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

achieved without the cooperation of most NHS doctors. So the profession need not let itself be hustled into accepting all or part of the white paper by impatient ministers.

Patricia Day and Rudolf Klein analyse the white paper's implications in a leading article on page 339. The *BMJ* published a summary last week (p 275), highlights the main proposals this week (p 392), and will be publishing an analytical series on the government's plans. The BMA has sent a special "white paper" edition of *BMA News Review* to all doctors and it is also distributing to all divisions copies of a video programme in which its leaders give their preliminary assessments. So even doctors who have not seen the white paper will have ample opportunity to assess what *Working for Patients* might mean for the NHS. They should take that opportunity and contribute to local and national meetings that the BMA and its craft committees are planning (p 392).

Will the government's promise be fulfilled?

The profession's first concern should be to judge whether the white paper, which offers no extra money for the NHS, will really fulfil the government's promise "to give patients, wherever they live in the UK, better health care and greater choice of the services available. . . ." Despite the government's claim to be preserving the principles of a tax funded health service its novel device of separating funding—which will continue to be mainly tax based—from the provision of services—for which radical ideas are introduced—lays the groundwork for future dismantlement of the NHS. Doctors will have to decide whether the working papers on general practice budgets and on self governing hospitals contain sufficient safeguards to prevent a two tier service developing. The dilemma will then be whether the necessary safeguards will not so restrict the two ventures as to nullify any worth they may have in offering a more flexible and independent use of resources. That dilemma might have been resolved without subjecting the whole service to upheaval if the government had accepted the advice of the BMA, Alain Enthoven, and others to try any new ideas out in pilot schemes.[2,3] The Secretary of State has rejected such an approach, which is odd given that the two radical proposals will be introduced only if hospitals and practices volunteer to take part. Doctors might be more willing to participate if there was evidence to show that the reforms produced better care for patients.

Ministers have not even waited for an evaluation of the six resource management initiatives due towards the end of this year.[4] The outcomes of these initiatives are crucial to the operation of general practice budgets and of self governing hospitals. Without accurate up to date information the new system will work no better than the existing one. Consultants at the CCHMS meeting last week were sceptical about the intention "during 1989, to extend preparation for the resource management initiative in up to 50 acute hospitals . . . with the aim of building up coverage to 260 acute units by the end of 1991-2." Several described the objectives as belonging to cloud cuckoo land.

Collecting and using information have long been great weaknesses in the NHS. The government proposes to spend £40m on information technology, but many think that much more than that figure may be needed. The encouragement of medical audit and the plans to monitor health authorities and family practitioner committees are to be welcomed. But these improvements together with the improvements in information might well have been enough to improve the service without resorting to untried plans for general practitioner budgets and the opting out of hospitals.

One of the Secretary of State's innovations, the information cascade for staff, suggests that he was anxious to get his message across before their own organisations had a chance to waylay his plans. That objective was jeopardised by the Labour party's leaked version of the white paper. This and earlier leaks gave the BMA a pointer to refining the next stage of its parliamentary and public relations campaign on the review.[2,5] Although doctors may not like it, the fate of this white paper could turn as much on the skills of public relations experts as on the arguments of medical experts. That ministers are wary of the BMA is suggested by remarks accusing it of a "dithering" response to the proposals and for never having been in favour "of any change of any kind on any subject for as long as anyone can remember. . . ." To anyone familiar with the BMA such hyperbole should be filed under that Whiteheall heading "being economical with the truth."

Some of the proposed reforms—for example, medical audit and more effective prescribing—will be supported by the public and by many doctors, and these and the more contentious ideas such as stricter monitoring of doctors' working patterns will be discussed by the profession's representatives and health ministers. For general practitioners, however, any discussions will be overshadowed by a year of little progress in negotiations on the white paper on primary care. The General Medical Services Committee's negotiators are angry that the Department of Health had continued these discussions when it must have known that they would be overtaken by the white paper.[6] The committee is meeting on 16 February to approve a paper setting out the history of the negotiations as well as the implications of *Working for Patients* for general practice. It will be sent to all practitioners to help them and their representatives prepare for a special conference of local medical committees on 27 April.

Doctors set to lose their influence

Local medical committees might lose much of their influence in primary care if the new family practitioner committees answerable to regional health authorities are set up. Indeed, the whole profession looks set to lose much of its influence in a service that will be run by management boards stripped of any local or staff representation. This change, the threat to the Whitley council's negotiating machinery, more local flexibility in pay, and freedom for self governing hospitals to negotiate their own terms and conditions of service all accord with the government's policies of greater competition and limited union power. They also have implications for the future of the review bodies, the career prospects of hospital staff, and the even spread of good quality hospital services throughout the country, which is a notable success of the NHS.

This review, which was born of a financial crisis, has turned out to be as radical as was Aneurin Bevan's 1946 NHS Act. Kenneth Clarke is also a formidable minister who is backed by a Prime Minister with a large parliamentary majority. The profession must formulate its views, remain united, and be prepared for a tough campaign to ensure that the public really does get a better health service and staff better job satisfaction.

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