D subsidies may therefore not succeed in maintaining threatened flows of patients for important research programmes. Conversely, higher prices of R&D ‘losers’ may ultimately be largely absorbed by purchasers in the quasi-market without precipitating strategic change.

For NHS managers, whether purchasers or providers, these new funding arrangements have immediate and significant implications. For managers of research hospitals, research performance becomes a central strategic objective which is as important to overall viability as service performance in the quasi-market. Implications for research performance become a main and explicit criterion in consideration of developments, new appointments and service strategies. For purchasers in places where research hospitals are located sustaining, and where possible improving, research performance becomes important because R&D funding helps sustain local service levels. The same is true for regional executive directors. The threat of losing major tranches of R&D funding for London regions, or the opportunities of gain for others, are becoming an important motive of regional market management.

R&D funding is likely to drive new academic and service configurations and collaborations, as researchers and managers together try to position their institutions for the changes which may come towards the end of the decade. Research is emerging as a central focus of management concern.

Reference
1 Press release. Department of Health, 15 December 1994.