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NHS review: the broad picture

Waiting for the small print

Given the determination of the opposition to present the review of the National Health Service as a revelation of the cloven hoof of Thatcherism and the government's determination to present it as a millenarian vision, it is all too easy to lose sight of its true importance. Its immediate impact is likely to be less dramatic than expected, apart from the demands on the negotiating time of everyone concerned; its effects over the next decade may, however, be to shift gradually the attitudes and practices of health service providers and consumers alike.

Leaving aside political hyperbole, *Working for Patients* is remarkable for what it does not say.[1] A policy review launched a year ago in an attempt to devise a new funding system has ended up by saying nothing about how to finance the NHS. The government has finally accepted that there is no financial wheeze that can absolve it from responsibility for taking decisions about funding.[2] Such decisions are inescapably political, given that there is no formula for deciding what is right. So the basic principles of the NHS, enshrined in its 1948 settlement, have been reaffirmed; it remains an overwhelmingly tax financed service, universal in its scope and mostly free at the point of use.

But if *Working for Patients* may from one perspective be seen as a preservation order slapped on an ancient monument the workmen are moving in behind the stately façade to remodel the old building. What started out as a review of finance emerged as a review of organisation. But irrespective of the preferences of the government or anyone else it was inevitable that the NHS would have to change.[3] The possibilities created by information technology are transforming managerial systems in public services and private enterprises; there is an international trend for large organisations to break up into smaller units and buy in skills and services from outside. Add to this the semantic revolution that has transformed patients (passive people to whom things are done) into consumers (people actively scrutinising what is on offer)—a transformation mirroring deeper shifts in society—and the inevitability of the NHS having to adapt to a changing environment becomes apparent.

The government appears to have three main objectives: to tighten up the managerial structure in order to ensure central control over the NHS's policies and priorities, to raise efficiency through competition, and to increase consumer choice. Are the proposals likely to achieve the objectives set or do they pull against each other? What needs scrutinising is not the government's emphasis on efficiency and value for money but the appropriateness of the measures proposed: are they feasible, can they be implemented, what will be the cost of so doing (and to whom), and will they yield the expected benefits?

Not surprisingly the clearest proposals are those that deal with the management structure and style of the NHS: their precision is in sharp contrast to the fuzziness of some of the other proposals. This reflects, no doubt, the fact that they build on the logic of the Griffiths managerial revolution. Within the Department of Health there is to be yet another attempt to divorce the political role of setting objectives and the managerial role of implementing policy. Whether relabelling the bodies concerned as the NHS Policy Board and the Management Executive will do the trick remains to be seen. Within the NHS all authorities—regions, districts, and family practitioner committees—are to become explicitly managerial in character: transmission belts for central policy rather than representatives of professional or local interests. Provided that such interests are given other institutionalised means for articulating their views this represents no loss. The contention that a scattering of often press ganged and reluctant local authority nominees is somehow a guarantee of democracy suggests ignorance of either what that concept means, what those nominees actually do, or both.[4]

Further down the line the proposals imply greater managerial participation in clinical practice. Specifically, managers would participate in defining the terms of consultants' contracts and in setting the criteria for both medical audit and distinction awards. All this could be seen as a threatening breach of the conventions of medical autonomy. Equally, however, it could be argued that the proposals simply implement more fully the logic of what covertly and incompletely has been happening over the last decade or so—that medical practices not only determine the way in which resources are used but also in turn are partly shaped by their availability. Similarly, it is clear that concepts like "quality" have various dimensions and that there are non-medical definitions that have to be accommodated within any audit system. If these arguments carry any conviction then the real test of the review's proposals may lie in the way they are implemented. The result should be to institutionalise greater clinical participation in managerial practice. This assumes, however, an investment in managing change which cannot be taken for granted.

The central paradox of the white paper is that it is trying to develop a stronger managerial framework in order to delegate

more freedom. But there is an asymmetry in how much the two sets of proposals have been developed[4]: Mr Clarke has got his bit and bridle, but the horse is still in the stable. Until the Department of Health produces its various supplementary papers it is difficult to come to a definite conclusion about the headline catching proposals for hospitals to opt out of the system and for family practitioner budget holders. Both reflect the influence of Professor Alain Enthoven's advocacy of an internal market to improve efficiency through competition.[5] In both cases everything will turn on the small print. For example, the white paper states that hospitals will be charged the full cost of their capital assets. If so the competitiveness of prices charged by hospitals will depend less on their clinical efficiency than on the way in which their sites and buildings are valued: a factor that may be particularly important in the case of London teaching hospitals with prime inner city sites. Again, in the case of family practitioner budget holders everything would seem to depend on how the government proposes to guard against the possibility of biased selection—that is, concentrating on low risk patients—and whether by the time various safeguards have been introduced there will be much incentive left to take on managerial responsibilities. Certainly the United States experience is not encouraging.[6] And it may be impossible to draw any general conclusions from the experience of a handful of pioneers. By definition they will represent a biased sample of enthusiasts, and even if such natural experiments are rigorously evaluated—as they should be—they may not be generalisable.

Furthermore, competition (whether among hospitals or family practitioners) cannot be equated with consumer choice, as the white paper rather too easily assumes. If a district health authority contracts for services with a particular hospital it will presumably be on price and quality. There will be no consumer choice, although health authorities could write indicators of consumer convenience into the contract: for example, that no patient should have to wait for more than 20 minutes before being seen in outpatients. Similarly, in the case of general practice there is much rhetoric about choice. But choice depends on practitioners competing against each other for customers. Whether increasing the proportion of income derived from capitation fees would bring about that result remains an open question. It is more likely to be brought about by making it easier for doctors to set up practice where they will; but there are no indications in the white paper of any move towards abolishing existing restrictions, and there is, moreover, an ominous sentence about the government seeking power to limit the total number of practitioners. Similarly, encouraging practices to manage their own budgets may limit choice; the incentives to create large practices may produce geographical monopolies. Lastly, increasing choice may cut across the government's desire to avoid increasing spending. This is particularly true of referrals, where the messages put out by the white paper are somewhat contradictory. It envisages general practitioners being able to refer patients to hospitals where the district has no contract; the health authority would subsequently pick up the bill. If this actually happens then it is difficult to see how district budgets can be controlled.

In interpreting all this, everything turns on how one reads the tone of the white paper. If it is seen as a blueprint of the future, as a firm commitment to specific actions, then there is real cause for scepticism: so much will depend on the fine print of the details, which are not yet available. If, however, it is seen as an indication of the direction in which the NHS will be going over the next decade then it would seem to merit at least two cheers. Some of the proposals are plainly wrong headed: the proposed tax concession for the health insurances of the over 60s sets an expensive precedent and may simply give a bonus to existing policy holders rather than promoting a dramatic growth in their numbers. There is a conspicuous and entirely lamentable failure to give the government's response to the Griffiths report on community care despite the obvious implications for the role of the district health authorities.[7] Too often the white paper gives the impression of designing an NHS for acute services, and particularly elective surgery, while ignoring the rest.

But, more positively, it does seem to set a new style for the NHS. It promises a more flexible organisation—as with wages and salaries—capable of adapting to new circumstances. And given the inevitable uncertainties of the future (who predicted AIDS a decade ago?)—the aim should surely be to shape the NHS into a more open, learning organisation where acceptance of change and the ability to cope with it become routine. But if that is indeed Mr Clarke's intention and if it is to be achieved without damaging the patient in the process there will have to be an investment in the change itself—in the new skills and techniques that will be required. If some of the weirder ideas floated in the white paper allow him to gain the Prime Minister's support in extracting the money from the Treasury then their inclusion will have been worthwhile. And, with a bit of luck, they will never be implemented.

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BMA's measured response

Doctors' views wanted

The BMA has responded cautiously to the NHS review,[1] not because it has been stunned by ministers' opening sell of their proposals (p 394) but for three reasons. Firstly, the association's leaders are doubtful that the promise in the white paper's title, *Working for Patients*, will materialise. Secondly, they believe that until the fine print of the forthcoming working papers has been analysed the profession would be unwise to make any policy response. Thirdly, they want the BMA council and the craft committees, which represent all NHS doctors, to give their constituents time to consider the proposals.

This response may seem risky in face of a Secretary of State in a hurry. The timetable for implementing the reforms (p 392) shows the government's keenness to press ahead. Yet, as members of the Central Committee for Hospital Medical Services warned last week (p 390), that timetable is unrealistic. To impose an election oriented programme on a service that has barely digested its third major restructuring in 15 years and which is still struggling from the nurses' regrading exercise could spell disaster. Furthermore, neither of the two radical proposals—establishing self governing hospitals and introducing budgets for larger general practices—can be