guy with the cheque book. My heart sinks that we're moving to that: you can't treat someone until you can find someone to pay the bill. It will destroy the ethos of the NHS."

The market system was imposed to get rid of waste, yet the cost of imposing the market was likely to be several times greater than any supposed savings, he said. He agreed that doctors should be aware of the costs of what they do—"but we never objected to resource management—which was ensuring value for money—or medical audit—which was ensuring the best outcome: we were doing both of these before the reforms, anyway." Dr Rowland Hopkinson, a supporter of his hospital's bid for trust status, agreed: "All this might have been achieved by resource management—without the politicking."

In Dr Elias's opinion the NHS's problem was not waste but underfunding of its marginal costs. "The government had proved that this year with its waiting list initiative, which was funding for marginal costs by a different name."

Birmingham had shown that you couldn't just let market forces rip: a certain amount of centralised planning was necessary. Predating the NHS reforms was the attempt to rationalise Birmingham's hospital services, "Building a Healthy Birmingham," which entailed the closure of many of Birmingham's hospitals. Self governing status looked like a lifeline for those hospitals threatened with closure, but the region had apparently decreed that none of them could apply to become trusts. (Its line seems to have softened recently with East Birmingham's application for trust status.) Commissioning Tomlinson to provide a strategic view of London's health care needs provided further proof that the market could not be left to itself to determine provision.

Competition, the engine that was meant to drive the reforms, requires surplus capacity and competing providers. Birmingham and London had these in abundance: if the rules of the game needed altering where they had the best chance of working then, Dr Elias wondered, why should they work unaltered elsewhere?

Futures

Even before the election results were known it was becoming increasingly difficult to think of the health service without the purchaser-provider split. In the year since I first talked to him Mr Alan Torbet, general manager of the Birmingham Family Health Services Authority, had been working on the consequences of this split for primary health care. West Midlands region and Birmingham City Council had jointly commissioned the authority to develop a primary health care strategy for the city. ("Building a Healthy Birmingham" had been limited mainly to secondary health care.) "We can't assume that four different purchasing plans [those of north, south, east, and west Birmingham district health authorities] are going to provide the best result for the city," said Mr Torbet. As well as representing the main providers of primary health care services the FHSA is the main purchaser of these services: it holds the purse strings. (Even fundholders remain contracted to the FHSA to provide primary health care services.)

In the past year his authority had pioneered two locality management sites. The plan was to appoint a primary care manager, accountable to primary care providers, for every 100 000 people. These managers could generate relatively robust information about the secondary care needs of their population. "Currently, there is no happy mechanism for translating information from the micro to the macro level," said Mr Torbet. Aggregated information on the pattern of general practitioner referrals could be used to draw up the district's purchasing plans; integrating the primary and secondary purchasing function would make sense, he said.

Coincidently, the fundholding Craig Croft practice also envisaged the future amalgamation of the district health authority and the FHSA (box). But when last month I spoke to Dr Dawson, one of Craig Croft's partners, he was preoccupied with the likely demise of fundholding. He needn't have worried: the new government has said that it will continue.

Would it matter if fundholding had been abolished—as long as the split between purchasers and providers remained? The advantages of fundholding don't depend on its survival. The right to refer a patient wherever his or her general practitioner likes merely re-establishes the status quo before the reforms. And having general practitioners helping to draw up quality standards for secondary care doesn't require fundholding: Mr Torbet's locality managers, advised by general practitioners, could do the job. They could also advise purchasers of secondary services where to place contracts to reflect general practitioners' wishes.

For this to work, however, requires the continuing separation of purchasers from providers. The enduring legacy of the government's reforms may well be to make anything other than this separation unthinkable.


Correction

European research: back to pre-eminence?

An editorial error occurred in table I of this article by Richard Smith (4 April, pp 899-903). The totals at the bottom of the columns for France, Germany, Switzerland, and the United States should be 24, 61, 13, and 165 respectively.