THE NEW NHS: Responses to the Government's White Paper

24 February 1998

1. Sources of information accessed

- *The new NHS : modern, dependable.* London : Stationery Office, 1997
- Journals taken from the King's Fund library (handsearched):
  - *BMJ* 3 January 1998, 17 January 1998, 24 January 1998, 31 January 1998
  - *Community Care* 22-28 January 1998
  - *GLACHC Update* December 1997
  - *Health Service Journal* 8 January 1998, 15 January 1998, 22 January 1998, 29 January 1998
  - *Health Visitor* January 1998
  - *Healthcare Parliamentary Monitor* 22 December 1997
  - *HealthCare Today* February 1998
  - *The Lancet* 10 January 1998
  - *Medeconomics* January 1998, February 1998
  - *Nursing Standard* 7 January 1998, 28 January 1998
  - *Nursing Times* 14 January 1998, 21 January 1998
  - *The Pharmaceutical Journal* 17 January 1998
  - *Public Finance* 12 December 1997, 19 December 1997, 9 January 1998
  - *The Health Summary* January 1998
- Databases searched:
  - King's Fund Library Unicorn Database

2. Information gleaned

- The qualified welcome identified in 1997 is still apparent, although fewer commentators are as enthusiastic about the proposals and more calls for clarification have been made.
- More questions have been asked about the origin of the money necessary to pay for the changes. It is not thought that savings from red tape will be enough to fund the reforms.
- Some commentators are concerned at the lack of detail in the white paper on the subject of rationing and several GPs fear that they may have to take this on.
- Some commentators have explored the possible new roles of the health authority.
- Several commentators believe that the primary care groups will increase bureaucracy rather than reduce it.
- The concept of primary care groups is liked in general, although the abilities, desire and time commitments of their potential members to do the job have been questioned.
- The composition of the primary care groups has also been questioned with representatives from groups other than just GPs keen to have their voices heard.
- The idea of collaboration rather than competition has been praised and explored further; however, some potential problems in collaborating with the social services have been identified.
- The quality initiatives (NICE, CHI, clinical governance) have been praised, but more detail about their structures and powers is wanted.
- NHS Direct has received more comment than in 1997 and is generally welcomed.

3. The reactions in detail

3.1 General attitudes to the white paper

The reactions to the new white paper *The New NHS*, recorded in the professional press in 1998, have been more considered than those published in 1997. The professional commentators have had more time to analyse the document and to predict its possible consequences. Matt Muijen describes the release of the white paper last year as an "opening gambit in a complex game of chess", after which has followed a "hushed silence" while everyone "contemplates their next moves"[41]. Some more serious comments are now beginning to appear, compared with some of those made in 1997. An editorial in *Medeconomics* describes this initial welcome:

> "Sections of the medical press reported it [the white paper] in terms so glowing, one wondered if they had written it themselves."[16]

This commentator goes on to explain that "a mild sense of panic" can be felt if one reads between the lines of the white paper, especially if the reader happens to be a GP. Although many commentators are still in favour of the reforms (examples are Sandy Macara from the BMA, journalists in *The Times* and *The Guardian*, all of whom have been quoted in *The Lancet*[33] and Chris Ham who describes the white paper as "a bold and imaginative vision"[31]), some others are beginning to question certain aspects of the proposed initiatives.

Much of the doubt expressed revolves around the practicalities of the proposals rather than the thinking behind them. Greg Parston and Laurie McMahon start their article in the *BMJ* by criticising this attitude of some of their colleagues:

> "Little is being said about the government's bold attempt to construct 'a third way' between old bureaucratic command and control systems and the fragmentation and distortions of the internal market. This new path will effectively result in the creation of nationalised health maintenance organisations, led by clinicians but focused on population health. Yet the most commentators seem to be preoccupied with questions about "How do they expect to...?" without much understanding of "Why?"."[42]

They go on to explain that they believe that the health maintenance organisation idea is a good one and that they actually welcome the lack of detail which has caused other commentators to question the practicalities involved in the changes:

> "[T]he lack of detail at this stage is a positive feature. If there is anything to be learnt from the last two decades it is that changing a complex organisation like the NHS is a long and subtle process."[42]

They then applaud the evolutionary approach of the English white paper. This process of evolution rather than revolution is, according to Catherine McLoughlin, writing in the *Nursing Standard*, already under way. She states that lessons which have already been learnt are now being put into practice. These learned lessons involve putting clinicians "at the forefront of decision making" and associating "accountability...with responsibility"[38]. Others do not view the proposed new system in this light. Jos Kleijnen and Gouke Bonsel, writing in the *BMJ*, do not view the new NHS as a democratic organisation. They claim that the white paper "emphasises the importance of national leadership by the Department of Health and the NHS Executive" as it foretells a much more top-down style of management than the NHS has perhaps been used to[34].

Other commentators have not restricted their analysis of the white paper to the context of the Department of Health. Sian Griffiths views it as a product of a wider organisation than the NHS. She puts it into the context of the broad government agenda. She categorises it with the Welfare to Work scheme, the Crime and Disorder Bill, the national childcare strategy and the education white papers, all of which, she says, "highlight the impact of social inequalities and the need to address the problems of the socially excluded"[30]. Richard Horton sees the white paper in this context also. He seems to find this a little more worrying though:

> "Tony Blair is committed to welfare reform and it is hard to see how his rhetoric about 'tough choices' can exclude the NHS. Will a non-comprehensive core NHS be part of his programme for welfare overhaul?"[33]

This is where Horton and Griffiths differ. Rather than seeing a smaller NHS, Griffiths believes that the white paper in fact broadens out the remit of the NHS. She states that it makes it clear that the NHS is not just about illness:

> "Health is not merely the absence of disease; nor is the role of the NHS only within health care. This message is made very clearly on the first page of the white paper"[30]

She agrees with Parston and McMahon that the lack of detail in the document is positive and that the health service should capitalise on the opportunities which will evolve as the proposals are developed and implemented.

Another *Medeconomics* editorial is less optimistic about the realisation of the white paper's content:

> "The white paper promises much. But until we know more, we must assume that it could easily deliver little."[18]

This editorial goes on to use an aquatic metaphor to describe the currently debated proposals for the changes in the health service:

> "In many ways, the water in Mr Dobson's swimming pool is still too muddy to know if diving in is a good idea. But sadly, this looks like one of those times when you cannot afford to look before you leap."[18]

Despite this foreboding statement, the general reaction to the white paper is still one of cautious welcome. Some of the contents of the document have been questioned and further worries have been identified, primarily regarding the primary care groups. Nonetheless, positive things have been said about the white paper in almost every journal accessed for this report.

3.2 The end of the internal market?

Very little has been written on the changes (or lack of them) to the internal market in 1998, as compared with 1997.

Horton highlights the Labour Party's change of heart in this matter:

> "During the 1992 general election, the Labour Party campaigned to reverse the purchaser-provider division created by the Conservatives. They have now placed it at the heart of their strategy."[33]

The initial furore about the retention of the purchaser-provider split has died down fairly quickly. Commentators seem to have accepted either that the internal market simply has been abolished (Linda Beecham cites professional organisations as welcoming the dismantling of the market[2]) or that the internal market is just here to stay and turned their attention to other matters within the white paper.

3.3 Problems with paying for the changes

3.3.1 The Savings Plan

The impression held in the field that the achievement of savings of £1 billion to pay for the changes is optimistic to say the least has continued into 1998. Ham describes the white paper as a "bold and imaginative vision" but also asserts that the "unanswered question is whether the money will be available to turn this vision into reality."[31]

There is widespread scepticism that the government's funding strategy will help in any way with the NHS's financial situation. Seamus Ward states that "there was little in the paper that will cure the financial ills of the NHS in the short-term"[51]. The long-term picture does not look any clearer to Horton. He explains that the proposed savings scheme "does not ensure the long-term relief of NHS funding pressures"[33]. This scepticism over the savings plan is shared in other quarters[2,31,36]. Ward says that "the government will have to accelerate the pace at which savings are made significantly if it is to achieve its ambitious target of cutting £1bn from NHS management costs by 2002"[50]. He explains that, even if the NHS saves £180 million over the next two years, it will still have to save £820 million after that in order to hit the £1 billion target. One of the reasons for the scepticism seems to be the financial climate in which the government proposes to revitalise the health service. Ward outlines this:

> "Four out of every five health authorities and one in four trusts in England were in deficit at the end of 1996/97, according to the Healthcare Financial Management Association, which represents NHS finance staff. The NHS had debts totalling £460m. In this climate, the NHS will be reborn and undergo a ten-year improvement programme, ministers said."[51]

Even the achievable financial aims seem to be difficult. Ham points out that cutting Extra Contractual Referrals (ECRs) and short-term service agreements hopes to save about £250 million a year. He goes on to say that, although this figure is still lower than the claims made by Labour spokespeople in opposition, "it will not be easy to release these sums unless there is a major programme of trust mergers and continuing action by the NHS Executive to bring high spending health authorities and trusts...closer to the average."[31]

Added to this problem, Ward points out that many health service organisations manipulate their finances in order to escape some of the cuts. He cites Stephen Thornton who, he says, has "openly admitted" that trusts and health authorities "play the system" in order to make their administrative costs appear to be smaller than they really are. The government has tried to plan for this by redefining management costs to include time spent by all clinical staff on administrative duties. Ward points out that there is a fatal flaw in this plan, however, which, firstly, could counter all attempts at efficiency savings and, secondly, could actually increase trusts' and health authorities' opportunities for altering their costs:

> "But identifying and costing this time will only add to the administrative burden and many believe that by increasing the complexity of the system the government has made it easier for trusts to fiddle the figures. Some argue this may be the only way the £1bn figure can be achieved."[50]

Several commentators are still emphasising the first of Ward's points, i.e., that much of the proposed reform will in fact entail more bureaucracy instead of less (see Section 3.4.2), all of which will need to be paid for. Paul Lambden explains that primary care groups will certainly "need servicing by good quality managers" and that this is not quite in tune with the reduction in bureaucracy suggested in the white paper[35].

Nick Black points out additionally that some of the quality initiatives proposed in the white paper will turn out to be very expensive:

> "Whichever organisational model is adopted, there is no escaping the fact that information of the quality required for clinical governance will prove much more expensive than that required for financial governance. Unless each level of the NHS is prepared to accept that and provide adequate funds for clinical data collection and analysis, the good intentions contained in the white paper will not be realised."[3]

The notion that the changes might require more money than perhaps can be found is taken up by Griffiths. She relates it to the required increase in interagency collaboration and partnership:

> "Yet the demands of intersectoral working should not be underestimated. The skills needed to develop effective partnerships within the community will require resources and training. Broadening the horizons of those who have traditionally worked only within health care and developing public understanding will take time."[30]

Not only does there seem to be an inadequate supply of funds to finance the changes, according to several of the commentators, but also several of them continue to point out that the issues of underfunding and rationing are already here and need to be tackled in light of the reforms.

3.3.2 Rationing

Ham points out that what will happen depends on the outcome of the NHS spending review and that the white paper "effectively pre-empts the spending review by committing the government to maintain a health service available to all on the basis of need, not ability to pay, and funded through general taxation"[31]. Several commentators have questioned the concept of a comprehensive health service; they see rationing as an unspoken, *de facto* part of the NHS now and as part of the NHS in the future (Lambden: "I really would like to believe that a comprehensive health service can be provided. But I fear that it cannot"[35]). This seems not to have been accepted by the government in the same way.

Horton, for example, states that two radical options for financing the health service have been simply ignored by the Labour Party. These are the introduction of a health tax and the reconsideration of the boundaries of the remit of the NHS:

> "If the NHS cannot remain comprehensive, what should a core NHS provide?"[33]

Niall Dickson explains that the problems of the acceptance or not of the existence of rationing lie in "the all-too-familiar NHS double-speak":

> "The NHS mantra - free, comprehensive, universal - simply does to describe the health service, yet everywhere politicians, managers and many professionals pay homage to it as if it were real."[13]

Dickson explains that the real situation involves *most* patients having access to care they need *most* of the time. This has implications for evidence based practice and clinical effectiveness, the bases of the quality initiatives proposed in the white paper. Dickson says that it is "unclear" how far NICE will be able to go in setting new parameters for the health service in light of these restrictions.

Horton explores further the relationship between rationing and evidence based practice, implying that the former is in fact going to have to be part of the new quality initiatives:

> "Profound inequalities in health care are already being fuelled by the cost of treatments and the uncertainty - despite best evidence - about their use...How do doctors go about denying someone a 'last-chance' treatment on the basis of slim, but still finite, evidence?"[33]

He goes on to criticise the white paper's assertion that "A modern and dependable NHS...will make the best available to all", saying that "without a commitment to substantially expanded funding, this is surely a promise too far". He gives the example of a recent systematic review that concluded that angioplasty was better than thrombolysis at reducing mortality among patients with an acute myocardial infarction, asking how could the NHS afford to implement these findings? Without enough money, he says that statements such as "NHS trusts will have a statutory duty for quality" are "meaningless nonsense". This view is also held by Dickson. Unlike several of the commentators however he states that the white paper has tackled the rationing issue head-one, just as the previous government did in *A Service With Ambitions*:

> "By accepting that some variations are not acceptable the current health team has managed to avoid being seen to defend the indefensible"[13]

The consequence of this, he says, is that although national boundaries should not be difficult to draw this will not happen for the purposes of political popularity. Instead, local differences will persist with members of primary care groups having to take responsibility for "some really nasty decisions"[13].

One of the main problems that is being anticipated is this transfer of responsibility for rationing decisions (whether that is what they will be called or not) to primary care groups. Horton describes the positioning of strategic planning and service delivery in the primary care sector as "simply good politics" but also points out that the other side to this is that "it will be general practitioners who will shoulder the responsibility - and eventual blame - for the new NHS"[33]. A tension exists between a needs led primary care service and the lack of extra resources.

This tension was highlighted at the December meeting of the BMA's General Medical Services Committee (GMSC)[21]. Several of the speakers were cited as calling for the government to take responsibility for rationing. In an article in *The Health Summary*, Lambden voices his suspicion that the reforms "may all be a clever method of involving all GPs in rationing"[35]. He suggests that rationing "like the poor, will always be with us" and that this could well be "just a way of passing the buck"[35]; he also suggests that there is some sense in asking GPs to make these sorts of decisions, however:

> "Why, after all should GPs be the only group of practitioners to escape from full accountability?"[35]

Despite this need for accountability, it certainly seems to the general practitioners and their spokespeople that they are being given a dirty job to do. An editorial in *Medeconomics* states that "GPs are concerned that its [the white paper's] changes will put them in the line of fire over rationing"[24]. Dr Peter Bailey, Cambridgeshire and Huntingdon Local Medical Committee (LMC) chair, is quoted in another *Medeconomics* editorial as saying that the new system could "make us [GPs] government agents of rationing and stop us being the patient's advocate"[19]. The GMSC has called for guarantees that GPs will be allowed to overspend if they need to[21]. Both Frank Dobson and Alan Milburn have been cited as stressing that patients will not be denied drugs because a primary care group lacks funds; however, John Chisholm has responded to this by suggesting that if funds are low then rationing could happen in other areas and that in these cases GPs may become the "fall guys for under-resourcing"[21,24]. Dr Tony Welch, secretary to five LMCs in the south east, explains how this could happen:

> "If patient demand and the cost of secondary care continue to rise, it will be at the expense of our staff and premises reimbursements. The only alternative would be to turn patients away, which we cannot and will not do."[24]

Confusion about rationing is rife. The government seems to think that all that is needed to improve the NHS is more efficiency; however, John Chisholm's criticism of this assumption[21] as being wrong is shared elsewhere. In fact, the majority of the commentators seem simply to accept that rationing will occur; they are more interested in how it will happen and whether the government is to take the lead than whether it will happen. Peter Lees, chair of the British Association of Medical Managers puts it well:

> "The issue of rationing has been fudged. We all do it, and we do it unsupported. I think the public understands that this debate needs to be had, and I think it will respond in a constructive way."[23]

There is certainly a discrepancy between the views of the profession, the public and the politicians. Horton concurs with George Alberti and Maurice Lessof from the Royal College of Physicians, both of whom he cites, who believe that there needs to be an increase in public discussion on the topic of rationing. Lord Hunt is quoted by Horton as refuting Alberti and Lessof's concerns about the possibility of rationing, saying that "new drugs can be expensive, but have the potential to reduce the need for hospital admission"[33]. The rationing issue certainly worries many commentators.

3.3.3 Fundholders' Savings

Several of the commentators have turned their attention recently to the uncertain destination of GP Fundholders' savings. Ward highlights this as being one of the unanswered questions about the white paper[52]. Hugh Lawrence suggests that the modification in the welcome of the white paper has come about in part through concerns that existing fundholders could cause a "run on the bank" by seeking the return of savings which are currently lodged with health authorities[36]. Ward, in another article, describes fundholders as perhaps being "the jokers in the pack"[51]. He points out that the NHS's debt could be reduced by taking their underspends and giving them to health authorities. If this is not done though he suggests that fundholders could go on a spending spree over the next financial year which would leave the health service's finances in a "sickly state".

Dr Tony Calland, GMSC Fundholding Subcommittee Chair, has refuted the claim put by Leicestershire GP Dr Michael Wright that health authorities will absorb fundholders' overspends. He says instead that overspends will "land in PCGs"[49].

Another financial problem which may arise via fundholders could be the cost of redundancies for staff in fundholding practices who lose their jobs. Dr Judy Gilley, GMSC Deputy Chair, has said that reassuring fundholders on the way in which these redundancies will be managed is an urgent task[25].

There are several concerns that the white paper's "vision for the organisation and provision of care that has attracted widespread support"[31] will be damaged through its financial problems. Ham is worried that the politicians' reluctance to be seen to be spending more public money will result in the underfunding and subsequent failure of the initiatives[31]. An editorial in *Health Visitor* is concerned that, without guidance from the government to health service managers, the current budget restraints could lead to more community nursing cuts. This, the editorial argues, will scupper the long-term vision for the NHS through a "distinct lack of community practitioners available to sit on primary care groups"[15]. Polly Toynbee is concerned that the priorities in the NHS will be skewed towards crude waiting list figures, just one part of the proposed reforms, as these types of figures "are almost the only thing that news editors understand"[23].

Part of the problem seems to be the distance which lies between the views of politicians and the media, as described by Ham and Toynbee, and those of medics, as described by Richard Horton. Horton implies that a sense of idealism is held by many doctors but that this is "crushed early at medical school through constant exposure to eroded goodwill among staff, outdated and inadequate buildings and facilities and lack of time to apply the carefully acquired skills of history taking and physical examination that underpin a compassionate, doctor-patient relationship"[33]. For the system to be improved at all, he implies, resources are required to try to regain some of that idealism and to prevent apathy. Any deviance from financial support, such as those possible situations outlined by Ham, *Health Visitor* and Toynbee could easily result in no appreciable improvements to the system at all.

3.4 Problems with managing the changes

3.4.1 Restructuring the management system

The question of the future role of the health authority has been explored by some commentators. Griffiths welcomes the move to place the lead for addressing the health inequalities with health authorities:

> "This responsibility signals a changing role for health authorities and a step forward on the pathway from health care to health. In future health authorities will provide strategic leadership, freed from unnecessary administration."[30]

The NHS Confederation has been cited as implicitly going along with this idea. Linda Beecham states that it has welcomed the strengthening of health authorities' strategic role[2].

Jonathan Boyce and Tara Lamont see this increased strategic role as being akin to old RHA status:

> "It looks as though their key functions will be resource allocation, strategic planning through health improvements programmes, and some reserve powers over capital investment and commissioning of superspecialist services. This is starting to look familiar. If the envisaged process of consolidation should result in say, 14 of these bodies, the re-creation of regional health authorities will be almost immaculate."[4]

The role of the health authority - or any other health service organisation for that matter - in the future development of specialist services concerns Christopher Bunch. He is pleased that each of the NHS Executive's regional offices has been given a clear responsibility for ensuring that effective arrangements for commissioning these services are established in every region; however, he is also worried that the potential development and the capacity to ascertain and cater for the future needs of and for these services has been ignored[6].

3.4.2 Increase in bureaucracy?

Critics of the white paper have still been voicing their opinions that, instead of reducing the bureaucratic burden, the proposals in the white paper will in fact increase it. Ward puts it very concisely:

> "The government is in danger of substituting health authority administration with a new bureaucracy based around groups of GP practices."[51]

Margaret Peach, a Social Worker at the Tile Hill Health Centre in Coventry backs this up. She is quoted in *Community Care* as doubting that the new arrangements will reduce bureaucracy[29].

Not only will there be an additional level of management via the creation of the primary care groups, but also, according to Ward, this layer of management could well prove to be very administratively heavy:

> "Apart from the extra tier of administration the proposals would create, doctors and nurses will not have the time to attend meetings and monitor contracts so managers and administrators will be needed to run the system. Money will still have to flow around the system, bills will have to be settled, a method of paying for treatments which fall outside service agreements found and disputes resolved."[51]

S.T. Atherton agrees with this and sees the possibility of primary care groups developing into highly administrative entities:

> "Is there potential for an explosion in bureaucracy, with more managers - a chief executive officer, finance director, and, possibly, medical director? All this, of course, runs counter to the white paper's promise to redirect money from bureaucracy to patient care."[1]

So the primary care groups could easily become highly bureaucratic themselves. Management is not necessarily a bad thing though. Another commentator, Howard Lyons, has written to the *Health Service Journal* about the need for managers. He implies that, without them, problems could occur in trying to monitor the changes and particularly refers to the way in which the savings themselves will be assessed without managers to do this. His entire letter reads thus:

> "If the government is majoring on performance measurement in its new, modern and dependable NHS, how does it intend to measure and demonstrate the removal of £1bn from unnecessary bureaucracy over the next four years?"[37]

Ward also seems to think that cutting management jobs is not the best way forward. In another article, he implies that this is not the best way to make efficiency savings. He refers to a wide-ranging self-examination by Wales's five health authorities of their potential for savings. They found, according to Ward, that there certainly was a potential for large savings, but that the money was not to be found by sacking managers but instead by improving clinical efficiency. The current proposals in the white paper do intend to achieve clinical efficiency but they also intend to reduce management. According to Ward, the reduction of management jobs should not be necessary.

3.5 The initiatives

3.5.1 The Primary Care Groups

Much has been written in early 1998 on the subject of the primary care groups and their possible composition, remit and success or failure.

McLoughlin, as just one example, is very enthusiastic about the changes. She likes the fact that clinicians (both nurses and doctors) will be placed at the forefront of decision making; that primary care is seen to involve more health service staff than just GPs; and that the primary care groups will realise the essential concept of the primary healthcare team by ensuring that information, advice, treatment and specialist services are available in the community[38]. Parston and McMahon are similarly eager about the changes. They see the grouping of general practitioners and their patients as the basic building blocks of a renewed national health service innovative[42].

3.5.1.1 More local fragmentation?

These groupings will be very localised in nature, however, and this could cause some problems. Although Muijen admires the potential for local variation in the primary care groups, in that this will encourage responsiveness to local choice, he can also see some difficulties arising through potential differences in choice within one health authority area. He asks what will happen if only some primary care groups in one health authority's jurisdiction take up the full range of options, leaving the authority to commission comprehensive services for some patches and delegating full budgets to others? He also asks what will happen if some groups want to merge with the community trust while others reject the option? He describes the idea of relying on the individual capacity of approximately 500 new primary care groups for commissioning services as "risky"[41].

The implications of local differences in experience and skills are brought up in a *Medeconomics* editorial. In this editorial, Jon Ford, Head of the BMA's Health Policy and Economics Research Unit, highlights the need for differences in GPs' remuneration. He says that the pro rata rate for key roles in primary care groups will have to be at least £50,000 a year to cover average net remuneration and goes on to describe how different primary care groups and their members will have to receive different levels of funding:

> "GPs also have to be rewarded for the managerial expertise they have built up commissioning services. The rate should increase with the level of responsibility taken on."[24]

This suggests that in any one area one primary care group could potentially receive much more money than its neighbour(s).

This potential localised fragmentation is touched upon by Lambden too. He states that "the issue of adjacent primary care groups setting different clinical priorities does not seem to be addressed"[35]. He sees the institution of the primary care groups as "the most fundamental issue of all" in the new white paper.

Others believe that the new system will in fact be much less disparate than the old one. Despite fearing that GPs will have to "shoulder the responsibility - and eventual blame" for the new NHS, Horton believes that the primary care groups will be an improvement on the current, fragmented health service:

> "Adequately financed primary-care groups will diminish the fragmentation that general-practitioner fundholding introduced into the NHS. These groups will very much resemble the American-style health-care purchasing agencies devised by Alain Enthoven, the man who imported the concept of purchasers and providers into the UK."[33]

More seamless type care is hoped to result from the primary care groups. The notion that the primary care groups resemble American health maintenance organisations is repeated elsewhere. Tom Butler and Martin Roland describe the new model of health service commissioning thus:

> "The fully developed model looks much like an extension of total purchasing, with the addition of fully integrated primary and secondary care budgets - not unlike an American health maintenance organisation."[8]

Thornton has been cited as saying that both models of primary care group could develop: either GPs leading UK-style health maintenance organisations or GPs acting as junior partners to health authorities[48]. Although he claims to have no preference, Thornton has said that there would be an advantage to the NHS in keeping GPs as independent contractors as this is "one way of keeping clinical professionals hard at work. In Germany they refer to this as the hamster wheel"[48].

3.5.1.1 The ability, willingness and time available of primary care professionals to undertake the extra work

A possible problem highlighted in the initial reactions and which has continued to be recorded in early 1998 is that of the ability of GPs and others to run the primary care groups effectively. Although some GPs seem very keen indeed to get started as members of the new primary care groups (and, in fact, one group of fundholders in Andover have already integrated themselves and their local community trust into a "primary and community care agency"[7,22]), others are not so confident. The *Medeconomics* survey of LMCs reported that GPs themselves were concerned that they would not be able to live up to the expectations of patients and the government[19]. Ward describes the developing situation as one in which "GPs are waking up to the possibility that the proposals may leave them exposed on the issue of their own efficiency"[52].

The GPs' worries have brought rather less positive comments into the debate. *Medeconomics* has surveyed LMCs across the country[19]. The results of this survey imply that GPs are not as happy with the reforms as perhaps some other members of the health service:

> "Our survey revealed no wholehearted support for the revamp, with the majority of those replying taking a cautious line or voicing vehement opposition to the plans."[19]

The overall response of GPs to the white paper, found via this survey, is described as "lukewarm"[19].

Lambden points out that GPs are going to have to move from being in competition with each other to collaborating with each other in a fairly short space of time:

> "In recent years GPs have competed with one another to provide the best services, to have the most comprehensive range of staff and, of course, for the patients. Family doctors receive, after all, a substantial amount of their income from payments based on the number of patients on their lists. For that reason relationships between GPs have often been strained, or worse. The result could be that it may be difficult to get agreements for GPs of all the practices to work together in any area and, sadly, the white paper may be naive in its aspirations."[35]

The *Medeconomics* survey also included GPs' own fears about the success of primary care groups working as cohesive units[19].

Lambden goes on to remind the reader that GPs may well be reluctant to involve themselves in anything which is management-related. For many, he implies, this is not why they joined the health service:

> "It should not be forgotten that many GPs do not want to be involved in fundholding, or commissioning, or in any activity involving purchasing where the budget may be capped. The concept of vocational medicine is still alive and well and many doctors, both in the hospital and in practice, resent the idea that treatments should be withheld because of financial shortages."[35]

It is not only the managerial abilities of GPs which have been questioned. Caroline Free and Martin McKee question in particular GPs' abilities to assess the needs of the black and ethnic minority groups within their populations[28]. They can see a problem inherent in giving GPs responsibility for population-wide needs assessment:

> "General practitioners are trained to identify and respond to the individual health needs of their patients...Their understanding of these needs reflects the variety and types of illnesses that patients present and is inevitably based on patients' current use of and demand for services."[28]

This use and demand, they say, often reflects not necessarily need, but factors such as the patient's health beliefs and knowledge, attitude and experience of services, the doctor's interests and the current supply of services. According to Free and McKee, an understanding of these relationships is vital if a service based on need is to develop.

Lambden refers to Professor Alan Maynard in suggesting that there is little evidence that GPs could in fact extend their commissioning role[35]. This view is repeated by Boyce and Lamont[4]. They believe that the commissioning skills in the country will be stretched in the new system. They refer to an Audit Commission report which showed that there was insufficient commissioning expertise in the country for even 100 health authorities, let alone 500 primary care groups. They refer to these problems as "functional".

There are also, they claim, "structural" reasons why the primary care groups may have less impact than expected and these, they say, are "possibly more profound". These structural problems comprise primary care group and health authority power. Boyce and Lamont predict that the primary care groups will experience inflexibility in serving populations as

large as 100,000. Unlike fundholders, they will not be able to move contracts easily between trusts and also, unlike health authorities they will not enough leverage to become the sole purchaser for local trusts. Boyce and Lamont describe primary care groups as being "neither 'small enough to walk' nor 'big enough to hurt'". They also fear that primary care groups' purchasing power could be reduced by the health authority. Any planned changes will have to be explored in association with the authorities who could always impose a veto on any primary care group decisions. This is also a concern of the GMSC[48].

The willingness of GPs to undertake the new work is also mentioned. Dr Ron Singer is quoted in *Medeconomics* as arguing that GPs will need a financial incentive in order to take part in the primary care groups:

> "Unless GPs are paid at a locum-plus rate, they won't be attracted in."[24]

Butler and Roland believe that other, more professional incentives will be needed. They claim that one incentive which harnessed the enthusiasm and drive of GPs for fundholding and total purchasing was the ability to change and improve services[8]. In order for the primary care groups' members to provide high quality, coordinated and equitable care, they will need management support and "access to public health skills to enable them to purchase effectively for their communities"[8].

Apart from their willingness to do this work, as Lambden reminds his readers, the primary care groups will bring more to the GPs' workload: how are they going to manage with these extra demands on their time?[35] This fear is cited elsewhere[19].

The extra time needed for primary care groups to work is mentioned by Patti Simonson, Principal Social Worker at the Royal Hospital for Neurodisability in London. She believes that GPs share little common ground with other professionals and that the need to work together will take up time and skills unnecesarily[29] leaving little time for the extra work. This view seems to be shared by Margaret Young, Team Manager in Milton Keynes Hospital Social Work Department. She is cited in the same article as believing that GPs will grow impatient with the complexities of health and social care[29]. These views may well be based on fact; however, they also indicate the yawning gulf of understanding which lies between general practice and social care.

3.5.1.1 The composition of the Primary Care Groups

Butler and Roland state that a "testing time"[8] lies ahead for primary care groups and health authorities. They suggest that there may be problems in balancing local, appropriate and cost effective needs, as well as balancing services provided in hospitals and in the community and in managing primary care group accountability. They put forward one answer to these problems: lay representation on the new boards.

The lack of user involvement in the proposals received a little more attention in the 1997 journals than it has done in those reviewed for early 1998. An editorial in *GLACHC Update* is one of the few voices which has recently called for user participation in the new system of local health care planning[20]. Judy Wilson, Director of the Long-Term Medical Alliance is another of these few. She thinks that one of the running themes of the white paper is "doctor knows best", an "old-fashioned" way of "not involving more people in the decisions about commissioning"[23].

Other comments have been made on the possible composition of the new groups, however; various groups of health care professionals' representatives have been cited in the professional press pushing for their members' inclusion in the running of the new system. Philip Bratley, for one, urges pharmacists to get involved and, perhaps, collaborate with each other in order to achieve a stronger position[5].

Other voices include those of social workers and nurses. Margaret Peach is cited by Mike George as wanting the primary care groups to include not just GPs and community nurses but also social workers and auxiliary health care professionals[29]. Kit Hall, a Social Worker managing an assessment and care management team in Newark Hospital goes further in wanting to see social service representation at the governing level:

> "It is essential that representation at all levels includes individuals who are close enough to social work practice to be able to accurately reflect and debate operational issues."[29]

She is also keen to see social workers retain their own professional identity in the new scheme. Jean Curry agrees with this, saying that "good medical and social care are complementary and mutually enhancing"[29].

Nurses initially seemed more optimistic about their involvement in primary care groups. Editorials in *Health Visitor* state that "the door is open to community nurses, allowing them for the first time to play a leading role in shaping the future delivery of health care"[15] and that "community nurses have for the first time been given the opportunity to shape the delivery of health care"[27]. Jackie Carnell, Community Practitioners and Health Visitors Association Director, has been quoted in the second of these editorials as saying that the reforms "give us much to celebrate"[27]. The first of these editorials, however, does not continue in this enthusiastic vein. The author explains that there may be problems in community nurses getting their voices heard when having to work alongside GPs who already have a strong power base in the community in the shape of the LMC:

> "Anyone who knows anything about GP politics will recognise just how influential these committees are and how any individual working alongside them may feel overwhelmed by them."[15]

The future of LMCs could hang in the balance, however; an editorial in the BMJ cites the December meeting of the GMSC at which the uncertain future role of LMCs was discussed as a cause for concern for GPs[21].

Nursing representatives it seems are fighting hard to get nurses' voice heard. Yvonne Moores was cited at the very beginning of the year as launching "an initiative...to allow nurses to have their say on the way forward for the professions"[17]. Christine Hancock has highlighted the abilities of nurses by applauding their involvement in commissioning as something which "makes good sense"[32]. Pippa Gough, the RCN's Assistant Director of Nursing Policy and Practice, spoke at a health service managers' conference in London, encouraging the attendees to see nurses as commissioners[16]. She said that a minority of nurses had been "commissioning by the back door" for a long time and since nurses made up 80% of the NHS workforce it makes sense to involve them in this process. She urged health authorities and trusts to consider their skills. The author of the editorial which described this speech, used the word "intimidating" to describe the challenges of the white paper from the point of view of nurses[16]. It seems that a lot of work is going on to try to include nurses in the commissioning process from the start.

Comments made about the primary care groups by GPs and their representatives indicate that perhaps not all of the other health professionals' concerns about their possible exclusion from decision making in the primary care groups are unfounded. Dr John Chisholm has been quoted in the *BMJ* as describing the primary care groups as being able to "make use of the expertise of fundholders and commissioners, maintain GPs' influence, allow for a plurality of commissioning methods, and let family doctors take on responsibility for the provision of all community services if they wish"[2]. This statement takes no account at all of other healthcare professionals' involvement in the commissioning and provision of services via primary care groups. A comment which implies a similar attitude to the management of the primary care groups was published in an editorial in *Medeconomics*:

> "If GPs do not take the lead, you can be sure someone else will. And once the primary care groups are in the hands of the bureaucrats, the idea of a 'GP-led NHS' will go for nothing."[18]

From the GPs' viewpoint it seems that the only other group to be included in running the primary care groups could be health service managers. Dr Hamish Meldrum has been quoted as stressing GPs to lobby health authorities in order to prevent the managers from "doing things which are counter productive to [GPs'] long term welfare"[44]. An advertisement for a series of workshops on how to "influence the future of primary care groups" which appeared in the *Health Service Journal* also seems to miss out candidates who are neither currently medics nor administrators[39]. The workshops are being run by Medical Management Services in association with the NHS Confederation, the National Association of Commissioning GPs and the British Association of Medical Managers and its expected attendees are said to be clinicians and managers. Joy Persaud, writing in *Medeconomics*, goes even further. In complaining that little direction has been given to GPs, she states that "in theory the government placed GPs at the helm of PCGs"[44].

In writing about the ways in which the District General Hospital could work with the primary care groups, Mike Pollard points out that "the term 'a primary care-led NHS' is not to be found in the white paper"[45]. He goes on to say that the new NHS is characterised by a "whole-system" approach to health care. Despite this, many primary care practitioners and especially GPs seem to be assuming that the contents of the new white paper relate primarily to themselves. It is true that primary care will eventually be taking the lead in commissioning services; however, another major part of the white paper refers to the duty of partnership and collaboration between different bodies in the health service. At the moment, this does not seem to have filtered down to the current front-line primary care practitioners and may take some time to do so. For more information on collaboration in the new system, see section 3.5.3.

3.5.2 NHS Direct

NHS Direct is still attracting quite a lot of attention in the professional press. It is seen by Rob Crouch as the NHS "[joining] the rush" to consumerism[10]. Many commentators are impressed by the concept. Jeremy Wyatt believes it will ensure "a more informed public"[54]; David Pencheon claims that it "heralds a fundamental shift in the NHS where more public participation in health care can happen closer to home"[43]. He also states that NHS Direct "may well be the most important development this white paper has to offer"[43]. Jeremy Dale puts this idea well:

> "(who would argue against making advice and information more readily available to the public?). If banks, insurance companies and many other service industries have all revolutionised their services,

won customers and made considerable cost savings through greater use of telecommunications and IT, then why not the NHS?"[11]

As well as praising the initiative, the articles published in the early part of 1998 have put the scheme in the context of other similar schemes and pilots. It has been related to the "888" project[11], to the work carried out by Kenneth Calman's review of out-of-hours hospital emergency care which recommended piloting a freephone emergency line as a way to reduce the demand for A&E and primary care services[10], to the Health Information Service[11] and to telephone services already offered by US health maintenance organisations and insurers[43,54].

Other pilot telephone schemes have received recent media attention in light of the white paper proposals. One of these is a pilot telephone hotline staffed by nurses in Ayrshire[53]. This scheme has not been one hundred per cent successful: many of the nurses providing the scheme are cited as not being happy with it and the Scottish Office is currently reviewing it following the deaths of two babies. Another scheme to develop recently is that launched by Ealing, Hammersmith and Hounslow Health Authority, intended "to divert patients from casualty wards" using £195,000 of winter pressure money[14]. This scheme had apparently been inspired by the Chief Medical Officer's Executive Letter (EL) which advised on measures to ease winter pressures. Although the new service has not been publicised, it has, according to a *Health Service Journal* editorial, been taking between 30 and 40 calls a day[14]. Dale has asked how NHS Direct will fit in with these current telephone advice and information lines[11].

Many questions have been raised about the practicalities of the new scheme. As Rob Crouch puts it:

"There seems to be widespread support for the service, but the proposal is not without its challenges"[10]

Several commentators have asked questions about the demand for the service and how this will be managed[10,11,54]. Crouch states that "it is not clear to what extent the service will create demand rather than identify existing unmet need"[10]. Dale indicates that some GPs are concerned that it will add to their workload if the automatic response to patients' enquiries is to suggest they visit the surgery[11]. He also states that the scheme's scope needs to be defined clearly. He asks whether it is supposed to be a "listening ear" regardless of the time of day or night and what its purpose precisely is. It could vary, he says, from providing information and advice about health matters and the NHS to being a common point of telephone access to the full range of primary care services within any particular area.

Another potential problem identified in the literature is the massive media hype of the service which could encourage more people to use the service than can be catered for:

"Pilot sites may be deluged with demand without having the time to develop the service in response to demand, leaving nurses being beleaguered by stacked up calls."[10]

Crouch predicts that this huge demand, engendered by consumerism and the media attention given to NHS Direct could force a national roll out of the service before it is really ready.

One suggestion, given by Crouch, as to why NHS Direct might be so inundated with calls is that it will take on the role of "surrogate grandparent"[10]. He states that society has developed an "increasing reliance on professionals rather than older members of the family"[10] in matters of health and wellbeing. Dale adheres to this view as well, saying that there is a risk that

NHS Direct will be deluged with calls from the "worried well" who in the past would have turned to family members or neighbours[11].

Dale goes on to describe a recent survey of telephone advice sought out-of-hours in order to give some indication of potential demand levels. Over an 80-hour period which included Good Friday, Easter Sunday and bank holiday Monday, in Lambeth, Southwark and Lewisham (resident population 70,000) more than 3,000 unplanned calls from members of the public were identified as having been made to A&E departments, GP services, community nurses, mental health services and community pharmacists. In each 24-hour period, this was equivalent to around 150 calls per 100,000 resident population. Extrapolating this level of demand to the whole of the UK population, according to Dale, suggests that something in the order of 50,000-100,000 calls might have been made to NHS providers of telephone advice lines during each 24-hour period over the Easter weekend. He says that had these all been directed to a single provider, a staffing level of 500-1,000 nurses would have been required during day and evening hours, and about 150-200 nurses during the early hours of the morning.

Not all the commentators simply accept that NHS Direct is likely to generate more demand for health services however; Pencheon sees it as a tool which will in fact help to manage the ever increasing demand which is made of the NHS by empowering the patient to take some responsibility for his or her care. After all, he says, the supply of services cannot really be cut and so access to these services needs to be mediated in some way:

> "The perennial fear is that increasing access increases demand. This may not be so. Managing demand by cutting supply may be effective for some services but it is hardly ideal in primary care. A better way of managing demand is to offer a more graduated access to health care, where patients are as aware of the risks and costs of health care as they are of the benefits, with incentives to match."[43]

The biggest and most important potential problem that he can see is that instead of empowering people, NHS Direct could in fact disenfranchise some groups. One of these groups could be people from black and ethnic minority groups. Free and McKee point out that NHS Direct needs to take into account the needs of those who neither speak English nor have easy access to an interpreter[28]. They claim that 23% of those in England and Wales whose country of birth was China, Bangladesh, India or Pakistan are estimated to have no functional communication skills in English and 70% to have insufficient, a total of almost 600,000 people.

These issues imply that those professionals staffing the telephones will have many responsibilities. Crouch emphasises the importance of training the nurses who will be staffing the telephones in both technology and communication skills:

> "It is essential that nurses undertaking this role are adequately trained in telephone consultation skills and are conversant with the necessary technology for the role, as well as being fully aware of their accountability."[10]

The RCN has been cited as raising concerns about the training received by the nurses running the service, especially in light of the Ayrshire scheme which is currently under review by the Scottish Office. Jim Wallace, RCN officer in Ayrshire is concerned that nurses may be putting themselves at risk by misdiagnosing a condition[53]. Dale asserts that contingency plans need to be in place in NHS Direct for unexpected surges in demand, for instance, in flu epidemics or meningitis scares[11].

Wyatt is interested to know more about the information used to diagnose and give advice. He wonders how the nurses will go about finding information to give the callers, implicitly asking how NHS Direct will fit into the quality initiatives which insist on evidence being used for decision-making and accountability to be maintained:

> "For example, what information sources will the nurse-advisors turn to, will they send a record of patients' symptoms and the advice given to general practitioners, or keep a copy in case the patient phones again or, worse, sues?"[54]

It is not only clinical training which is needed by the staff on the hotline though. Dale points out that the "888" scheme found that a lot of nurses needed very basic training in computer skills and had to practise using the software for about 15 to 20 hours before they were competent to cope with the system[11]. Others found the computerisation daunting[11].

Not all the commentators simply accept that nurses would be the obvious choices for the providers of the service. Dale states that the very concept of NHS Direct "challenges organisational boundaries"[11] and that ambulance service trusts may well feel that they are the natural choices; however, for the service to be effective, so says Dale, different organisational values to those appropriate for running an emergency service will be required. Other groups such as GP co-operatives or community trusts could, he says, "fairly readily evolve an NHS Direct service as an integrated element of local service provision"[11]. However the scheme evolves though, Dale is adamant that the effective and sensitive, albeit more difficult, way of doing it is to take a piecemeal approach involving "networks of local providers working to nationally agreed standards"[11].

3.5.3 Collaboration not competition

Many aspects of partnership have been mentioned in the professional press: the partnership needed between the government, health service managers and other staff in order to ensure the reforms work[2,46], partnerships between GPs in primary care groups[35], between unions and the various agencies[23], between GPs and health authorities[8], between GPs as commissioners and the hospitals from whom they will be commissioning services[45,35], between GPs and other medics in the health service[1], between GPs and specialist mental health trusts (the fear is that as GPs' interest in mental health varies from area to area, so will the types and amount of services commissioned[40]) and, of course, partnerships between the health and social services[4,29,30,41].

One less obvious aspect of partnership which has been picked up on is that of staff involvement with government in the planning and implementation of the changes. Thornton states that staff consultation did not take place prior to the writing of the white paper and that "implementation must not go the same way[23]. Atherton by praising increased staff involvement by implication believes that it will in fact take place in planning the new NHS[1]. Cockroft and Williams examine the white paper from the point of view of the improved conditions it offers to staff[9]. They too welcome the increased participation promised to staff in decision making.

The majority of the comments centre on the relationship between health and social services though. Muijen worries that although partnerships with the social services are crucial in order to eliminate bed-blocking and duplication of community services, "no consistent structural solution" has been offered for the development of joint planning[41]. He is concerned

that "the new boundaries with primary care trusts may re-open old wounds over the responsibility for people with minor mental illness".

The potential problem with geographical boundaries is mentioned by Boyce and Lamont:

> "An integrated approach between health and social services is necessary, but given that primary care groups and health authorities will seldom be coterminous with local government bodies, it is not clear who will liaise with whom. Duplication and confusion are real risks."[4]

According to Alison Moore, "many commentators have argued that it would make sense for health service boundaries to coincide with local authority ones"[40]. She cites Cath Cunningham, the Local Government Association Health Policy Advisor who agrees with this, but can see some problems appearing in cases where health and social services are already working well together[40].

Griffiths is concerned about the lack of explanation of the new statutory duty of partnership[30]. She is concerned that several issues are unclear. These are: the sharing of accountability between statutory authorities; the ways in which health and local authorities will make their relative contributions; and the parts to be played in these partnerships by community health councils, voluntary organisations and the public.

Despite these worries, it seems that there are already some existing examples of successful collaboration between social services and primary care. Mike George describes this method of joint working as "nothing new"[29]. He cites several members of social services staff who are involved in such schemes. One of these is Margaret Peach. She describes the service which she works at as "very reassuring" and explains that time is saved as there is no need to argue about whether a patient's needs are related to health or to social care[29]. Roy Trent, a GP who works in the same service, likes the fact that continuity of care is maintained:

> "If I have a patient who needs social care, I would normally have to phone up a social services department and speak to a clerk, who takes your name. Then the referral disappears into the ether and you don't know who will pick up the case, how or when. But here anyone in the team can access the social worker and vice versa."[29]

The notion of seamless care is picked up also by Councillor Brian Harrison from the Local Government Association. He is keen to ensure that local authorities interweave the integrated care of the NHS into seamless social support services[23].

Trent suggests that the success of such services is partly dependent on flexibility and being able to "bend the rules" and switching money to and from different budgets. Unfortunately, another social worker cited in the same article, Sue Collyer, sees problems with this. She cannot envisage such co-operation being widespread:

> "As long as there are separate budgets from which the primary care group money is pooled, there will be efforts to protect them by toughening eligibility criteria, producing unseemly, unhelpful and time-consuming wrangling over who pays what."[29]

The potential future pooling of health and social care budgets has also been touched upon here. The white paper is seen as calling for this[29]. Margaret Peach is cited as supporting this, while others of her colleagues in social care foresee problems with the practicalities of doing this[29]. Mike George, the author of the article in *Community Care* which cites these social workers, believes that "it is unclear how the various agencies...will be persuaded to part with

their money"[29]. He is backed up here by Jean Curry, the Chair of the British Association of Social Workers' special interest group for health-related social work:

> "Everyone will have to be clear where the social care money is coming from. It's important that budgets aren't jealously guarded by particular groups of professionals."[29]

As Sue Collyer, a Senior Social Worker in a team for elderly disabled people in Hertfordshire, has put it, without the pooling of budgets in "good faith", it is possible that primary care partnerships will suffer[29]. This seems to be essential to the success of primary care groups; however, it is one issue which seems also to be unclear and which will be difficult to resolve.

Parts of the problem may lie in the lack of understanding of the work of the two agencies and their cultural differences. Margaret Young insists that GPs will have to understand that community care cannot be prescribed like a drug[29]. Hugh Lawrence believes that simply too much trust has been placed in the new spirit of collaboration[36].

3.5.4 Longer-term contract planning

Very little has been written lately on the changes to the lengths of service contracts. Those comments which have been made throw up a few issues of interest though.

Ward asks how the primary care groups will be able to set three-year contracts when the level of their funding is subject to the outcome of the annual public expenditure survey round[51]. He goes on to say that a solution may be possible in the shape of the introduction of "medium-term funding assumptions for health". This would allow the Department of Health to tell each health authority how much it had to distribute among its primary care groups in advance.

Atherton relates the need for long-term contracts and views to workforce planning, saying that "we need to look at how to develop integrated workforce plans together with integrated care"[1].

3.5.5 Quality initiatives (NICE, CHI and clinical governance)

The proposed quality initiatives in the white paper have continued to receive praise. McLoughlin, for example, welcomes both NICE and the CHI:

> "Both, particularly the Institute, will build on the wealth of information gathered through audits, much of which motivates and encourages openness and excellence."[38]

Muijen is similarly enthusiastic about the new proposals to distribute information via NICE which, he says, "could make more impact than any of the proposed structural changes"[41]. An editorial in the *BMJ* claims that GPs have "welcomed the emphasis on fairness, equity and quality" in the white paper[21] and Beecham states that, in general, all professional organisations have welcomed NICE[2].

A few comments have been made which question some aspects of these initiatives. Wyatt has asked how NICE will link in with the work of the Centre for Reviews and Dissemination in York[54]. He also asks for clarification on the role of national guidelines since "the most effective guidelines are those that have been locally adapted"[54]. He is concerned that

professional societies currently receiving NHS support for guideline development may instead receive a "nasty shock" if this money is channelled instead to NICE alone.

Kleijnen and Bonsel also comment on guideline production in the new NHS[34]. They suggest that NICE could profit from investigating what has already been done in other countries. They also suggest that the prospective users of the guidelines should be involved in their preparation and that the various groups undertaking this development should be coordinated in order to avoid duplication of effort and waste of money. They also suggest that in order to disseminate the information effectively, NICE should cooperate with centres for evidence based medicine and health care groups within the Cochrane Collaboration.

Kleijnen and Bonsel identify one particular problem which the CHI might have and which NICE should not[34]. They say that it may be a challenge for the CHI, as a top down organisation, to influence daily practice in the NHS as improvements can only really be made by those who are engaged in providing the services. NICE, on the other hand, they say, may have an easier task as the nature of the dissemination of guidelines is bottom up.

Mike Pollard implicitly concurs with this. He sees the role of the CHI as being intimidating to clinicians, but also does not view this as necessarily a bad thing:

> "Whether intentional or not, performance management is a threatening process. It will prompt GPs and specialists to work together to deliver within such a framework."[45]

It is not only within the realms of the CHI that performance monitoring has received comment. Atherton states that "enormous difficulties exist in measuring the quality of clinical care"[1] in general and that "more work needs to be carried out on outcome measures if we are to determine which health care intervention produces the best outcome"[1]. The issue of clinical governance has certainly received plaudits; however, Nick Black for one can see some potential problems with the methods of monitoring it. These he describes as "controversial"[3], due to the fact that current systems of comparing performance will not be appropriate for this. He suggests that there should be a greater reliance on national specialised clinical databases which can achieve higher levels of detail, completeness and accuracy in order to adjust for differences between trusts in case mix. If this is to happen, he then asserts that the CHI should not involve itself directly in large data gathering exercises but "act as an umbrella organisation, harnessing help and input from the specialist groups"[3] and monitoring the quality of the databases. He states that this would mean that initially it would monitor only some areas of health care but that this would be preferable to a "potentially misleading comprehensive audit"[3].

Another potential problem with clinical governance, pointed out by Jeremy Wyatt, is that of confidentiality from the clinician's point of view:

> "Some clinicians may fear that governance will lead to occasional mistakes becoming too widely known - especially with the forthcoming Freedom of Information Bill. The professions need to debate urgently what constitutes appropriate publication of clinical performance data, to complement the confidentiality safeguards covering individual patient data."[54]

Lambden states that the logic of the white paper is "somewhat confused" in relation to the performance and the involvement in the new system of hospital clinicians. He says that the white paper claims to reverse the sense of disempowerment which had been experienced by this group of people under previous reforms; however, he goes on to point out that these

reassurances are difficult to reconcile with the hospital clinicians continuing accountability to GPs[35].

It is not only the hospital clinicians whose performance is being questioned here though. Several comments have been made about the way in which the primary care groups will be able to be accountable for their decisions and actions. Boyce and Lamont indicate its importance, saying that as almost 90% of hospital and community care will be purchased by primary care groups "proper accountability is crucial"[4]. Dickson suggests that, despite the words of the white paper primary care groups may well be no more accountable than health authorities are today:

> "Unelected health authorities have always struggled with this democratic deficit, some fundholders worried about it too. Why should unelected primary care groups, made up of doctors, nurses and managers be any more accountable?"[13]

Nonetheless, much comment has been made lately concerning just this issue. Atherton, for one, suggests that it will be "interesting" to see who takes on the role of accountable officer in primary care groups, given the GPs' independent contractor status[1]. Butler and Roland see the resolution of the way in which accountability will be managed within the new commissioning groups as vital for their success:

> "Conflicts may arise in achieving a balance between local, appropriate and cost effective needs, and especially between services provided in hospitals and in the community. In theory primary care groups will have to work within the strategy of local health improvement programmes. How accountability will be managed and control exerted will be central to resolving the conflicts that will arise."[8]

Before the question of the way in which accountability will be managed can be resolved, the type of accountability to be used by the new system needs to be identified. Shapiro sees the accountability measures in the new white paper as taking two forms: clinical accountability and "the power of a web-like accountability framework"[47]. These two forms seem to incorporate self-regulation and top-down action if performance fails. Shapiro describes this situation thus:

> "The carrot and the stick are both there, but...the balance between the two is unclear."[47]

He also suggests that different health authorities will use their regulatory powers differently, resulting perhaps in variations of accountability in primary care groups in different parts of the country.

He goes on to state that in order for the changes in the system to work, the "blame frame" within the NHS must be altered and that a balance must be achieved between permissive accountability (in which organisations are encouraged to do more and to carry an increasing share of responsibility for their actions) and punitive accountability, which, he says, is more prevalent in the current NHS and which does the opposite in that it "expects bad behaviour and tries to prevent it"[47].

The issue of accountability within the new commissioning groups and within the new NHS as a whole is likely to be monitored closely by the professional commentators.

3.5.6 The merging of budgets

Little has been written in early 1998 on the proposed unification of GMS and HCHS budgets. Those comments which have been made relate to the effect this will have on GPs and their services and conditions of employment. An editorial in *Medeconomics* puts these concerns thus:

> "For GPs, the most tangible change is going to be unified budgets at locality level...You do not have to be a rocket scientist to work out that the potential effect is rationing services, or cuts to staff and premises reimbursements. You cannot turn away patients. So what is the likely outcome? A gradual decline in the funding you receive to run your practices. Add this to the news that a government working party is looking into cash limiting the GP pay pool, and this already looks like a far from happy new year."[26]

The GMSC has also been cited as worrying about the proposal to unify these budgets and on the potential for cash limiting the GMS budget[21]. This is picked up in another *Medeconomics* article, by Jeremy Davies. He explains that the only part of the NHS budget held by health authorities or primary care groups that is excluded from the unification is the non cash limited GMS budget, "in other words, the GP pay pool"[12]. He goes on to explain that this, coupled with the Advisory Committee on Resource Allocation (ACRA) hunting for a needs-based capitation formula, has caused some consternation as one basis already mooted for this formula could be GP consultation rates. Although he cites the GMSC as refuting any possibility of such a scenario occurring he still seems concerned that GP pay could suffer from local differences:

> "Your pay would depend not on who comes into your surgery, but on where your surgery is and how much your HA is allocated."[12]

Whether or not such a situation would transpire, those GPs who have mentioned the unification of these budgets seem, in the journals analysed and at present at least, seem to be concerned about the proposed merging of primary care and hospital and community health service budgets.

4. Conclusion

Some of the comments made in the early 1998 journals reviewed for this report are very similar to those made in the first wave of reactions to the white paper in 1997. Questions have again been raised about the detail of several of the initiatives, including in particular the primary care groups, NHS Direct NICE and the CHI. A general feeling of welcome is still apparent; however, this has been tinged with a sense of unease, which comes from the GPs in particular, about how the new system will work.

BIBLIOGRAPHY

1. Atherton, S. T. The New NHS: commentaries on the white paper: from specialist services to special groups. Involving clinical professionals in managing and planning services. *BMJ.* 31 January 1998, p. 379.

2. Beecham, Linda. Broad welcome given to NHS white paper. *BMJ.* 3 January 1998, p. 10.

3. Black, Nick. The New NHS: commentaries on the white paper: encouraging responsibility: different paths to accountability. Clinical governance: fine words or action? *BMJ.* 24 January 1998, pp. 297-298.

4. Boyce, Jonathan and Lamont, Tara. The New NHS: commentaries on the white paper: from command economy to demand management. The new health authorities: moving forward, moving back? *BMJ.* 17 January 1998, p. 215.

5. Bratley, Philip. Amalgamated Local Pharmaceutical Services (ALPS) - is this the way forward? *The Pharmaceutical Journal.* 17 January 1998, pp. 94-95.

6. Bunch, Christopher. The New NHS: commentaries on the white paper: from specialist services to special groups. Challenging times for specialist services. *BMJ.* 31 January 1998, pp. 378-379.

7. Butler, Patrick. Community spirit. *Health Service Journal.* 15 January 1998, p. 11.

8. Butler, Tom and Roland, Martin. The New NHS: commentaries on the white paper: from command economy to demand management. How will primary care groups work? *BMJ.* 17 January 1998, p. 214.

9. Cockcroft, Anne and Williams, Sian. The New NHS: commentaries on the white paper: from specialist services to special groups. Staff in the NHS. *BMJ.* 31 January 1998, p. 381.

10. Crouch, Rob. Demanding times. *Nursing Standard.* 7 January 1998, pp. 14-15.

11. Dale, Jeremy. Wired for sound. *Health Service Journal.* 29 January 1998, pp. 24-27.

12. Davies, Jeremy. White paper briefing: what will happen to GP pay? *Medeconomics.* February 1998, p. 20.

13. Dickson, Niall. Health inequalities for all. *Nursing Times.* 21 January 1998, p. 24.

14. Editorial. 24hr helpline could ease A&E pressures. *Health Service Journal.* 15 January 1998, p. 8.

15. Editorial. A golden opportunity. *Health Visitor.* January 1998, p. 1.

16. Editorial. Commissioning skills needed. *Nursing Standard.* 28 January 1998, p. 8.

17. Editorial. Consultation on new nursing strategy. *Nursing Standard.* 7 January 1998, p. 7.

18. Editorial. Editor's comment. *Medeconomics.* February 1998, p. 19.

19. Editorial. GPs say no to Labour's plan for an NHS revamp. *Medeconomics.* January 1998, p. 9.

20. Editorial. GPs to take lead in NHS reforms. *GLACHC Update.* December 1997, p. 1.

21. Editorial. Medicopolitical digest: GPs highlight inconsistencies in the white paper. *BMJ.* 3 January 1998, p. 78.

22. Editorial. Proposal for first primary care trust. *Health Service Journal.* 8 January 1998, p. 5.

23. Editorial. The white paper - what they said. *HealthCare Today.* February 1998, p. 5.

24. Editorial. White paper briefing: budgets and pay. *Medeconomics.* January 1998, p. 14.

25. Editorial. White paper briefing: the timetable. *Medeconomics.* January 1998, p. 12.

26. Editorial. White paper briefing: your role in Labour's NHS plans. *Medeconomics.* January 1998, p. 11.

27. Editorial. White paper offers community nurses central role. *Health Visitor.* January 1998, p. 3.

28. Free, Caroline and McKee, Martin. The New NHS: commentaries on the white paper: from specialist services to special groups. Meeting the needs of black and minority ethnic groups. *BMJ.* 31 January 1998, p. 380.

29. George, Mike. Mixed reception. *Community Care.* 22-28 January 1998, pp. 20-21.

30. Griffiths, Sian. The New NHS: commentaries on the white paper: encouraging responsibility: different paths to accountability. From health care to health. *BMJ.* 24 January 1998, pp. 300-301.

31. Ham, Chris. The New NHS: commentaries on the white paper: from command economy to demand management. Financing the NHS. *BMJ.* 17 January 1998, pp. 212-213.

32. Hancock, Christine. Party to a vision of the future. *Health Service Journal.* 15 January 1998, p. 20.

33. Horton, Richard. The realpolitik of a new National Health Service for the UK. *The Lancet.* 10 January 1998, pp. 76-77.

34. Kleijnen, Jos and Bonsel, Gouke. The New NHS: commentaries on the white paper: encouraging responsibility: different paths to accountability. Guidelines and quality of clinical services in the new NHS. *BMJ.* 24 January 1998, pp. 299-300.

35. Lambden, Paul. The new cooperative NHS: what future for primary care now? *The Health Summary.* January 1998, pp. 17-18.

36. Lawrence, Hugh. NHS white paper: new 'partnership plan' for NHS bodies and local authorities; new responsibilities for budget control for GPs, community nurses; 'leaner' HAs. *Healthcare Parliamentary Monitor.* 22 December 1997, pp. 3-5.

37. Lyons, Howard. Red tape measures [letter]. *Health Service Journal.* 8 January 1998, p. 20.

38. McLoughlin, Catherine. Local teams to take the lead. *Nursing Standard.* 7 January 1998, pp. 14-15.

39. Medical Management Services. Your chance to influence the future of Primary Care Groups [advertisement for regional workshops for clinicians and managers]. *Health Service Journal.* 15 January 1998, p. 2

40. Moore, Alison. Mental health in the melting pot. *HealthCare Today*. February 1998, pp. 30-31

41. Muijen, Matt. Gently does it this time round. *Health Service Journal*. 22 January 1998, p. 22.

42. Parston, Greg and McMahon, Laurie. The New NHS: commentaries on the white paper: from command economy to demand management. A third way? England - yes; Scotland - maybe. *BMJ*. 17 January 1998, p. 213.

43. Pencheon, David. The New NHS: commentaries on the white paper: from command economy to demand management. NHS Direct: managing demand. *BMJ*. 17 January 1998, pp. 215-216.

44. Persaud, Joy. White paper briefing: how can GPs take the lead? *Medeconomics*. February 1998, p. 19.

45. Pollard, Mike. The regeneration game. *Health Service Journal*. 22 January 1998, pp. 26-27.

46. Shamash, Jack. Nurses at centre of drive to raise quality. *Nursing Standard*. 28 January 1998, p. 8.

47. Shapiro, Jonathan. The New NHS: commentaries on the white paper: encouraging responsibility: different paths to accountability. Counting and accounting in the new NHS. *BMJ*. 24 January 1998, pp. 296-297.

48. Slingsby, Carole. GPs fear loss of status in primary care groups. *Medeconomics*. February 1998, p. 9.

49. Slingsby, Carole. White paper briefing: what will happen to fundholders? *Medeconomics*. February 1998, p. 25.

50. Ward, Seamus. Elusive savings on NHS admin. *Public Finance*. 9 January 1998, p. 7.

51. Ward, Seamus. Review no cure for NHS sickness. *Public Finance*. 12 December 1997, p. 5.

52. Ward, Seamus. Squeeze put on GPs. *Public Finance*. 19 December 1997, p.7.

53. Wright, Colin. Criticism of nurse hotline sparks service review. *Nursing Times*. 14 January 1998, p. 7.

54. Wyatt, Jeremy C. The New NHS: commentaries on the white paper: encouraging responsibility: different paths to accountability. Will improved clinical information help realise the new NHS? *BMJ*. 24 January, 1998, pp. 298-299.