numbers of operations must also be considered since these patients will have to be cared for in addition to local patients being treated simultaneously. This review would have to take place both at the ward and community levels. Hospitals which accept further workload will have to use existing establishments cautiously as many already suffer from low morale and staff shortages. Higher pay might attract additional good quality staff and help to retain existing staff.

Finally, what medicolegal obligations would the sellers assume? Would they be totally responsible or would part of this responsibility still be borne by the buyer? Subcontracting of patients would at least require a legally binding contract specifically setting out these responsibilities. This would be an appropriate role for regional health authorities in addition to the negotiation and administration of contracts.

Challenging times ahead

The NHS review will instigate a radical new free market climate in our health care system. It espouses the principles of consumer choice and value for money. Hospitals are to be encouraged to seek the most cost effective services available and will be free to offer services to their own and other districts in order to attract funds. Finance will follow patients and successful hospitals will thrive while there is a possibility that less successful ones will contract and even cease to exist.

The days of the local hospital having a natural monopoly on the provision of services to its population are numbered, even if that hospital does not chose to opt out of administrative control by the district. Hospitals and individual clinical departments will therefore depend to a varying extent on attracting business from wherever it may be found. In specialties such as orthopaedics where the demand for elective surgery is high fierce competition may be expected. How smaller district general hospitals will fare against their larger teaching hospital rivals remains to be seen. Competition between hospitals of similar size may take the form of price or non-price wars with departments offering either a cheaper operation or one performed more quickly.

Though the discussion has been directed at orthopaedic surgery the same considerations apply equally to all medical and surgical specialties. When hospital departments begin to trade in internal markets they will be obliged to consider their position as buyer or seller of services (or both in some cases). They will have to face problems, such as the definition of product, pricing, constraints, clinical and legal responsibility, risk, etc.

We thank the Yorkshire Regional Health Authority; the Nuffield Institute of Health Service Management, University of Leeds; and the Health Economics Consortium, University of York for arranging the day conference on internal markets, and we are grateful to the members of the group who discussed the implications for orthopaedic services and who shared their ideas with us. The views expressed here are the personal views of the authors.

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A GP's perspective

Andrew Harris

The flaw in the white paper is that though the NHS review was set up as a result of political pressure about the NHS cash crisis, it produces no new funds.[1] But pleas for increased funding or protests about the hidden agenda of future privatisation, although justifiable, will be ineffectual. Mr Kenneth Clarke said in the Commons, "We shall, of course, listen particularly to the views of the public and the patients." He will not be negotiating with the medical profession for agreement, only to discuss operational details. The question now is, "Will the government's reforms improve services and choices to patients or not?" We should welcome some of the managerial and efficiency reforms, but highlight our concerns for patient care by urging our patients to speak out.

The proposal for tax relief on private health insurance for the over 60s—even if taken out by a relative—coupled with the Prime Minister's remark that those who can pay for themselves should not take up beds of others, is a clear indication that Mrs Thatcher views the NHS of the future as a safety net rather than a comprehensive service for all. Comprehensive cover for the over 60s with BUPA is about £2900 a year, an amount few can afford. Retired people who have such means should not be made to feel guilty about using the NHS nor should they need to consider private care if the government's proposals for an internal market are successful. In a Gallup poll published in February 56% of pensioners were against the tax relief proposals intended for them, and I believe we should encourage them and organisations such as Age Concern to voice loud consumer protest.

Fundamental changes eclipsed

So much attention has been focused on the opportunity for hospitals to become self governing trusts that the fundamental changes in funding and provision of all health authority services has been eclipsed. Health authorities will be funded for the populations they serve, hospitals will be funded according to the services they provide, and general practitioners will be free to refer out of the district with the patient's own district health authority paying the hospital that the general practitioner chooses. While this will create increased choice for mobile patients who are not acutely ill, there are two dangers. Firstly, community health services for the chronically ill and elderly will wither. Secondly, the core services to which patients need to be guaranteed local access by the district health authority will be inadequate where the district health authority elects to use non-local hospitals for some services. I doubt that there will be many hospitals that opt to be independent trusts. While in the short term

London SE22 0QR
Andrew Harris, MRCP,
general practitioner

Correspondence to:
77 Underhill Road, London SE22 0QR.

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they will offer a competitive stimulus to improve services in surrounding hospitals, especially in London, tight restraints are needed to prevent them from concentrating on profitable forms of health care to the detriment of the community.

With the internal market pressures towards efficiency savings how will health authorities ensure that hospitals provide the less marketable services such as domiciliary physiotherapy, district nursing, health visiting, occupational therapy, and community psychiatric nursing without a deterioration in standards of care? Mrs Thatcher's distaste for local government led to the sidetracking of the Griffiths proposals for community care, and the lack of a response from the government puts a big question over the future of community care. The only clue I can find in this white paper is the bringing of family practitioner committees under regional health authority control, and a sentence, "Larger districts might eventually become candidates for mergers with family practitioner committees." Is this a prelude to moving community health services to a budget, shared with general practice, under family practitioner committee control?

. . . I suspect that practice budgets will become an insidious way of commercialising primary health care.

If we are to ensure that we do not return to pre-1948 days when funding a health service was seen as funding a hospital service the government must chart a way forwards for care in the community, including personal social services, public sector housing, and rehabilitation services. With general practitioners and local authority members losing their representation on health authorities, we should press for a mechanism of local accountability. Just as directors are answerable to their shareholders at the annual general meeting, so should health authority members be answerable to patients and general practitioners in the area, perhaps by an annual report to community health councils.

Shorter consultations and longer waits

The government's commitment to increasing the capitation element of general practitioner pay is retrogressive. In some areas it will lead to shorter consultations and longer waits, although its effect might be softened if there was a much larger weighting for elderly patients. It is important that practices with large lists, who seek to recruit nurse practitioners or extra administrative staff, are not prevented from doing so by cash limiting of the ancillary staff budget. More serious is Mr Clarke's stated intention to replace item of service payments with target payments for childhood immunisation (90%) and cervical cytology (80%). This is potentially damaging to inner city practices, where the rapid turnover of socioeconomically deprived patients will prevent attainment of these targets, thus establishing a disincentive for such activities. Despite the promise of special help for inner city practices made by the government in *Promoting Better Health* we still await the financial details.[2]

The development of prescribing information systems into indicative drug budgets for general practitioners is an important and useful source of information, which in future will be provided for every general practice. Providing the budgets are set to take into account individuals who need regular appliances and highly expensive drugs such as growth hormone, immunosuppressives, drugs for anaemia in renal dialysis, and antiviral and AIDS agents, they should not be feared.

Real difficulties will develop for all practices if large group practices begin to operate their own budgets:

- Even the most organised of practices will need an enormous increase in management and administrative staff, premises improvement, investment in high technology, and training of the primary care team
- Despite the promise of a management fee for those practices operating a budget it is unclear where the resources will come from or how the budgets can be fairly set
- If practices with budgets are able to increase their income and offer extra services, such as their own physiotherapist and minor surgery, two tier general practice will inevitably develop
- Market forces may make small practices relatively uneconomic and thus more scarce
- Consumer choice will be limited and the scheme will sound the death knell for the best of traditional small general practice, where the doctors' knowledge of the families on their list probably outweighs the advantages of any information system
- The inclusion of drugs in the practice budget will present difficult ethical problems because for the first time a doctor's choice of drug for a patient will have a direct effect on the practice income.

Even more worrying is that despite the Secretary of State's reassurances[3] some practices with budgets will find it financially prudent not to register chronically ill or disabled people or the frail elderly person, as their consumption of health care may be viewed as an unacceptable financial burden. Patients needing referral for investigation or treatment may not feel confident that they are being offered the best advice—particularly at the end of the financial year—as they will have that nagging doubt that the budgeting considerations of their doctor played a part. This is a totally unacceptable alteration of a professional relationship, quite out of keeping with the traditions of British, or indeed much European, practice. Furthermore, it creates a position where there is an incentive for the general practitioner to refer his patients privately.

I suspect that practice budgets will become an insidious way of commercialising primary health care. None of the reassurances of Mr Clarke that there are ways of auditing practice accounts and giving financial incentives to practices, to prevent professional standards from suffering, are convincing. General practitioners who want to opt for their own budget are either greedy or naive. It is essential that patients—particularly in large group practices—make their views known to their doctor.

This white paper skilfully transfers responsibility for obtaining or providing services on to the shoulders of general practitioners without extra government money for patient care. So when there is an outcry in the future about underfunding the health service the government will point the blame at the managers and doctors. General practitioners don't want to be part of Mrs Thatcher's political agenda, but unless the patients' views are voiced independently of the medical profession and party politics, and doctors refrain from defending their illusory clinical freedom, all our misgivings will be ignored.

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