

# Clarke's Strong Medicine

The government's long-awaited NHS review has finally seen the light of day. **Chris Ham** tries to sort out the wheat from the chaff



Kenneth Clarke: Far-reaching and imaginative proposal

**T**he NHS occupies a special place in the Left's thinking about the welfare state. Born of the postwar settlement, it demonstrates what can be achieved when socialist ideas are translated into practice. As a consequence, any proposals for reform are likely to be met with suspicion, especially when they emanate from this government.

It was therefore no surprise to hear Robin Cook and other Labour Party spokespeople claim that the white paper on the NHS, *Working For Patients*, marks the beginning of a policy of privatisation. In fact, there is little in the white paper to justify this claim. The prime minister may wish to see higher levels of private finance and provision in health care, but this is unlikely to result from the programme set out in the white paper.

Instead, the programme seeks to preserve the basic principles on which the NHS was founded and to tackle its weaknesses through a series of incremental and imaginative reforms. These reforms centre on the introduction of incentives to doctors and hospitals to provide services that are more responsive to patients. In tandem, competition between providers will be used to stimulate greater efficiency in the use of resources.

Although the white paper supports the further development of the mixed economy of health, public finance will supply the major portion of health service funding for the foreseeable future. But within the NHS, *the funding*

of services by health authorities will be separated from their *provision*. In future, health authorities will act mainly as purchasing agents on behalf of their communities, buying services from a range of public, private and voluntary providers.

The white paper envisages that the separation of funding and provision will create the conditions for *managed competition*. In other words, health authorities will seek the best deal for their residents by buying services from competing providers. This process will be carefully managed to ensure that appropriate services are available in each locality.

What are we to make of the white paper? There is little doubt that the proposals will be a disappointment to those on the Right who have argued for a major reform of NHS funding and provision. It will continue to be funded largely out of taxation and there are no plans to extend user charges. Tax relief on private insurance premiums is to be made available to those aged over 60, but the significance of this is more symbolic than real. For the majority of the population, access to health services will be based on need and not ability to pay.

To those on the Left, a discriminating response is appropriate. Outright rejection of the white paper would be both wrong and a missed opportunity. The NHS clearly has a number of weaknesses that need to be tackled, including a lack of responsiveness to patients, the wasteful use of resources and the lack

of accountability of doctors. Where the government's proposals offer the prospect of addressing these problems, they should be welcomed.

Equally, where there is a danger that vulnerable groups will lose out and standards of care will widen, the proposals should be challenged. At this stage, the main concerns are threefold: the quality of care may suffer in the quest for efficiency, local accountability will be diminished, and there may be insufficient safeguards to ensure that the stimulus of competition does not erode the core values of the NHS. Whether these concerns are realised depends in part on the details of the government's strategy, to be published in eight working papers. Also, the precise implications of the white paper will not be clear until the ideas are tested in practice.

*Working for Patients* is, then, a high-risk strategy, not least because it seeks to extend the enterprise culture into the one service that has largely escaped the Thatcher revolution and which continues to enjoy high-level public support. The danger with this approach is that it may widen inequalities in health and the use of health services, and undermine the principles on which the NHS is based. On the other hand, it may bring about modernisation of aspects of the NHS and enable some of the real problems that exist to be addressed. Whether it does so depends on the fate of two major innovations: GP budgets and self-governing hospitals.

**GP practice budgets will be available** to practices with at least 11,000 patients. These practices will be able to apply for their own budgets to cover both the services provided by GPs themselves and a defined range of hospital services. The hospital services included within the scheme are diagnostic tests, such as X-rays and laboratory tests, outpatient services, and non-emergency in-patient and day case treatments.

One of the main aims of practice budgets is to create a stronger incentive for GPs to use resources efficiently. The government hopes this will be achieved by GPs having to consider more carefully whether to refer a patient to hospital and to prescribe drugs. If GPs underspend their budgets then the savings may be used to improve practices and to extend the range of services on offer. Equally, if budgets are overspent, the money is recouped from the practice in the following year. Persistent overspending will result in an audit and possibly the practice losing the right to hold its budget.

The potential merits of practice budgets are clear. GPs will be forced to think more rigorously about what form of treatment is best for their patients: they will have an incentive to provide services directly instead of using more expensive hospital services; and by basing budgets mainly on the number of patients served, the government hopes that GPs will respond more positively to

the demands of their patients.

To this end, the government intends to make it easier for patients to change GPs, and to make an informed choice of their doctors. GP practices are to be encouraged to provide information about their services and the government wants advertising of the services offered by practices to become the norm. These proposals are designed to stimulate competition and to give patients more influence over the kinds of services they receive.

Set against this, practice budgets face some obvious pitfalls. The first and most serious is that they may encourage GPs to be more careful in accepting patients. Much will depend on the detailed formula that is introduced for paying GPs. The white paper indicates that practice budgets will be based principally on the number of patients served, weighted to reflect age, health and other characteristics. The precise weightings will need to be finely tuned if GPs are not to favour younger, healthier patients at the expense of those who are older, sicker and more expensive to treat.

**A** second danger is that GPs will respond to budgetary constraints by undertreating patients or by providing inferior treatment. The government argues that the safeguard against this is the freedom of patients to change GPs if they feel dissatisfied. In practice this freedom will be easier to exercise in some parts of the country than in others. And even where a genuine choice of group practice exists, patients may find it difficult to judge the quality of the service on offer.

Medical audit, in which doctors regularly review the quality of their work, is to be introduced as a routine part of general practice and this should help to raise professional standards. But medical audit is essentially a form of professional self-regulation and, unless the results are made public, patients will not be in a position to exercise the informed choice to which the white paper aspires.

A third concern about practice budgets is whether GPs have the interest and ability to take up the challenge that is being thrown down. The scheme is to be voluntary and initially will be limited to large practices which are presumably considered more likely to have the managerial expertise required to run a budget of £600,000 or more. The white paper makes it clear that each practice's budget will include a fee to cover the start-up costs of participating in the scheme. No doubt this will be used as a carrot to encourage volunteers to come forward. In practice, those GPs who are already well organised and provide a good service to their patients are likely to be among the first of those to opt for a budget, leaving smaller practices and single-handed GPs operating as at present. There is a clear danger here that standards of care in general practice will diverge even further. And, consistent with the inverse care law,

those patients whose needs are greatest will continue to receive a second-class service. On the other hand, there will be an incentive for smaller practices to amalgamate and in time this could help to raise standards.

**The second major innovation in the** white paper is the proposal that some hospitals should become self-governing. In essence this involves larger general hospitals establishing themselves as NHS Hospital Trusts. These hospitals would no longer come under the control of a district health authority but would be free-standing hospitals within the NHS. They would earn their revenue from the services they provide and much of this money would come from contracts negotiated with health authorities. These contracts would specify the range of services to be provided, their cost and quality.

Self-governing hospitals would also make contracts with GP practices holding their own budgets and with private purchasers of care. This form of funding would enable hospitals to overcome the so-called 'efficiency trap' in which treating extra patients increases expenditure but brings in no additional income. Furthermore, as money travels with patients, self-governing hospitals would have a stronger incentive to respond to the demands of patients.

The decision on whether a hospital should become self-governing is likely to depend to a large extent on the attitude of medical staff, although the initiative may come from other sources. Local service users may play some part in the process but their views are not given much attention in the white paper. This is consistent with the new role for health authorities involving less local public participation in the work of authorities and more emphasis on their management responsibilities. Community health councils will continue to represent public opinion to health authorities but there is no escaping the conclusion that greater efficiency is being sought at the expense of local accountability.

A number of questions arise in considering self-governing hospitals. First, if these hospitals are to be funded for the work they do, will they concentrate on profitable services that are in demand by purchasers of care outside their locality at the expense of services that are needed by local people?

Second, if self-governing hospitals attract patients from a wide geographical area, what kinds of patients will benefit most? Will the needs of younger, more mobile, better educated patients be more effectively looked after than the needs of older, less mobile patients who may be unwilling or unable to travel for treatment and be less aware of the possibility of so doing?

And third, will the economics of competition result in the concentration of services at a smaller number of hospitals able to provide these services

**'There are doubtless those close to the government who hope for a much bigger role for the private sector and this may be the hidden agenda'**



to a higher standard and lower cost? If so, who will decide whether the trade-off between efficiency and accessibility is worth making?

To raise these questions is to illustrate the potential dangers of introducing market principles into a public service like the NHS. Anticipating possible criticism, the white paper insists that self-governing hospitals must continue to provide services to local people where no alternative exists. But striking the right balance between competition and regulation will not be easy. Constraining the competitive spirit by introducing too many safeguards may be self-defeating. Equally, allowing competition to be unregulated is likely to produce results which are inconsistent with the aim of providing accessible and comprehensive services. Where the balance will be struck is unclear.

**A** further complication will be how to manage competition within limited budgets. Health authorities and GPs with practice budgets will have to provide services within financial allocations agreed in advance. Service providers will thus be competing for a bigger share of a fixed cake. If self-governing hospitals, or indeed the hospitals that remain under the control of health authorities, attract additional patients and income, this will be at the expense of other hospitals. While it is possible to compete for finance from

private purchasers, this has obvious limits. Indeed, private hospitals themselves may in future compete more aggressively for NHS contracts.

The implication is that unsuccessful hospitals will have to reduce their services and in some cases close. Will the government be prepared to sanction these closures, particularly if it means that a community will have no hospital services available locally? If not, will extra money be allocated to the NHS to enable these hospitals to remain open?

**The white paper sets out an ingenious manifesto for reform.** In contrast to previous NHS reorganisations, carried out uniformly on a single appointed day, the government's proposals are evolutionary yet far-reaching. Instead of mandated change, a complex mix of incentives will be set in train designed to influence behaviour, particularly in the medical profession, in order to achieve the government's stated aims of increasing efficiency, putting patients first and enhancing professional accountability. This method of reform - using incentives rather than structural reorganisation - may hold as many lessons for the Left as the substance of the white paper.

Much of the package will depend on the willingness of the key players to participate. It is a safe bet that the incentives will be structured in a way to move the players in the desired direction. Thus, the freedom given to

self-governing hospitals to set pay rates, hire and fire staff, and raise capital on the private market will make this option attractive to many. Equally, the ability of GPs to manage practice budgets flexibly, compared with closer audit of prescribing costs for GPs who do not opt for budgets, will tempt GPs to choose budgets.

This approach, subtle and sophisticated, makes it more difficult for those who are opposed to the white paper to organise their resistance. And despite the emphasis on a voluntary approach, it is clear that the government is not interested in experimenting with change. The direction has been specified, the negotiation now is about the pace and precise route to be taken.

If the white paper contains risks for patients, it also has dangers for the government. Much will have to be done to win the support and commitment of key producer interests, most notably the doctors. And in time, giving GPs more responsibility for budgets may make the rationing of services more explicit, especially if patients are denied treatment because budgets are exhausted. This in turn could fuel the demand for increased expenditure. The funding crisis which sparked the NHS review, and which the white paper does nothing to address directly, will then reappear. The risks for the government in its chosen strategy are thus considerable. More than one political career rests on its success. •

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