Pride and prejudice

Time to recognise the weaknesses of the white paper

Where the effect of change is speculative... where the competition rules have not been thought out and we do not know what they will be, where changes almost certainly will not result in better or cheaper health, I believe with all humility that a period of further thought would be the path of wisdom.

Thus Lord Wilberforce, "intellectually brilliant and eminently reasonable," in the debate in the House of Lords.¹ But one change has been made to his speech: he was talking about "advocacy" rather than "health," for the discussion was about the radical changes proposed for the legal professions. The lawyers have won some sort of breathing space; so far the doctors have not—why?

The answer may lie in pride and prejudice. Mr Clarke's pride, his political reputation, is at stake for he was put at the Department of Health to do an impossible job. His short timetable is aimed at the next general election rather than at the public's health, given that introducing the scheme by 1991 will mean the parliamentary draughtsmen having to start work this autumn. Mr Clarke's prejudice comes from too little contact with doctors and nurses—those in daily touch with patients. For, compared with lawyers, few doctors are MPs or peers, and it is easy to stigmatise the unknown, the health professionals, as unreasonable opponents inevitably and implacably opposed to any change.

The reality is different. The crisis arose out of complaints from the care givers of the long term underfunding of the health service, threatening standards of civilised care. Something had to be done, but skill was needed to ensure that things became better rather than worse. If the reforms were to be radical then debate and experiment would be vital and detail was all important. None of this could be achieved without consulting those who do the work: doctors, nurses, and managers. In the event consultation did not take place, and the plans for the largest industry in Europe became enshrined in 60 000 words of waffle.

If serious discussion was lacking on the government side, it has emerged in the professional comments. Thus not only has our series of articles detailed the impossibly short timetable, the failure to experiment, and the lack of information systems but it has also come up with positive suggestions: Professor David Morrell, for example, has shown how in general practice agreed standards together with audit could raise the quality of care without major disturbance.^{2,3}

Inevitably, however, complaints and suggestions from the

profession will be dismissed as trade union pleading. So let two sets of knowledgeable outsiders comment. In an interview published last week Professor Alain Enthoven saw several good ideas in the white paper, among them separating the demand and the supply side of the NHS, making money follow patients, and greater local delegation.⁴ But he regrets that the government has not chosen to experiment. Given the large changes, the pace of the timetable is amazing, he believes; health care just does not change at that speed.

The second group of comments come from Patricia Day and Rudolf Klein in their evidence to the social services committee. Like Enthoven, they welcome the review's drift, with its insistence on accountability, suggesting that the dangers of a competitive market have been exaggerated. But their real question is: "whether all this can be done without demoralising the providers and without destroying the inherited capital of professional dedication." How the proposals are implemented is crucial. Experiments are inevitable, Day and Klein conclude: the best way of convincing conscripts is to show that new ideas work. And to overcome the disruption and threat inevitable in change the government should provide a special budget.

With Mr David Mellor's recent statement about the plans not being tablets of stone some have detected signs of willingness to negotiate. Doctors would welcome this, and the major points for debate should emerge at the BMA's special representative meeting next week (the most important for the health of Britain since 1948). Given that the concept of medical audit has come from the profession, for example, they would agree to this as a plank for reorganisation. (I suspect also that they would concede a reasonable date for concluding the principal negotiations.) But they should not compromise on the widely agreed major defects of the plans. The timetable is too short. There have been no experiments. The special needs of the community, teaching, and research have been ignored. And above all there is an absence of detail. The nation's health is too important to be threatened with such ill thought out changes. Nor are the health professionals kulaks to be coerced against their will.

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1 Alexander R. True cost of the law reforms. *Independent* 1989 Apr 18:19 (col 4-6).

2 Morrell D. The new general practitioner contract: Is there an alternative? *Br Med J* 1989;298:1005-7.

3 *British Medical Journal*. The NHS review—what it means. London: BMJ, 1989.

4 Smith R. Words from the source: an interview with Alain Enthoven. *Br Med J* 1989;298:1166-8.