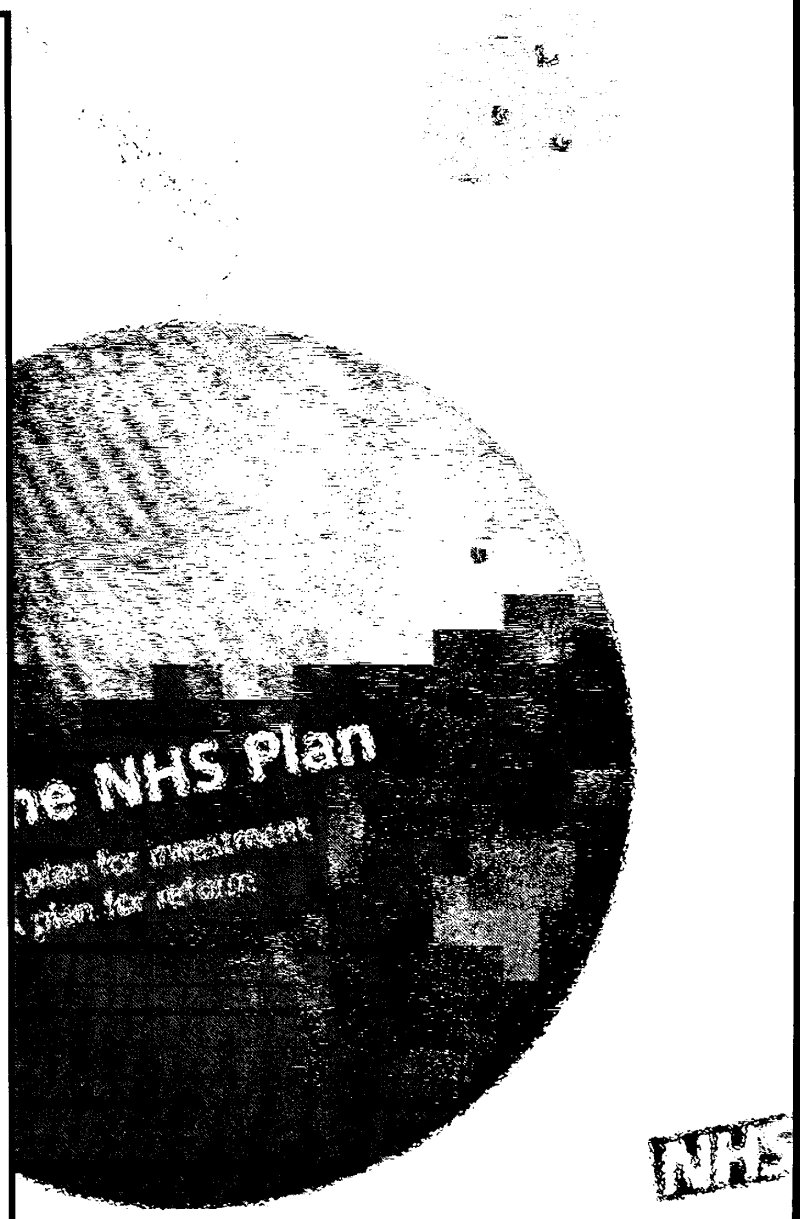
King's Fund

Health Care UK

The King's Fund review of health policy

Edited by John Appleby and Anthony Harrison



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Looking forward

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EDITORIALS

In this issue

The NHS Plan ... what do the public think? ... primary care groups ... public health ... waiting lists ... long-term care finances ... political parties' policies

John Appleby

The NHS – and, indeed, the nation's health – has a high political profile. Funded through taxation and ultimately accountable to Parliament, it is hard to see how the NHS could not be of central political concern. And so, a change of government in May 1997 brought a change of policy towards the service, and a change in the emphasis of policies towards health in general. The last three-and-a-bit years have seen, among other things, the abolition of the internal market and GP fundholders, changes in structure for commissioning services, a Minister for Public Health and, more recently and perhaps most significantly, a very large increase in funding and a Plan for the NHS.

In this issue of *Health Care UK* we take a look at the last three years of this Government's policies towards health and health care. Inevitably, with the publication of the NHS Plan, we also look forward.

Rudolf Klein concentrates on the NHS Plan, and immediately identifies an apparent paradox: the Plan proposes a relaxation of the command and control style of management that Labour has been accused of exercising over the last few years – but given the Plan's ambitious targets, surely Ministers have more reason than ever to retain a strong grip on policy implementation?

The extent to which any government's health care policies will be popularly judged a success is the impact they have on public opinion – only partially informed by the facts of course. **Jo-Ann Mulligan** surveys the surveys on public attitudes towards the NHS between 1989 and 1998 and finds a significant increase in satisfaction with the NHS between 1996 and 1998.

As **Justin Keen** notes, who, last year, would have predicted that the NHS Plan would contain a whole chapter devoted to concordats with the private health care sector? The Plan also contains strong reaffirmation of the principles of public service and rejections of alternative – particularly private – sources of funding for the NHS (excepting, of course, the Private Finance Initiative). Nevertheless, the proposed concordat will have some potentially significant knock-on effects within the health care system, which will need to be addressed.

GP fundholding is dead! Long live ... er ... primary care groups? Given the choice, would the current Government have gone down the primary care group/trust route? Possibly, but incoming administrations don't have the starting point of their choice. As **Steve Gillam** notes, along with the extension of the Personal Medical Services (PMS) pilots, clinical governance and numerous other initiatives in primary care, Labour could yet break

the NHS under the weight of its good intentions.

From the point of view of public health, **Anna Coote** lauds New Labour's theory – more overt recognition of the multiple causes of ill health, the clear statements on the undesirability of health inequalities – but finds their practice somewhat lacking. Health care rather than health seems to remain uppermost in Ministers' minds.

One health care issue the Government has had to grapple with is that of professional self-regulation. **Steve Dewar** and **Alison Hill** describe various models of medical regulation and note that the new forms of regulation – at national and local levels – will have direct impacts on accountability and professional autonomy.

Another NHS issue that has been high on the Government's agenda since the last General Election has been waiting lists. The UK is almost unique in the volume and detail of statistics it collects on waiting lists – it's very difficult to carry out any comparisons with other countries, for example. Labour's pledge to reduce the numbers waiting for hospital admission by 100,000 has proved an enormous mountain to climb and has taxed managers and clinicians no end. It seems, as **Anthony Harrison** points out, that the target has been reached; the NHS Plan has now set even more ambitious maximum waiting *times* targets. Waiting times are more sensible targets but, as ever, the knock-on effects and implications of such targets could be significant.

Two further issues are examined in this issue. First, the long, drawn-out saga of the reformation of long-term care finances. **Janice Robinson** tells the story of the problems caused by the duality in funding and also in provision of long-term care. The recommendations of the Royal Commission on Long-term Care have been only partially accepted by the Government, and it still remains unclear what younger generations can expect in the way of support when they are old.

The second issue is management. **David Hunter** takes a critical look at the style of this Government's management of the NHS. There is no doubt, as he says, that managing the NHS is a complex and messy business, but rather than the panoply of performance indicators, targets and standards, the Government should start with trying to understand and work with the multiple sub-cultures that exist within the service.

Finally, **John Appleby** sets out the three main political parties' policies on health and health care (including the NHS Plan). A week is, of course, a long time in politics, and some – or indeed all – of the policies described could have changed by the time of publication!

The new model NHS: political and managerial dynamics

Rudolf Klein

There is a curious tension at the heart of the Government's Plan for transforming the NHS.[1] On the one hand, the Plan sets out the longest and most ambitious list of policy commitments in the history of the NHS. If these are not achieved, if waiting times are not cut to a maximum of six months or if there are not enough bedside telephones and television sets for patients (to take just two examples), the failure will be highly visible and speak for itself. So Ministers collectively – and Mr Blair personally – have nailed their political reputations to some very specific targets; if these are not met, the political costs for the Government will be heavy. On the other hand, however, the Plan proclaims a new era in the relationship between the Centre and the periphery: 'The Centre will not try and take every last decision. There will be progressively less central control and progressively more devolution as standards improve and modernisation takes hold.' Perplexingly, therefore, Ministers are proposing to relax their grip on the NHS just when they have more reason than ever to ensure that they can command and control what happens – from waiting times to the installation of television sets.

What explains this seeming contradiction? Are Ministers deceiving themselves or hoodwinking the public in presenting themselves as re-born devolutionists? Or have they devised a model that can reconcile, as they claim, the competing demands of achieving national standards and devolution? Cynicism is likely to be the reaction of those with historical memories. Over the decades successive governments have swung from centralisation to devolution and back again in an ever-repeating cycle.[2] The sudden if temporary conversions of governments to devolution is nothing new. But the answer, we argue, is more complex. Implicit in the National Plan there is indeed a more sophisticated theory of how to achieve the Government's policy goals while still conceding a degree of autonomy, of a kind, to those working in the NHS. Similarly, the Plan proposes to clear ministerial desks of some time-consuming and politically troublesome issues not directly linked to the achievement of the Government's main objectives. So what looks like emerging is a more sharply focused – and therefore more effective – form of centralisation: a Centre that is more powerful than ever before but also more selective in how it chooses to use that power.

In the original 1997 vision of the future,[3] *The New NHS: modern, dependable*, the Government introduced a battery of instruments designed to strengthen the grip of the Centre. New Labour in effect embraced Old Labour's ambition, in Nye Bevan's words, that the NHS should generalise the best. There were to be national service standards, and national performance indicators to measure progress towards achieving them. New institutions for setting and monitoring such standards – the National Institute for Clinical Excellence and the Commission for Health Improvement – were set up. In effect, Ministers ensured that if

things went wrong in the NHS – as they inevitably did – blame would be centralised. But absent in *The New NHS: modern, dependable* was any theory of how change was to be brought about, if not by ministerial willpower and insistent intervention. Mrs Thatcher's internal market was based on precisely such a theory: competition. Having rejected that, however, *The New NHS: modern, dependable* seemingly had no alternative to offer, save some high-minded but empty phrases about co-operation and partnership.

In contrast, the NHS Plan attempts to fill this vacuum. The NHS is being brought into line with New Labour's overall philosophy for modernising the public sector and with practice in other services, notably education. As the Government's 1999 White Paper[4] put it when spelling out this philosophy, 'If staff are to adopt new ways of working and a culture of continuous improvement, they must be rewarded for doing so. We must provide incentives for innovation, cross-boundary thinking, collaborative working and excellent service delivery.' Accordingly, the new emphasis in the NHS is on incentives, with pay increasingly related to performance. Compliance with the Government's policy goals will be rewarded in a variety of ways, with a reformed system of distinction awards for consultants and bonus payments for other NHS workers. And the same policy is to be adopted towards institutions: 'The NHS has to move from a culture where it bails out failure to one where it rewards success', the NHS Plan boldly proclaims. And to the extent that voluntary compliance can be achieved (or, better still, positive enthusiasm can be generated) by the new system of incentives and rewards, so the reliance on the mechanisms of command and control can be relaxed. In the new model NHS intervention is to be 'in inverse proportion to success'.

Perplexingly ... Ministers are proposing to relax their grip on the NHS just when they have more reason than ever to ensure that they can command and control what happens – from waiting times to the installation of television sets.

Here we come to a subtle modulation on the incentives theme. There are, clearly, limits to the extent to which it is possible to reward success financially in the NHS. If extra money goes to the better-performing institutions, then the result would inevitably be to create a two-tier service, with the stragglers caught in a downward spiral. Such a strategy is incompatible with 'generalising the best'. So it turns out that the reward on offer is not money but 'earned autonomy'. Hence the elaborate colour coding system for classifying NHS organisations. Green organisations (i.e. those meeting all core national targets) will be given automatic access to the national performance fund, face less frequent monitoring by regional offices and CHI and have greater freedom to decide the local organisation of services. In contrast, red organisations (i.e. those 'failing to meet a number of the core national targets') will be placed under a form of tutelage. They will get their 'fair share of extra funds', but these will come with strings attached. The new Modernisation Agency will oversee their spending plans and they will be visited more frequently by the inspection teams from CHI. All else failing, the Modernisation Agency will send in teams to run red organisations whose performance is not improving.

There is lot to be said for such a strategy of selective but more effective control. It means that limited managerial resources can be concentrated where

there is most cause for concern. It offers some hope of relief from continuous, nagging pressure to managers and clinicians in organisations that perform well. But there are problems. In classifying organisations, *The New NHS: modern, dependable* allocates a key role to the Performance Assessment Framework, the Government's compendium of performance indicators. So, for example, green organisations will be in the top quartile of the Framework as well as meeting all core national targets. However, it is not self-evident that performance indicators can sensibly be used as dials for reading off performance as distinct from tin openers signalling the need for further investigation.[5] Data may, notoriously, be unreliable. Constructing league tables is a statistical minefield.[6] And these problems are compounded when attempts are made to sum up the heterogeneous activities of different NHS organisations (and the different dimensions of performance) in a single indicator. What appears to be a neutral, technical formula for distinguishing deserving and undeserving organisations may therefore turn out to be contentious and politically fraught in the course of implementation.

More fundamentally still, will the much-touted autonomy be worth earning? The NHS Plan promises 'more freedom to run their own affairs' to organisations that 'perform well for patients'. But it will seemingly be a negative rather than a positive freedom,[7] i.e. freedom from top-down intervention rather than freedom to set their own priorities. For the drive towards national standards, National Service Frameworks and national patterns of provision continue and organisations will be judged by their success in conforming to national policy goals. So the paradox would seem to be that organisations will earn their autonomy by, in effect, renouncing any ambitions to steer a distinctive course or experiment with a different pattern of provision. What, for example, would happen to a trust that decided that there were more urgent calls on its resources than providing patients with bedside telephones and television sets? Almost certainly a ministerial reprimand would quickly follow. If 'earned autonomy' is to be taken seriously as a currency of rewards, Ministers will therefore have to be much more specific about what divergences from national policy goals are going to be acceptable and how much scope there will be for innovative experiments.

Such reprimands may – for all the rhetoric of devolution – be all the more likely because Ministers will have more time on their hands. In the new model NHS, many decisions previously taken by Ministers are to be delegated to new, independent bodies. The NHS Appointments Commission will make all appointments to boards; the National Independent Panel will resolve disputes about major changes, such as hospital closures. In short, a determined effort is being made to de-politicise and devolve much central decision-making. In many respects this is welcome: the system for appointing non-executives has long been a shambles and has rightly attracted much criticism. But how will Ministers use the space so created? It would be encouraging to think that Mr Milburn and his colleagues will spend the time gained in seminars with their newly created Strategy Unit thinking about long-term problems. Many issues remain unresolved by the NHS Plan. Will consumerism by command work? Or will there be a growing demand among consumers for choice between doctors and hospitals? What if consumers want to use all the promised extra information about hospitals to make their own decisions about where to be treated and by whom? If so, what are the implications for the NHS? There is much for Ministers to brood on. Alas, it is more likely that Ministers will do more of what they have always done, which is to react to media stories and Parliamentary pressures by intervening in the routine running of the service. The crucial question of whether it is possible to insulate the NHS from such day-to-day pressures remains unanswered: short of a new constitutional settlement for the NHS, the doctrine of Parliamentary accountability

will continue to draw decision-making to the Centre.

If anything, the new NHS is likely to suffer from a confusing cacophony of accountabilities. The central Modernisation Board – to which the NHS's Chief Executive will be accountable – is to be replicated at the local level. But it is not at all clear whether or not there will be an accountability relationship between trust chief executives and the local modernisation boards (and whether or not these, in turn, will be accountable to the central board). Then every trust will have its patients' forum, with the right to visit and inspect any aspect of the care provided; these will, in effect, be the replacements for the community health councils due to be abolished. Last (and most interestingly), the NHS Plan has picked up the notion[8] of giving local authorities the right to scrutinise local NHS services. Chief executives of NHS organisations will be required to attend the main local authority all-party scrutiny committee at least twice a year. This is clearly a very limited form of accountability: an obligation to explain and justify without any sanctions. But it could put NHS chief executives in a somewhat delicate position if the views of democratically elected councillors differ from those of democratically chosen Ministers: if local authorities, in scrutinising local services, challenge central priorities or strategy.

In repudiating the command and control model, in proclaiming a new era of devolution, the NHS Plan offers a vision of a new era in the history of the NHS. A new mix of policy tools – regulation, inspection and incentives – will be used to re-mould the culture of the service from being profession-centred to being patient-centred. A new style of policy implementation will be developed: instead of relying on Whitehall mandarins or NHS managers (as in the past), a band of missionaries will be recruited to preach the ministerial gospel of modernisation. There will be rewards for the faithful and sanctions for sinners. It is a coherent strategy even though the process of implementation will inevitably throw up problems. The real gamble is whether the strategy – and the billions of pounds that go with it – can deliver the goods in the time allowed: the NHS change cycle does not necessarily fit into the political election cycle. If the service does not produce the targets to which Ministers are committed, then precedent suggests that Ministers will revert to a command and control style. And the irony is that the National Plan will have strengthened their ability to operate in this mode.

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CALENDAR OF EVENTS

JUNE 2000

1 **Professional regulation**: Government responded to Ritchie report. The Minister said the report provided strong backing for the measures already taken to do everything possible to prevent, detect and take action against doctors like Rodney Ledward.

2 **Health promotion and prevention:** Health Development Agency launched to help tackle health inequalities and ill health due to poverty.

8 **Exercise:** Government announced proposals to improve access to exercise through a range of initiatives, including physical activity standards in schools, exercise for cardiac rehabilitation and local projects to encourage more people to take regular exercise. The proposals form part of the Government's commitment to tackle health inequalities and will increase access to physical activity for more people.

9 **Care for older people:** *Out in the Open* report published by the Public Services Productivity Panel presenting the results of service changes in four pilot sites.

12 **Hospital infections:** the Government's Antimicrobial Strategy published. It will include:

- *surveillance*, to monitor 'how we are doing', and provide the data on resistant organisms, illness due to them and antimicrobial usage necessary to inform action
- *prudent antimicrobial use*, to curtail the 'pressure for resistance' by reducing unnecessary and inappropriate exposure of micro-organisms to antimicrobial agents in clinical practice, veterinary practice, animal husbandry, agriculture and horticulture
- *infection control*, to reduce the spread of infection in general (and thus some of the need for antimicrobial agents) and of antimicrobial resistant micro-organisms in particular.

Cancer: consultation announced on a manual of national standards and performance indicators to provide the framework for assessment of the quality of cancer care, with an additional £3 million funding being made available to support regional and local action on cancer.

Prevention: Secretary of State announced that there will more check-ups and screening programmes, more help for people at risk from heart disease and more help for people to give up smoking.

13 **Clinical quality:** *Organisation with a memory*, the report of an expert group on learning from adverse events, published. The report examines the key factors at work in organisational failure and learning, a range of practical experience from other sectors and the present state of learning mechanisms in the NHS before drawing conclusions and making recommendations. Its recommendations include the creation of a new national system for reporting and analysing adverse health care events, to make sure that key

lessons are identified and learned along with other measures to support work at local level to analyse events and learn the lessons when things go wrong.

16 **Nursing**: 91 nurse consultant posts announced (141 were announced in January).

Cancer nurses: *Nursing Contribution to Cancer Care* published, setting out a strategy that includes:

- developing the role of nurses in cancer prevention by educating the public and by providing support and advice
- influencing the R&D agenda, to build nursing research capacity, to encourage sustained programme funding and to secure evaluation of the effectiveness of new nursing roles
- taking stock of the cancer nursing workforce against current and projected service plans, to identify gaps and establish recruitment, retention and educational strategies to remedy deficits
- supporting the cancer education needs of health care support workers, nurses working in non-specialist services, nurses who need to develop specialist skills, specialist cancer nurses who need to advance their knowledge and the continuing professional development of all cancer nurses
- supporting the development of aspiring nurse leaders.

19 **Information technology:** £5.8 million allocated to the second phase of the National Electronic Records Development Implementation Programme. Thirteen demonstrator sites allocated funds to test how information systems and electronic records can improve delivery of patient care.

23 **General practice:** £54.5 million allocated for family doctors to:

- extend the range of services provided in GP surgeries rather than hospitals, focusing on those areas of care that have the longest local waiting times
- speed up patients' access to GPs and the nurses and professionals who work with them. This could include extending opening hours in the evening or opening surgeries over the weekend so that working people would find it easier to see a GP or other health professional
- support the development of intermediate care for older people, by providing rapid response or rehabilitation teams to co-ordinate care for older people in nursing or residential homes.

26 **Drugs:** Report of the Advisory Council of the Misuse of Drugs published. This found that:

- the number of drug-related deaths in the UK is high and must be reduced substantially
- improvement is urgently needed in the data system and its operational use at national and local level
- there needs to be a radical curtailment of methadone-related deaths
- more should be done, particularly by drug agencies, to reduce injecting drug use
- awareness of the threat posed to injecting drug users by illness resulting from hepatitis infections is at present far too poorly developed.

JULY 2000

3 **Health promotion:** £2 million allocated to promote consumption of fruit and vegetables by children. The schemes announced will examine the most effective ways of increasing access to fruit and vegetables for children, including fruit tuck shops, breakfast clubs, creating new menus or recipes and incentives to encourage children to eat healthy foods.

6 **Drug prices:** Government announced its intention to cut the cost of generic drugs. The main elements of the maximum price scheme are:

- statutory maximum prices for the main generics, adjusted in light of the consultation
- maximum prices to take effect from 3 August 2000, with lower reimbursement prices for pharmacists effective from the beginning of September. This gives both wholesalers and pharmacists four weeks to clear stocks
- a review of the scheme to be started within 12 months and completed within 15
- information requirements (primarily on sales and volumes) to be simplified in the light of consultation
- an appeals procedure to be put in place
- penalties in the event of contravention.

Walk-in centres: national evaluation announced, to be led by a team from the University of Bristol.

11 **Heartburn and indigestion:** National Institute for Clinical Excellence issued guidance on treatment for heartburn and indigestion. This recommends that a patient with an ulcer caused by other medicines should be prescribed an acid suppressant, usually a proton pump inhibitor. Alternatively, a patient with mild indigestion or heartburn may be treated with a low dose antacid, gradually trying stronger medicines until his or her symptoms are controlled. After this, the dose should then be gradually decreased to the lowest possible level that controls the symptoms.

12 **Cancer:** National Institute for Clinical Excellence asked to carry out a two-year programme on cancer drugs in support of the national cancer plan currently under development.

Information: by the end of 2000, all local NHS organisations will be required to publish information on the Internet about the performance of their local health and social care services. They will also be required to provide user-friendly information on accessing local GPs, pharmacists, dentists, opticians, social services and key voluntary services.

13 **Performance indicators:** the second set of indicators published. They continue to reveal wide variations in access to care and in the outcomes of care.

14 **Drugs:** Pharmaceutical Industry Competitiveness Task Force reported progress in three areas: international intellectual property rights, closer involvement of UK-based industry in health service development, e.g. through involvement in the development of National Service Frameworks, and the development of European licensing.

20 **Efficiency:** Public Services Productivity Panel issued report on the use of strategic outline cases in project planning, using the National Electronic Library for Health as a case study.

27 **National Plan for the NHS in England:** *The NHS Plan: A plan for investment, a plan for reform* published.

28 **Cancer:** cancer research network announced. The aim is to increase the number of patients involved in clinical trials.

AUGUST 2000

1 **R&D:** Publication of consultation document, *NHS Priorities and Needs R&D Funding.*

Professional regulation: consultation papers issued on Government proposals for the Nursing and Midwifery Council and the Health Professions Council,

which are intended to 'modernise self-regulation' to encourage more flexible training and work arrangements.

The Health Professions Council replaces the Council for Professions Supplementary to Medicine and its 12 boards. The key objectives of the changes are:

To reform ways of working, by requiring the Council to:

- treat the health and welfare of patients as paramount
- collaborate and consult with key stakeholders
- be open and proactive in accounting to the public and the professions for its work.

To reform structures and functions, by:

- giving wider powers to deal effectively with individuals who present unacceptable risks to patients
- creating a smaller Council, comprising directly elected practitioners and a strong lay input, charged with strategic responsibility for setting and monitoring standards of professional training, performance and conduct
- linking registration with evidence of continuing professional development
- providing stronger protection of professional titles
- enabling the extension of regulation to new groups.

7 **Waiting lists:** teams sent into seven hospitals deemed to be failing in respect of waiting times for out-patient appointments. The number of people waiting longer than 26 weeks fell slightly over the three months April–June, but the numbers waiting for more than 13 weeks rose by 42,880. The sending in of the teams anticipated the use of the red, yellow and green light status proposed in the NHS Plan. The trusts concerned to receive 'intensive support' from the Modernisation Agency. They will have to draw up a recovery plan specifically for out-patient waits and show a dramatic improvement within six months.

8 **Winter planning:** a minimum of 340 extra critical care beds to be put in place for winter 2000 and £63 million for step-down facilities announced. The money is intended to:

- provide step-down care in hospitals, private nursing homes and support at home
- reduce A&E waiting times
- speed up the assessment of patients ready for transfer, ensuring that patients are either discharged or transferred to a more appropriate level of care more quickly
- provide a further drive on staff recruitment and retention for the winter.

9 **Drugs:** patient group directions guidance issued in light of new legal requirements. This allows named nurses, midwives, physiotherapists, health visitors, optometrists, chiropodists, radiographers, orthoptists and ambulance paramedics to supply or administer medicines, under tightly specified circumstances.

15 **Heart disease:** ten fast-track schemes announced to provide rapid response for heart attack patients and follow-up care. Specialist doctors, nurses and technicians, as well as local GPs, will form fast-track teams. They will work across NHS management boundaries and between hospitals, to provide integrated heart disease care across local areas, and will:

- provide rapid response to and effective emergency care for patients who have a heart attack
- bring together the whole process of testing and treating heart disease patients so that their care is planned in advance in a way that is as

convenient as possible for individual patients
- speed up access to care by reducing bureaucracy and tackling bottlenecks.

18 **Drugs:** NICE guidance issued on Rosiglitazone, as an alternative to Insulin.

NHS R&D: consultation paper *NHS Priorities and Needs R&D Funding* published.

20 **Mental health:** £5 million allocated to child and adolescent mental health services to fund an increase in in-patient bed numbers and other specialised services.

POLICY COMMENT

What do the public think?

Labour's increases in NHS funding may be in tune with public opinion, but poll evidence shows that the Government is far from coasting on health.

Jo-Ann Mulligan

As the party that established the NHS in 1948, Labour has always seen the health service as its political trump card. Yet the last three years have not been trouble free and although a whole raft of new proposals has been initiated, culminating in the NHS Plan, Labour (like the Conservatives before them) has at times looked vulnerable on health. Pictures of patients waiting on trolleys in crowded corridors are still a regular feature each winter and Labour's image has also been dented by a number of high-profile cases where the health service has been seen to fail patients.

Damaging headlines are not new, but to what extent have public attitudes towards the NHS changed since the departure of the last Government? How have Labour's first three years affected public perceptions of the Government's handling of health and the NHS? And what are the prospects for the NHS Plan to improve public confidence in the health service in the run up to the next General Election?

Opinion polls can give only partial answers to these questions, and they are subject to a variety of practical problems. Public attitudes are influenced by the mass media, are often claimed to be 'uninformed' and are subject to knee-jerk reactions. Yet, reviewing the state of *actual* public opinion as opposed to *well-informed* public opinion (which other techniques such as deliberative polling seek to address) does provide some measure of changes in the social and political climate.

SATISFACTION WITH THE NHS OVERALL

We start by looking at satisfaction with the NHS overall during the period just after Labour was elected, compared to the previous decade of Conservative rule. The trend data are taken from the British Social Attitudes survey (see Box 1). Looking back, it is *dissatisfaction* rather than *satisfaction* that appears to fluctuate more widely. Table 1 shows that in 1998, one year after the Labour Government had outlined its initial plans for the NHS, dissatisfaction with the overall running of the service had fallen from an all time high of 50 per cent in 1996 to 36 per cent – its lowest level during the last decade.

BOX 1: THE BRITISH SOCIAL ATTITUDES SURVEY

The British Social Attitudes survey (BSA) is an annual survey conducted by the National Centre for Social Research (formerly SCPR). Each year a random sample of around 3500 respondents is selected to answer interview and self-completion questionnaires. Questions cover a wide range of topics on aspects of national economic and social policy. All BSA data presented here are available from the National Data Archive at Essex University.

Table 1

SATISFACTION WITH THE NHS, 1989–98

	1989 %	1993 %	1996 %	1998 %
Very or quite satisfied	37	44	36	42
Neither satisfied nor dissatisfied	18	18	14	22
Very or quite dissatisfied	46	38	50	36
Base	*2930*	*2945*	*3620*	*3146*

Source: British Social Attitudes survey.

Table 2

DISSATISFACTION WITH THE NHS BY AGE AND SEX, 1989–98

	% Dissatisfied (very or quite)			
	1989	1993	1996	1998
Men				
18–34	43	44	57	43
35–54	50	42	57	37
55+	32	34	42	29
Difference between young and old	*+11*	*+10*	*+15*	*+14*
Women				
18–34	40	39	52	39
35–54	44	40	52	39
55+	27	29	41	31
Difference between young and old	*+13*	*+10*	*+11*	*+8*

Source: British Social Attitudes survey.

The NHS Plan noted that dissatisfaction with the NHS was higher among younger age groups. In fact, Table 2 shows that the young have always expressed more dissatisfaction than older age groups. What is less clear is whether these differences reflect the views of a particular

cohort or generation or whether they are simply due to age alone.

One obvious interpretation of the overall fall in dissatisfaction between 1996 and 1998 is that it reflects a 'honeymoon' period for Labour voters after the Party was elected. In fact, when the results are broken down by political allegiance, the greatest decrease in dissatisfaction is indeed shown in Labour supporters, down from 60 per cent in 1996 to 39 per cent in 1998 (see Table 3).

More recent evidence from polls carried out this year, however, suggests mixed views on the Government's overall performance. The NHS Plan reported that a quarter of the public felt dissatisfied with the NHS overall. Yet a MORI poll undertaken in July 2000 suggested that a much larger proportion – 64 per cent – thought that the NHS had not improved since Tony Blair became Prime Minister.[1] This result is strikingly similar to an NOP poll undertaken for the *Jonathon Dimbleby Programme* in March 2000, which found that 66 per cent believed that there had been no improvement in the NHS since the last General Election.[2] Finally, an ICM poll in January 2000 showed that 76 per cent of the public believed that the NHS had got worse or had remained the same under the Labour Government.[3]

Comparing the results between different polls is problematic. The precise question wording, order and context can all affect the recorded levels of satisfaction or dissatisfaction, hence the preference for trend data over one-off polls. Notwithstanding this cautionary note, one explanation for the apparent initial optimism could be that memories of the last Government's performance on health were still fresh in the public's mind and, by implication, early impressions of Labour were high. The fact that more recent polls suggest that the public has become sceptical of Labour's performance on health is probably not unexpected for a government at mid-term. It does, however, indicate how big the job will be to restore public confidence.

IN-PATIENT AND OUT-PATIENT CARE

If dissatisfaction with the overall running of the NHS initially fell just after Labour took office, did attitudes towards specific parts of the service change as well? Table 4 shows that in contrast to perceptions about the general state of the NHS, satisfaction with in-patient and out-patient hospital services had not changed significantly after Labour's first year, remaining at just over 50 per cent.

One reason for the apparent contradiction between the perceptions of the overall running of the NHS and specific services could be that responses to more general questions tend to reflect the public's overall mood towards the Government. On the other hand, people tend to answer questions about *specific* services on the

Table 3

SATISFACTION WITH THE NHS AND PARTY ALLEGIANCE, 1996 AND 1998

	Conservative		Labour		Lib. Dem.	
	1996	1998	1996	1998	1996	1998
	%	%	%	%	%	%
Very or quite satisfied	49	46	28	39	33	35
Neither satisfied nor dissatisfied	13	21	12	21	14	26
Very or quite dissatisfied	37	32	60	39	54	39
Base	*1012*	*818*	*1528*	*1398*	*391*	*324*

Source: British Social Attitudes survey.

Table 4

SATISFACTION WITH IN-PATIENT AND OUT-PATIENT SERVICES

	1989 %	1993 %	1996 %	1998 %
In-patient care				
Very or quite satisfied	65	64	53	54
Neither satisfied nor dissatisfied	14	18	17	20
Very or quite dissatisfied	15	14	22	17
Out-patient care				
Very or quite satisfied	53	57	52	52
Neither satisfied nor dissatisfied	14	17	18	20
Very or quite dissatisfied	30	23	25	22
Base	2930	2945	3620	3146

Source: British Social Attitudes survey.

basis of their own experience. Thus, while Labour may have been initially successful in making people feel good about the NHS in general, the Government appears to have had less impact on perceptions and experiences of actual performance of health services locally.

WAITING LISTS AND NHS STAFFING

As Kneeshaw noted in *Health Care UK 1997/98*, waiting lists assumed a new level of political significance after the Election in May 1997 when the Labour Government committed itself to reducing their size by 100,000.[4] Three years on, waiting lists are still at the top of the Government's agenda and their eventual replacement in favour of booking systems and targets on waiting times are key features of the NHS Plan, along with increasing the numbers of doctors and nurses.

The public appear to endorse the targeting of these areas. As part of the National Plan the Government undertook a consultation exercise in May 2000 to gather views on the NHS from the public and NHS staff. The so-called 'census' came under heavy fire from commentators and the media, largely because of the short time allowed for reply, the lack of a methodologically sound questionnaire and the fact that the published results rather conveniently matched Government proposals. Nevertheless, the consultation found that waiting lists and NHS staffing were the two top issues of concern. This broadly agrees with data from the 1998 BSA survey, which show that waiting times and staffing levels attracted criticism from around 70 per cent of the public (see Table 5). By contrast, only a third of the public thought that the actual quality of care received in hospitals was in need of improvement.

The obvious problem with interpreting opinion data on waiting lists is that media coverage of the issue is likely to play a big part in influencing public attitudes. Even if the Government's continued obsession with waiting lists is not misplaced, there is other evidence to suggest that the public still prefers to see resources going towards improving actual health outcome measures. For example, a poll carried out by MORI on behalf of the King's Fund in December 1999 found that the public ranked reducing deaths from heart disease and cancer above reducing hospital waiting lists.[5]

Table 5

ASPECTS OF THE NHS IN NEED OF IMPROVEMENT

Area	% saying area in need of a lot or some improvement
Waiting times	
Hospital waiting lists for non-emergency operations	78
Waiting time before getting appointments with hospital consultant	82
Time spent waiting in out-patient departments	70
Time spent waiting in A&E departments	76
Staffing levels	
Of nurses in hospitals	71
Of doctors in hospitals	69
Quality of treatment in hospitals	
Quality of medical treatment	35
Quality of nursing care	32
Base	*3146*

Source: British Social Attitudes survey.

PUBLIC TRUST IN NHS PROFESSIONALS

When the public is asked to comment on the performance of professionals working within the health service, rather than the organisation of services, the response is invariably positive. This reflects the importance of distinguishing between the NHS as a bureaucratic system and the actual medical care delivered by doctors, nurses and other health professionals. As was noted in *Health Care UK 1999/2000*,[6] the first ever National Survey of NHS Patients in October 1998 found that nine out of ten patients were happy with their GP's diagnosis. The satisfaction for nurses was even higher, with 99 per cent of respondents saying nurses treated them with 'courtesy and respect'.

Even several recent high-profile cases concerning the performance of individual doctors don't appear to have dented public confidence. In an opinion poll carried out for the BMA in March (after the conviction for murder of the Manchester GP Harold Shipman), the public still rated doctors the most trustworthy of a number of occupations.[7] Eighty-seven per cent of those polled said they would generally trust doctors to tell the truth. Although the figure for doctors is 4 per cent less than in a similar poll taken in 1999, most of the 16 occupations listed also showed a decline.

PUBLIC SPENDING AND THE NHS

There is no doubt that the single most important part of the NHS Plan – the huge cash injection – is precisely what the public wanted. On the same day in March that the Chancellor announced the biggest ever spending increase for the NHS, an ICM poll found that most (56 per cent) thought that 'if the Chancellor has extra money to give away' they would most like it used to help the health service.[8] Trend data from the BSA show that health is consistently the top priority for extra spending and the majority of respondents are apparently happy for taxes to increase in order to spend more on the health service (63 per cent in 1998). These

results agree with another recent survey undertaken by Angus Reid for the *Economist* in February 2000, which showed that 58 per cent of UK respondents thought that more should be spent on public services even if they would have to pay more tax.[9]

This time around the Chancellor has avoided raising income taxes to boost the funding of the health service. A future Chancellor may not be so fortunate, and come election time most politicians don't believe that voters will really stand for increased taxes, however desirable the resultant spending. For example, although the Angus Reid/*Economist* survey showed that a majority favoured higher spending and higher taxes, only 8 per cent of the same survey sample thought that the current level of tax was 'too low' – a striking if not unpredictable contradiction. Unsurprisingly, evidence from elsewhere suggest that support for extra spending diminishes if the tax implications of a rise in health spending are made explicit in terms of respondents' own economic circumstances.[10]

CONCLUSIONS

The demise of the NHS was predicted many times during the 1990s and a string of alternatives has been suggested. These radical visions have failed to materialise and Labour has instead come forward with the perhaps more mundane solution of pumping more money into the health service. What's more, for the first time in the history of the health service, a government has promised that the NHS's share of resources will continue to rise in the long term.

While this may be in tune with public opinion, it is by no means certain that the mere knowledge of money being spent without a visible recovery in the state of the health service will suffice. The disconnection of public attitudes towards taxation and public spending will also ensure that the currently stifled calls for alternative funding options will inevitably resurface.

This Government, perhaps more than any other, seems particularly sensitive to the ebb and flow of public opinion. The most recent evidence from opinion polls shows that Labour is far from coasting on health. And while the implications of the bumper cash injection for the NHS and rolling out of the National Plan remain to be played out, one thing is certain: both will raise public expectations of what Labour (and the NHS) can deliver before the next Election.

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Private hospitals: in from the cold

The NHS Plan, with its chapter on concordats, will enable a more sensible debate about the role of private health care than at any time in the recent past.

Justin Keen

In May 1999, anyone who predicted that the NHS Plan[1] would devote a chapter to concordats with the private hospital sector would have been greeted sceptically. There had been no mention of the private sector in the 1997 White Paper, *The New NHS: modern, dependable*.[2] Secretary of State Frank Dobson's preference, reflecting long-standing Labour instincts, was to leave the sector to its own devices. He maintained his position in the face of widespread perceptions that existing regulations failed to protect consumers properly,[3,4] and claims that private health care distorts NHS priorities.[5] The policy was that there was no policy, and hence no enthusiasm to overhaul regulations.

Then Frank Dobson was succeeded by Alan Milburn in October 1999. There were signs of a major policy change in a speech given by Alan Milburn in December 1999.[6] The direction of change was confirmed by Prime Minister Tony Blair on BBC's *Newsnight* in February 2000, when he indicated that he had no ideological objection to the use of private health care. The NHS Plan confirms that there is now a policy on private health care, and that it has two main planks.

First, the Government is hostile to the use of private medical insurance, and devotes an entire chapter of the Plan to arguing that it is both inefficient and inequitable. The Government has, though, stopped short of limiting its use directly. Instead, it is pursuing improvements in NHS performance, particularly in shorter waiting times for treatment. Implicitly, the Government envisages that this will reduce the demand for private hospital care, and hence insurance, in the future.

Second, there are to be three concordats between the NHS and private providers of care, covering elective surgery, transfers from private hospitals to NHS intensive care units, and intermediate care. Thus, publicly financed, privately provided services are to be included in policy-making.

In theory, the Government could stop here. The Plan would amount to little more than formalisation of policies and practices already found in the NHS. Local NHS organisations could enter into public-private partnerships as they saw fit. Indeed, if the NHS continues to face high private sector prices for elective surgery, then it may not extend purchasing much beyond its present level of around 850,000 procedures each year.[7] Private sector interest in developing intermediate care would, similarly, depend on commercial judgements about the benefits of entering the market at prices largely determined by the NHS.

It is more likely, however, that the NHS Plan signals a real departure. The current organisation of UK health care implicitly favours equity of financing over equity of access for

hospital-based services. The NHS is financed largely from general taxation and compares well in terms of equity of financing with other developed countries. People who pay for private health care tend to be better off, and they pay for it over and above their taxes. In this circumstance, the use of private payment creates a closer relationship between ability to pay and actual payment for health care.[8]

Private payment also leads to faster access, however, with the result that access is less equitable, as it is based on ability to pay rather than clinical need. The new policy goal is that access should be more equal than it is at present. The Government envisages that this will be achieved, in part, through reduced use of private medical insurance, with more people opting to use the NHS. The Plan suggests that in future there will be just as much emphasis on equity of access as on financing.

This is, to say the least, a difficult path to tread. At present, the pattern of private elective surgery is to a significant extent controlled by surgeons. The concordat for elective surgery risks simply cementing existing working practices. If the Government wishes to change working practices, in order to make access more equitable, and in pursuit of its Modernisation Agenda, it will have to take greater control of surgeons' working practices. The Government recognises this, and presumably also appreciates the incendiary nature of the debate that will be stirred up by attempts to limit private practice.

The Plan proposes that newly qualified consultants should not be allowed to practise privately for around seven years. This is an odd idea, whose significance may lie only in signalling difficult negotiations ahead with consultants. (After all, consultants might work in NHS pay bed units during those seven years without technically leaving the NHS.) The Government's strategy must, rather, be to outflank consultants who undertake significant private work by using the concordats, to subject private hospitals and consultants to standards contained in National Service Frameworks and other policy instruments. These could be used to constrain the working practices of consultants. The Plan notes that there will need to be better information exchange between the NHS and private sectors. The concordats might therefore be used to give the NHS much better information about consultants' working practices.

Creating a closer relationship between the NHS and private providers will also force a review of the regulation of provision. The Care Standards Act, which received its Royal Assent on 20 July 2000, maintains the separation between NHS and private providers. There are important anomalies in the current arrangements. For example, a private hospital with a contract to treat NHS patients will be regulated as a private establishment by the National Care Standards Commission. Yet patients will presumably, as at present, have access to NHS complaints mechanisms should any problem arise. It is not difficult to envisage a Government announcement about a further review of regulations at some point in the next two years.

The Government appears to have decided that the political fudges agreed at the time of the creation of the NHS are no longer sustainable. They need to be replaced with more transparent contracts between the state and the professions, which in turn will allow the Government to honour a new contract with patients – a service that is more accessible and more sensitive to patient needs. The Plan does not tell us why the use of the private sector will be beneficial, or the mechanisms whereby benefits for patients will be achieved. The NHS Plan nevertheless moves us forward and allows us to have a more sensible debate about the role of private health care than at any time in the recent past.

Even if the problems noted here are successfully addressed, though, the new system will still contain important elements from the past. Private medical insurance will still be available, ensuring an alternative route to health care beyond the reach of the NHS. Consultants might find their access to private practice more limited than at present, but they will seek to

protect their current control over public-private boundaries. The concordats will not, therefore, be a panacea because they cannot deal with the private sector in its entirety.

What is more, the transition from one set of long-standing relationships to another is unlikely to be smooth. Private firms may perceive that there are opportunities to secure new sources of funding for their services and market themselves more aggressively than ever. If NHS managers sense that it is appropriate to agree contracts for radiology services, or some day case procedures, then new markets could be created for privately provided services. In short, the transition will be dynamic and possibly difficult to control. The blue touch paper has been lit – and anyone not involved should stand back.

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POLICY ANALYSIS

<<<<<<<<<<<< looking back <<<<<<<<<<<<

New Labour and primary care: the balance sheet

This Government's approach to primary care development has proved more radical than anticipated, but there are dangers inherent in diversifying access routes and dismantling the existing payment mechanisms.

Steve Gillam

INTRODUCTION

The policy preoccupations of successive governments over the last 20 years have been consistent: containing costs and increasing efficiency, addressing variations in clinical quality, increasing professional accountability, and improving access and user responsiveness. The Conservatives introduced reforms in 1990 that concentrated on controlling costs and quality through the introduction of an internal market.[1] A central policy instrument was fundholding, which capitalised on general practitioners' intimate knowledge of local services (derived from their traditional 'gate keeping' function) and their financial entrepreneurialism (derived from their traditional autonomy as independent contractors). Fundholding came to be seen as the spearhead of a 'primary care-led NHS'.[2] If the previous decade had been one of unparalleled turbulence in the service, any expectations that the pace of change might slow with a change of government were soon to be discarded. This article begins by considering New Labour's inheritance and goes on to chronicle key reforms inaugurated since 1997 (see Table 1). It takes stock of achievements in addressing the same policy imperatives listed above and looks ahead at the likely impact of changes proposed in the NHS Plan.[3]

THE IMPACT OF FUNDHOLDING

Although the proponents of GP fundholding claimed great benefits from the scheme, the evidence to support these claims was equivocal. The Audit Commission concluded that most fundholding practices had produced only modest improvements, which were probably insufficient to justify their higher cost.[4] Fundholding spawned a variety of attempts to adopt a more

comprehensive and integrated approach to health care, including total purchasing, multi-funds and locality commissioning. Each in their different ways recognised a need to plan and budget for comprehensive provision, usually for populations considerably larger than that of the average general practice. Despite the continued emphasis on the role of general practice in purchasing hospital and community services, the evidence from the evaluation of total purchasing suggested that most sites were at least as concerned to develop primary care services as part of an integrated network of provision.[5]

Ultimately, fundholding was unsuccessful in several respects.[6] It was bureaucratic, involving high transaction costs. It was perceived as unfair: fundholders generated inequities in access to care (two-tierism). It was difficult to demonstrate that general practitioners were effective or impartial as advocates of their patients' interests. Most importantly, the internal market failed to deliver anticipated efficiency gains. Yet fundholding did entrench political support for widening the involvement of general practitioners in resource allocation and service planning.

TRANSITIONAL OBJECTS: THE CURIOUS PLACE OF PMS

General medical services (GMS) and general practices as providers of services were left otherwise untouched by the internal market. A new contract was imposed in 1990. It provided tools to increase the accountability of GPs but failed to address deep-rooted deficits in primary care and was criticised for its lack of local flexibility. This was a central theme emerging from Gerald Malone's appeasement offensive, the 'Listening Exercise' of 1995.

The *Choice and Opportunity* White Paper of the same year was in many ways a response to pressure for change from within the medical profession.[7] The General Medical Services Council was seeking to renegotiate the compulsory contractual requirement of 24-hour responsibility for care and to define more tightly the nature of 'core' general medical services.

Table 1

CHRONOLOGY OF EVENTS

April 1997	NHS Primary Care Act passed
May 1997	New Labour Government elected
December 1997	*The New NHS: modern, dependable* published
April 1998	85 first wave PMS pilots go live
June 1998	*A First Class Service* published
August 1998	Beacon practices announced
March 1998	First NHS Direct pilot evaluation reported
April 1999	PCGs go live
April 1999	20 first wave walk-in centres announced
May 1999	Frank Dobson announces restrictions on Viagra prescribing
October 1999	NICE publishes first recommendation on Relenza
October 1999	Second wave PMS pilots go live
November 1999	First Healthy Living Centres launched
November 1999	*Supporting doctors, protecting patients* published
December 1999	Coverage of NHS Direct extended across the country
January 2000	Harold Shipman convicted
February 2000	Commission for Health Improvement launched
April 2000	17 first wave primary care trusts go live
May 2000	Third wave of PMS pilots announced for April 2001 – up to 25% of GPs subsequently expressed interest
July 2000	NHS Plan published

Recruitment and retention of doctors were problematic and there were many indications that a growing minority of GPs were seeking salaried or alternative employment options.[8]

The NHS (Primary Care) Act 1997, passed in the dying days of the *ancien régime*, nevertheless

marked a revolutionary change.[9] The launch of Primary Care Act Pilot Schemes marked the ending of GPs' monopoly of primary medical care with new market entrants in the shape of NHS trusts and nurses. The long cherished national contract was no longer to apply universally, with the development of alternative employment options to that of the independent GMS/GDS contractor. However, the priority attached to this part of their inheritance by Labour was initially unclear.

THE NEW NHS

The publication of the Labour Government's White Paper, *The New NHS: modern, dependable*,[10] formally announced the demise of GP fundholding and the internal market. It underlined the role of the NHS in improving health, set out a renewed commitment to equity in access and provision and tackled the need to ensure quality through clinical governance and accountability to local communities. Of fundamental importance was the move to loosen the restrictions of the old tripartite structure (separating general practice, hospital and community health services) by moving towards unified budgets and imposing a duty of partnership. The major structural change introduced to deliver these policy goals was the formation of primary care groups (PCGs).

PCGs undertake three principal functions on behalf of their local populations:[11]

- improving the health of the population and addressing health inequalities
- developing primary and community health services
- commissioning a range of community and hospital services.

They bring together local providers of primary and community services under a board, which represents local GPs, nurses, the local community, social services and the health authority. PCGs serve populations averaging around 100,000 people, and were expected to evolve over time, learning from existing arrangements and their own experience (see Table 2).

Table 2

PCG LEVELS

1. Supporting and advising the health authority in commissioning care for its population.
2. Taking devolved responsibility for managing the budget for health care as a sub-committee of the health authority.
3. Becoming established as a free-standing body accountable to the health authority for commissioning primary and secondary services.
4. Becoming established as a free-standing body accountable to the health authority for commissioning care with added responsibility for the provision of community health services.

At levels 1 and 2 PCGs operate as sub-committees of the health authority. At levels 3 and 4 they become independent primary care trusts. For the initial period of operation, all PCGs would begin operating at either level 1 or level 2. Following a period of consultation shadow PCG boards were established in September 1998, as a preliminary to taking up their responsibilities. In April 1999, 481 PCGs were established throughout England. Seventeen of these formed the first wave of PCTs a year later.

PCGs were saddled with heavy expectations. In obvious respects they represented an evolutionary advance as any attempt to 'universalise the best' of fundholding was bound to do. Their size, scope and key supports borrowed from their immediate precursors: total purchasing pilots and GP commissioning groups. Evaluation of total purchasing pilots suggests likely predictors of PCGs' 'success'. These included scale of investment in organisational development and support from the local health authority.[12] The experience of fundholding predicted possible concerns, for example that PCGs serving healthier, wealthier areas might progress more swiftly to trust status than those serving needier populations. Nonetheless, the creation of budgets encompassing general

medical services, prescribing, hospital and specialist care remained a major step forward. How have they fared?

TRACKING PROGRESS

Work from the Audit Commission[13,14] and two recent reports of the Department of Health funded evaluations[15,16] together provide a comprehensive account of how PCGs are approaching their core functions. The broad conclusions are remarkably consistent. Establishing the organisation has been a key early preoccupation and PCGs have made sound progress in their first year. They are beginning to translate priorities into clear local health strategies, targets and action plans. However, important challenges need to be addressed if PCGs and PCTs are to realise their undoubted potential.

Not all PCG boards function in a corporate manner and there is a tendency for general practitioners to dominate board meetings at the expense of contributions from nurses, social services and lay members. There remain significant concerns about the degree to which practices are effectively engaged in the work of PCGs, and about the relative lack of progress in involving lay stakeholders.

Many health authorities and PCGs have struggled to find the right balance between 'letting go' and 'holding to account'. Health authorities retain a very important role in strategic leadership via the Health Improvement Programme (HImP) and co-ordination of the local health economy.[17] They have struggled to provide the support required for key areas of PCGs' work. Management budgets have varied widely between PCGs, with clear consequences for their organisational development.

Some PCGs are getting to grips with their responsibilities for managing budgets, including the management of service level agreements and the development of incentive schemes, but many lack the necessary information and financial management capacity. A combination of unrealistic targets, a lack of resources and the inadequacy of existing systems are seriously impeding PCGs' ability to generate the information needed for carrying out their core functions.

Many PCGs have made considerable progress in developing minimum standards for practice services, agreeing plans for redistributing resources and making service improvements. Most groups have made a good start in establishing an infrastructure for clinical governance and initiating a range of activities involving practices and other staff. Much more remains to be done, however, in finding ways to tackle poor performance and deal with 'outliers'. In contrast, many PCGs have given little attention to commissioning or health improvement. Although most PCGs have begun to develop closer links with social services departments, wider relationships with local authorities are embryonic at this stage. Boundary differences remain an obstacle to closer partnership working.

There is a danger that national policy imperatives, central directives and guidance will stifle the development of local policies addressing local needs. Two-fifths of PCGs are hoping to become PCTs in 2000 or 2001, but many want time to develop and deliver tangible changes for their practices before any move to PCT status. The decision to become a trust should be based not on administrative or financial considerations, or a desire for independence, but on a demonstration of how trust status will help deliver better services, combined with evidence of capacity to take on new roles and responsibilities. They need to feel that they have 'permission' to remain as PCGs for the medium term, able to focus on developing primary care and on delivering tangible improvements in services. Finally, the traditional clinical focus on the individual patient needs to be counterbalanced by a stronger focus on population health. Medical models of health, illness and the role of health care need to be supplemented by wider definitions of health and support for the interventions necessary to address its social determinants.[16]

In summary, PCGs are developing as organisations at different speeds. They have made progress in developing and integrating primary care but their commissioning and health improvement functions are as yet rudimentary.

PERSONAL MEDICAL SERVICES: THE QUIETER REVOLUTION

Though initially eclipsed by PCGs, Labour eventually extended the Personal Medical Services (PMS) initiative. The pilots proved unexpectedly popular after a slow start. With the third wave going live in April 2001, they may cover as much as a quarter of the population. They are preferentially distributed at this stage in urban, more deprived areas where the salaried option has been heavily taken up. Some of the financial risks of running a practice are reduced and, unsurprisingly, a reduction in the bureaucratic burdens of the job is welcome to many GPs.[18]

But not all has been plain sailing. Some community trust-based pilots languished in the face of local medical committees' resistance to nurse-led primary care. Some community trusts underestimated the complexity of providing general medical services. In these instances, doctors found themselves taking on administrative responsibilities from which they had imagined they would be relieved. Defining measures of quality of primary care against which to hold practices to account is surprisingly difficult. An early content analysis found little evidence of more appropriate quality standards being incorporated into PMS contracts.[19] Much of what the first wave of pilots was seeking could have been achieved through the use of other red book flexibilities and it is too early to state how much service development can properly be attributed to PMS.

PMS provides entrepreneurs with some of the independence enjoyed by fundholders, but the pattern of expansion of PMS suggests that its success reflects in part its appeal to practices disaffected with the current reforms. Paradoxically, many practices see PMS as a way of defining their own priorities and insulating themselves from the intrusions of PCG/Ts. Unfortunately, such has been the pace of change that many PCG boards have lacked a strategic position on local PMS. They have certainly lacked the resources to provide developmental support. Nonetheless, PMS provides crucial leverage for the primary care trusts that will in future hold their contracts. For the first time PCTs hold truly integrated budgets with the ability to commission local primary care. Where all practices are contracted to their local PCT, the vision of a UK-style HMO is already being realised.

ADDRESSING VARIATIONS IN QUALITY

Variations in the quality of primary care, particularly in inner cities, have been a prominent concern of policy-makers since the inception of the NHS. The previous Government sought to import organisation-wide quality improvement strategies perceived as successful in manufacturing and service industries. The 1989 White Paper *Working for Patients* extolled the virtues of audit.[20] In some disciplines, 'the critical analysis of the quality of health care' was already established as best practice. What was new was an attempt to generalise audit activity. Over £500 million was spent on audit in the hospital and community sectors, to mixed effect. The audit movement fell short of expectations in various ways.[21] First, audit topics reflected the priorities of doctors with little non-medical involvement (cf. the shift from medical to clinical audit). Second, it proved difficult to make audit activity routine. *Working for Patients* did not free resources for health professionals to dedicate time to audit. Finally, involvement remained patchy. Clinical audit did not engage the traditionally 'hard to reach'. Participation in audit was voluntary and not a contractual obligation upon general practitioners.

The invention of clinical governance heralded the latest of many attempts in the NHS to exercise greater managerial control over clinical activities. Clinical governance has been defined as a system through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high

standards of care by creating an environment in which clinical excellence will flourish.[22] It draws together elements of quality assurance that are often ill co-ordinated. The corporate nature of this new responsibility requires, in the overused phrase, major 'cultural change'. For PCGs, this implies sharing intelligence about quality across professional and practice boundaries and health professionals seeing themselves as collectively accountable for the clinical and cost-effectiveness of their colleagues' work. Table 3 illustrates the scope of clinical governance in primary care.

Table 3

THE SCOPE OF CLINICAL GOVERNANCE IN PRIMARY CARE

- Clear lines of responsibility and accountability for the overall quality of clinical care
- A comprehensive programme of quality improvement activities:
  - evidence-based practice
  - National Service Frameworks/NICE
  - workforce planning and development
  - continuing professional development
  - safeguarding patient confidentiality
  - clinical audit and outcomes
  - quality assurance
  - R&D
- Risk management
- Identification and remedy of poor performance

Clinical governance presents particular challenges for PCGs. In setting their own clinical governance priorities they will have to reconcile national 'givens' with local concerns if the priorities they identify are to be 'owned' by their constituents. They need to link forward planning and implementation of clinical governance with primary care investment and the implementation of their local Health Improvement Programme. Clinical governance implies a new understanding about the nature of professional accountability. Is there any evidence of progress where previous attempts to improve quality of care have failed?

PROGRESS ON CLINICAL GOVERNANCE

The Audit Commission found wide differences between the amount that PCGs planned to spend on clinical governance this year (ranging from £5000 to £128,000, but averaging £1667 per practice). This in turn has ensured variable levels of local support in the form of new staff. Most PCGs appointed a doctor and nurse to share the brief.[23] Reporting mechanisms are in place and lines of accountability are clarified but the extent to which these have been internalised by clinical governance leads, let alone the 'rank and file', is more debatable. Many are scrabbling up steep learning curves and only now beginning to understand the complexity of their jobs. Most PCGs have set up a clinical governance sub-committee. In over three-quarters of PCGs, practices have appointed their own clinical governance lead. However, levels of support from other agencies such as public health departments, academic bodies or education networks vary considerably.[24] While cross-links with clinical governance structures and community trusts are developing swiftly, particularly among those planning an early transition to primary care trust status, links with the acute sector are largely invisible.

Clinical governance activity should be part of an integrated package focused on HImP priorities. Seven out of ten PCGs confirmed that their clinical governance programme would include inter-practice audit of treatment/referral for conditions mentioned in their HImP.[25] Most commonly, these were heart disease, hypertension and diabetes. Improving data quality through the agreement of common coding classifications, for example, is a high priority, as is adverse event monitoring. However, only one in three PCGs is trying to agree evidence-based protocols for community or practice nursing interventions. It is important that clinical audit is not confined to medical

issues and the treatment of specific conditions but examines the total package of care available to patient groups.

One enduring challenge is the search for a package of performance indicators to help identify sub-standard performance. The easily measurable is rarely useful. Technical obstacles, such as the difficulties of controlling for casemix, are not easily resolved. Most indicators are influenced by factors outside the control of health systems. Measures of process will continue to be more useful than measures of outcome. The former can be truly 'evidence-based'.

The management of poor performance presents PCGs with a major challenge. Complaints, colleagues' expressed concerns and financial audit visits by the health authority are the main means of detection at present. The consultation paper *Supporting doctors, protecting patients*[26] proposed compulsory annual audit and appraisal for all doctors, with assessment and support centres for failing doctors but it is not yet clear how they will operate.

The emphasis this year is on setting the right cultural tone as much as on concrete achievements. In the year of the Shipman verdict, this has not been easy. PCGs are trying to adopt a non-threatening, facilitative and developmental approach to clinical governance while setting up new local monitoring mechanisms.[27] The threats to both independent contractor status and professional self-regulation have increased doctors' feelings of beleaguerment. They are unconvinced by the rhetoric of a 'no blame' culture.

THE ACCESS CARD

The new Labour administration was no less concerned than its predecessors to ensure timely access to care. The first National Survey of NHS Patients confirmed that difficulties booking appointments and waiting times for routine or emergency care were prominent public concerns.[28] Fair access formed one dimension of a new Performance Assessment Framework but, at first sight, the raft of policy initiatives designed to improve access to primary care appeared populist and reflexive. Early commentaries on *The New NHS: modern, dependable* White Paper concentrated on the structural reforms drawing attention away from NHS Direct, the national nurse-led telephone helpline. The purpose of the new service was to provide 'easier and faster advice and information for people about health, illness and the NHS so that they are better able to care for themselves and their families'. But NHS Direct was about more than a response to the consumerist demands of the 24-hour society. It followed the recommendations of the Chief Medical Officer's report *Developing Emergency Services in the Community*, published earlier that year.[29] More specific objectives for NHS Direct included the encouragement of self-care at home and reducing unnecessary use of other NHS services, i.e. management of demand.[30]

The extension of NHS Direct on the basis of early research was oddly fumbled. The interim report of an evaluation funded by the NHSE hardly gave credence to claims that NHS Direct, though popular, was achieving its aims.[31] General practitioners were sceptical of claims that NHS Direct would reduce their workloads. They were quick to seize on the spinning of 'evidence' to rationalise a decision (on the extension of the service country-wide) already taken. The final report confirmed that the new service has had little impact on other emergency services.[32]

Already sensitive to threats to their professional monopoly over first contact care, the medical profession was therefore doubly wary of the introduction of walk-in centres. These were presented by Frank Dobson as a specific response to the apparent success of instant access primary care facilities established by the private sector, notably on railway stations serving time-pressed commuters. Anything Medicentres could provide, the NHS could provide better. More serious concerns revolved around the experience of walk-in centres in other countries, notably Canada. Multiple access points with poorly co-ordinated record keeping could result in

fragmented care. Most of the first wave of 36 walk-in centres were to be nurse-led. Walk-in centres were therefore easily conflated with other threats to the future of independent contractor status.

In summary, these innovations nicely crystallised the differences in priority different players attached to access. Their apparent popularity with patients contrasted with their reluctant acceptance by health professionals. Concerns over their cost-effectiveness remain.

NEW LABOUR, NEW CRISES ... NEW PLAN

That general practitioners will prove capable of cost-effective stewardship of the NHS remains an article of faith. Labour's was allegedly a ten-year project but the development of effective primary care trusts was always going to take more time than the electoral cycle allowed. Similarly, the implementation of clinical governance was never going to keep health scandals from the national news. Prime Ministerial frustration at the slow pace of modernisation was understandable. The genesis of the NHS Plan is described elsewhere in this issue. In terms of the policy objectives considered above, what does it presage for primary care?

Improved access?

The expansion in hospital bed and consultant numbers with consequent reductions in waiting times, if realised, will ease the burden of containment in primary care. The expansion in GP numbers is less impressive. Moves to integrate NHS Direct and GP out-of-hours services make sense. The vision is of a single phone call to NHS Direct as the one-stop gateway to all out-of-hours health care. But even allowing for investment in other community-based services, GPs will not easily be able to improve access to their services or extend consultation lengths.

Increasingly, patients who currently go to hospital will be able to have tests and treatment in one of 500 new primary care centres. Consultants who previously worked only in hospitals will be seeing out-patients in these settings while specialist GPs will be taking referrals from their colleagues in fields such as ophthalmology, orthopaedics and dermatology. The model for these is untested. Evidence suggests that the work of outreach clinics and minor injury units is low volume and cost-inefficient.

Better quality?

The investment in intermediate care represents another triumph of ideology over evidence. Services both to facilitate and to prevent hospital admissions have the potential to improve the quality of life of older people if appropriately targeted, but evidence to date does not suggest that they will yield efficiency savings. £1 billion pounds is to be invested in premises. The refurbishment of 3000 practices should improve the quality of inner city care.

Greater efficiency?

New care trusts are to commission and be responsible for health and social care. These bodies are unlikely to overcome all the long-standing barriers to joint working at this interface but this remains a logical progression. Given the organisational immaturity of many PCTs, it is at least reassuring that their establishment will 'have to take account of the capacity of PCTs'. The need for hospital consultants to have a greater role in shaping local health services is acknowledged. 'Strengthened forms of commissioning' are to draw more directly on their expertise in developing long-term services with PCG/Ts.

Greater accountability?

Patients are to receive more information, for example about their practice (size, accessibility, performance against NSF standards – the dreaded 'league tables'). There are to be a new patient advocacy service, new independent local advisory fora and reconfiguration panels. It is not self-evident that these developments will bring patients and citizens into decision-making at every level of the service and they form just one part of the drive to increase professional accountability.

THE *QUID PRO QUO*

The Government feels it has fulfilled its part of the bargain but will expect more than just 'principled motivation' in return. How will the additional resources be linked to improved performance? The most significant change to the ways GPs work will be the elaboration by 2004 of a new contractual framework building on the stipulations for improved outcomes that are supposed to be inherent in the PMS approach. PMS does not automatically spell the end of independent contractor status but the NHS Plan makes clear the direction of travel. Single-handed practices are an immediate target for 'quality-based contracts' but the experience to date of PMS pilots suggests that they may be harder to devise in practice.

New Labour has been repeatedly criticised for its centralising tendencies at the expense of local experimentation. Henceforth, intervention is to be inversely proportional to success. There will be progressively less central control and more devolution as standards improve, but a system of 'earned autonomy' implies robust systems for measuring progress. PCG/Ts will be required to meet well-defined criteria to access the National Performance Fund. The next version of the Performance Assessment Framework embracing PCTs will be awaited with interest, but the portents are discouraging. The requirement to establish systems for monitoring referral rates from every GP practice by April 2001 'to match the information currently available on GP prescribing' betrays a disregard of evidence. Referral rates are an unreliable guide to performance[33] and there are few well-validated measures of the quality of prescribing.

Health professionals were already bracing themselves for annual appraisals and mandatory audit in support of revalidation. They have reason to fear the tightening noose of professional accountability. The loss of struggling colleagues and the time out needed to participate in continuing professional development will increase workloads and it remains to be seen whether these changes will do enough to reassure the public.

CONCLUSION

The outgoing Conservative Government presented the new Labour administration with many of the tools it has wielded in its quest for modernisation. The internal market has been adapted in gradualist fashion within a framework of mandatory collective funding. In other respects, this Government's first four years have proved unexpectedly radical. The cost-efficiency of the NHS has long been attributed in large measure to the strengths of British general practice, key features of which are the provision of continuity of care and a comprehensive financing system. Arguably, this Government has begun to tamper dangerously with what is right, as well as with what is wrong, with primary care.[34] Notably, health outcomes could be impaired if the establishment of free-standing emergency centres compromises continuity of personal care.[35] There are risks in abandoning too hastily the infamous 'red book', which has, at least, proved adaptable as a mechanism for the central direction of general practice. New payment systems could prove less flexible, with higher transaction costs.[36]

If the NHS Plan hardly heralds a decisive shift in their direction, most primary care professionals welcome the reaffirmation of faith in existing funding mechanisms and the scale of recent investment. Much depends on the manner of its implementation. Their leaders were heavily involved in its development, for recent history has underlined how important it is to defuse the opposition to change of organised medicine.[37] The leaderships of the main representative bodies have been mostly constructive in their responses to the Plan. Whether the Government has won the hearts and minds of health professionals and managers is another matter. Many are cynical after years of costly restructuring with no apparent benefits for patients. They appreciate that such governmental largesse is unlikely ever to be repeated but New Labour could yet break the NHS under the weight of its good intentions.

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New Labour's public health policy: theory good, practice middling to poor

New Labour's approach to public health is certainly different to that of its predecessor, but it seems that health care rather than health remains uppermost.

Anna Coote

The New Labour Government's approach to public health is certainly different from that of its predecessor. It has introduced significant structural changes: a designated Minister for Public Health for the first time, an overhauled Health Development Agency, and primary care groups and trusts charged with responsibility for public health. It has brought in new procedures and initiatives: Health Improvement Programmes to be drawn up by health authorities in partnership with local councils and other agencies; Health Action Zones; Healthy Living Centres; Sure Start. What are the implications for health improvement? In this article, we look first at New Labour's conceptual framework for public health and consider how far it has found expression in the Government's strategies for health, including changes in primary care, new local partnerships and the role of health targets. We look at policies initiated outside the health sector that may have an impact on health and, finally, at the implications for public health of the NHS Plan.

A NEW CONCEPTUAL FRAMEWORK

One of Tessa Jowell's first moves after her 1997 appointment as Minister of State for Public Health was to commission the Independent Inquiry into Inequalities in Health, chaired by Sir Donald Acheson. After years in which inequality had been – quite literally – unmentionable in official health circles, it was now back on the agenda and, apparently, requiring urgent attention. The report of the Inquiry, in 1998, left no doubt about the links between health and social and economic factors. It showed that the 'health gap' had widened dramatically:

> *In the late 1970s, death rates were 52 per cent higher among men in classes IV and V compared with those in classes I and II. In the late 1980s, they were 68 per cent higher. Among women, the differential increased from 50 per cent to 55 per cent.*[1]

This was not news to anyone. But what had changed was that there was now a government pledged to fight poverty and social exclusion, which could not be seen to ignore the evidence or the thrust of the recommendations in the Acheson report. It had to be acknowledged that improving health and reducing health inequalities meant moving upstream to address the multiple causes of health and well-being:

education and housing, income and employment, neighbourhood and environment, family and social relations, self-esteem and power. This, in turn, meant that it became imperative to work across sectoral and departmental boundaries, to create new partnerships and to 'join up' policy-making and implementation. Health could evidently not be left exclusively to the health sector, but required input from most government departments and many other players, on many fronts and at all levels. Sure Start, the flagship multi-agency programme for 0–3 year olds, brought together health, education and social services to give children, especially in disadvantaged areas, 'the best possible start in life'.[2]

At the same time, New Labour espoused the idea of responsibility for health being shared between individuals, intermediate organisations at local level, and national government. This was a fine example of 'third way' politics. Individuals were not to be left to fend for themselves and their families (with woolly hats and private insurance), as the neo-liberal right would have it. Nor was health policy simply a matter of cradle to grave protection by the state, of which the 'old left' once dreamed. Instead, it was a bit of both – and something in the middle, too. After two decades of being demonised as the work of long-haired social engineers or dangerous subversives, 'community development' was rehabilitated and, suddenly, in demand. Recognition was dawning that health was profoundly affected by the way people experienced their neighbours and neighbourhoods, and the degree to which they were able to shape their environment and improve their own lives. The new Government's Green Paper, *Our Healthier Nation*, set out a three-way 'contract' between individuals, communities and Government, specifying different ways in which each party could contribute to better health. The same theme was repeated in the White Paper, *Saving Lives*. New Labour's high-profile effort to tackle social exclusion through a programme of neighbourhood renewal[3] underlined the new legitimacy of building capacity and cohesion within local communities.

Some of these themes emerged in policies produced under the Conservatives, but Labour's conceptual framework is clearer and more consistent. It is also more committed to intervention by government – not merely to provide services, but to build up the social and economic infrastructure that should enable people, individually and severally, to be co-producers of their own health.

THEORY INTO PRACTICE

How far has the new framework found expression in the Government's strategies for health? Improving health and tackling health inequalities have not been among the Government's practical priorities, which have been to rescue the NHS from its perpetual 'crisis', cut waiting lists and unravel the embarrassment of GP fundholding. Theory, good; practice, middling to poor.

PRIMARY CARE AND PUBLIC HEALTH

There have been some significant innovations in the public health field. But these have taken place in a hinterland of second-order issues, where mixed messages and organisational confusions abound. New primary care groups and trusts (PCG/Ts) have been given responsibility for improving the health of their local populations. This may be an advance on primary care practitioners having no particular brief for population health, but it is not clear how well they will acquit themselves in their new role. Although primary care groups and trusts include nurses, health visitors and others whose work is more about prevention than cure, most are dominated by general practitioners who, by training and professional ethos, are inclined towards the medical model of health care and concerned with addressing the needs of individual patients. Moreover, doctors already feel they have more than enough to do without taking on additional responsibilities. There is a huge task to be accomplished in building capacity in PCG/Ts, creating enough space and time, and transferring appropriate knowledge and skills, mainly from public health departments of health authorities. It may be

even more difficult to transform the hierarchical and cultural patterns that are well embedded – both in health authorities, which are often reluctant to lose control of public health, and in primary care – so that the new organisations are able to fulfil their responsibilities for public health. In their first years of life, the turmoil of reorganisation added to the considerable volume of routine primary care work has rendered many of them incapable of thinking beyond the immediate challenges of clinical care.

Health Improvement Programmes

Meanwhile, health authorities have been charged with developing Health Improvement Programmes (HImPs) in partnership with local authorities, PCG/Ts and other local agencies. HImPs are potentially a key instrument for delivering public health locally. They are expected to produce a strategy for action on local as well as national priorities, based on wide-ranging, early consultation with the public as well as local organisations and interest groups. Early appraisals suggest there is widespread enthusiasm for the process,[4] but it is too soon to tell how far they will make an impact on population health.

The goal of 'health improvement' can be pursued in various ways: by improving health care, raising the quality and effectiveness of preventive medicine, promoting healthy behaviour through education, exhortation and advice, protecting the public from harm, improving the social, economic and environmental conditions in which people live, and empowering communities to improve their own health.[5] Clearly, all these approaches are important and it is now widely understood that population health will not be enhanced, nor inequalities reduced, by confining action to the clinical/promotional end of the spectrum. Research by the King's Fund[6] showed that, while primary care groups played only a minimal role in the first round of HImPs, there was more input from local authorities, who were enthusiastic about the idea of partnership but expressed concern about their role in implementation. New arrangements to allow for budgets to be pooled between health and local authorities may facilitate joint practical action, and new powers of scrutiny announced in the National Plan (see below) will also help to strengthen links.

As increasing numbers of primary care groups assume trust status, health authorities are bound to change. In the best case, they may become lean and effective strategic bodies, specialising in integrated planning and promoting high standards of performance. Alternatively, they may become vestigial bodies, merging with each other and possibly withering away, leaving the Regional Offices of the NHS Executive to co-ordinate the work of primary care trusts. It is not clear who then would champion the cause of population health. It is too early to tell whether primary care trusts will become strong advocates and leaders of health improvement in the widest sense. Local councils, for their part, are expected to develop their own Community Plans for improving local services and promoting a better quality of life. Having two plans running side by side may be awkward and confusing and there is a strong case for merging them into a single operation. So far, this has been resisted.

Much will depend on how relationships develop between the key HImP partners and how far, as time goes by, they experience conflicting demands on their energies and resources. If the health sector fails to integrate planning with local government and other non-health organisations, it is more likely that HImP-related activities will focus on areas directly controlled by the NHS. In that case, there is little chance of achieving real improvements in health, except those arising from the direct effects of clinical interventions and associated health care.

PRIORITIES AND TARGETS

To a large extent, strategic priorities are driven by a superficial view of public opinion. For example, polls show that that people do not want to wait for health services. The

Government reflects that simple opinion back to the public and reinforces it by pledging, as a top priority, to cut waiting lists, and ordering monthly reports on progress towards its goal. The media, increasingly keen to snap at the Government's heels, add force to the view that waiting lists are all that matter by producing a steady stream of news about waiting times not being cut, or even lengthening, sometimes with catastrophic results for individuals. This in turn adds to the pressure on the Government to focus its resources on the waiting list initiative. There is evidence that the public, in all social groups, is concerned about addressing the causes of ill health, not just clinical issues. A MORI poll conducted for the King's Fund and the *Evening Standard*, asked Londoners what they thought most affected their health and what the new London Mayor should do to make London healthier. Eighty-eight per cent put environmental factors at the top of the list (air traffic, road traffic, dirty streets and poor housing) and 89 per cent said the Mayor should prioritise environmental issues – and these results were consistent across all social groups.[7] They suggest there is scope for persuading voters to support a different order of priorities. The Government is not averse to leading and changing public opinion, but in this case it is held back, trapped by its own pledge and fearing that a more radical shift of emphasis would destabilise the coalition of interests that produced its 1997 landslide victory. So health policy remains focused primarily on the NHS and particularly on the pressures on the acute sector.

'Saving lives'

Targets have played a crucial role in shaping public health priorities. The Green Paper, *Our Healthier Nation*,[8] identified four national priorities: cancer, coronary heart disease and stroke, accidents and mental health. These echoed the target areas set out in the Conservative Government's public health strategy, *The Health of the Nation*,[9] but with sexual health omitted. Unlike its predecessor, *Our Healthier Nation* gave considerable prominence to the underlying causes of ill health, to introducing the three-way 'contract' between 'government, local communities and individuals' and to establishing three 'settings for action': healthy schools, workplaces and neighbourhoods. The subsequent White Paper, *Saving Lives*, firmed up the focus on targets, with four crisp pledges: by 2010 to reduce deaths from cancer by 100,000, from coronary heart disease and stroke by 200,000, from accidents by 12,000 and from suicides by 4000. These are now the centrepiece of the Government's public health policy. The four target areas have enjoyed broad support. There has been little appetite, since the litany of unfulfilled promises in *The Health of the Nation*, for another long wish list. There is strong evidence that the four targeted conditions are major causes of premature death and disproportionately affect the lower socio-economic groups, and they do not rule out upstream preventive strategies. But there have also been concerns about the potential effects of public health policy being so obviously driven by minimalist, disease-based targets. If the Government thinks it will be judged by specific numbers of deaths avoided by 2010, there must be a strong temptation focus on downstream clinical activities – both because these are more obviously susceptible to management by the NHS and because results are easier to measure. To put it crudely, if you can avoid so many deaths per annum by installing defibrillators in stations and shopping malls, you may feel there is less urgency to tackle the more complex and challenging causes of heart disease, such as poverty, powerlessness, poor nutrition, stress, sedentary habits and smoking. But it is doubtful whether this way of 'saving lives' would amount to 'improving health'.

Problems with evidence and evaluation

Across the policy agenda, New Labour has set great store only by promising what it can deliver and delivering on its promises. All its 1997 manifesto pledges were minimal and specific. The danger with this approach is that it reduces political ambition to what can be counted. In public health, this is especially problematic. We are at a stage where there is a widely shared and sophisticated understanding of the causes of ill

health and the need for innovative, cross-boundary working that is 'bottom-up' as well as 'top-down'. These newly shaped convictions are combined with a strong commitment to action that makes a demonstrable difference. But most innovative, bottom-up activities do not lend themselves to conventional forms of evaluation or measurement. Few can be judged by numbers of lives 'saved'. They are messy and indeterminate; their impact on morbidity and mortality rates is often indirect, or too slight to be statistically significant, and may not be felt in any measurable way within a decade. A new, shared framework is needed for evaluating community-based action for health – one that can be embraced by those directly involved as well as by the clinical and academic grandees who have traditionally decided what evidence is worth taking into account and what is not.[10] The new Health Development Agency is supposed to be taking the matter in hand but, in the meantime, innovators in the public health field will be fighting an uphill battle for admission to the mainstream, for priority status and for a decent share of resources.

NON-NHS POLICIES

When it comes to tackling inequalities and the underlying determinants of health, policies initiated outside the health sector are at least as important as those originating within it. At national level, the Treasury, the DfEE, the DSS and the DTI have arguably done more to address the 'health gap' in three years than the Department of Health could ever do. Taken together, the 'new deals' to get people off benefit and into paid work, the minimum wage, the working families and child care tax credits, the national child care strategy, the increases in child benefit, and reform of the Child Support Agency amount to an ambitious and extensive programme to improve the life and health chances of those who are poorest and most vulnerable to ill health. At local level, the revival of areas suffering from multiple deprivation through projects funded by the single regeneration budget, and the New Deal for Communities led by the DETR, are probably the most effective way of tackling health inequalities, especially in the cities. Similarly, Education and Employment Action Zones are just as likely to improve health in the longer term as Health Action Zones.

THE EFFECTS OF DEVOLUTION

In London, a city-wide Coalition for Health and Regeneration was convened by the NHS London Regional Office, to draw up a draft strategy for London's health. Its core sponsors are the Government Office for London, the Social Services Inspectorate, the Association of London Government and the King's Fund, who work with a wide range of partner organisations drawn from different sectors across the capital. The Coalition forms the basis of the new London Health Commission, promised by Ken Livingstone in his Mayoral manifesto, and the Commission is likely to retain a strong emphasis on regeneration and tackling inequalities. It is fair to say that none of this would have happened in London if the Government had not established an elected regional authority. It was in anticipation of the GLA that London acquired a single, city-wide Regional Office for health, and it was in anticipation of the Mayor taking an interest in health issues that the London Regional Office convened the cross-sectoral partnership that drafted the first strategy for London's Health. Not only in London, but also in Scotland and Wales, constitutional reform – one of the hallmarks of the New Labour Government – has encouraged innovative, cross-sectoral approaches to public health.[11]

BUILDING STRONGER PARTNERSHIPS

Initiatives outside the health sector may do a lot for health without specifically trying, by helping to combat poverty and social exclusion, and to improve the quality of life for those who are worst off. However, much more could be achieved if links with health improvement were more often made explicit in policy-making and implementation. Where schemes, local or national, are 'health blind', they may unwittingly introduce new risks to health – for example, as a result of new industries being introduced into a locality, or by excluding

marginal groups with mental health problems.* They may also miss valuable opportunities for the health sector to contribute to regeneration. The NHS has extensive capital assets and is often the largest source of employment in a locality, especially where traditional industries have declined. How hospitals and other NHS trusts choose to deploy their resources, and recruit and train staff, can have a more or less positive impact on the local economy and on the quality of life of local residents.

It is one thing to recognise the need for 'joined-up government'; it is quite another (obviously) to make it work in real terms. Sure Start, which originated with the Department of Health, has managed to integrate health more successfully with other policy areas than, say, the Strategy for Neighbourhood Renewal, which emanated from the Cabinet Office, or the subsequent New Deal for Communities, which falls within the DETR. It is not that policy-makers in other sectors are uninterested in health issues, but that they have their own preoccupations and priorities; they speak a different language and have few ready points of contact with health expertise. Incentive structures are often unhelpful or perverse: people seldom get rewarded for forming partnerships or achieving goals set by other organisations. Nevertheless, there is a growing awareness of the importance of linking health with regeneration and other policy areas to address the social and economic causes of ill health. Bids for SRB funding, for example, are now required to include plans for health improvement.

To achieve better results in the longer term, it would help if policy-makers at all levels, as well as opinion formers and the wider public, had a clearer understanding of how investment in non-health sectors produced health-related outcomes. This suggests a need for more research and monitoring as well as better education and awareness both inside and outside the statutory sector. One obstacle here is the Government's reluctance to be 'outed' as a redistributor of income and opportunity. Its response[12] to the Acheson report was slipped out quietly on the day it published Saving Lives, with what might be described as inverse spin: no publicity at all. This may have been partly because it had not found ways of meeting all 39 recommendations in the report. It had, however, made impressive progress towards meeting many of them, but seemed to fear that, if word got out about its egalitarian tendencies, 'middle England' voters would take fright.

It would also help if the links between sectors could be strengthened and embedded in operational systems. There is a case (noted earlier) for bringing Health Improvement Programmes into much closer alignment with the Community Plans led by local authorities. There could be more intensive scrutiny of the impact on health and health inequalities of policies developed in other sectors, such as education, housing, transport and employment. And the NHS itself could play a more constructive role in tackling inequalities and social exclusion. It could do this both by contributing to area regeneration through workforce recruitment and capital spending, and by improving services to vulnerable groups and disadvantaged communities.

Developing capacity for innovation

It may make sense to join up Health Action Zones with other action zones. The jury is out on whether the HAZs have been – or will be – a success. The idea of encouraging innovative inter-sectoral working is sound, but the new Government's desire for 'quick wins' may have led to unreasonably high and urgent demands, with too many initiatives crammed into too

* In one inner city area, a regeneration programme brought in media and entertainment industries, which encouraged a lively nightlife and, with it, a flourishing drug culture. Had the effects on health been anticipated at the outset, a preventive strategy might have been introduced before the problem got out of hand. The other example refers to the involvement of residents in the refurbishment of an estate: vulnerable residents with mental illness were excluded, or excluded themselves, from the process; as a result their needs were not taken into account and they became more marginalised, to the further detriment of their health.

many tight spaces, all desperate to show results in a hurry. By the summer of 2000, many Health Action Zones had underspent their budgets quite spectacularly, unable to implement a sufficient volume of appropriate activity and they were attracting criticism for being insufficiently connected with mainstream activities. Healthy Living Centres – another 'big idea' forged in haste – have suffered a similar fate: so far only seven have received funds from the New Opportunities Fund. If the lesson is that it takes time to build capacity for innovation at local levels, then there may need to be more investment in long-term, mainstream community development rather than glitzy new projects.

THE NHS PLAN

Some of these lessons appear to have been taken on board by the NHS Plan, which set out in July 2000 the Government's intentions for the health service, following the Comprehensive Spending Review and the dramatic decision to increase NHS funding by a third in real terms over five years. Chapter 13 of the Plan, 'Improving health and reducing inequality' announces a raft of measures to develop new partnerships to tackle inequality. The NHS is now to 'play a full part' in the National Strategy for Neighbourhood Renewal, drawn up by the Social Exclusion Unit – a significant advance, since health was barely mentioned in the 30 'key ideas' set out in the SEU's consultative document on neighbourhood renewal. Local Strategic Partnerships are to provide a means of integrating health and other action zones. By 2000, each region is to have a 'new, single, integrated public health group', organised across the Regional Offices of the NHS and the DETR. A Healthy Communities Collaborative is to spread best practice, using evidence from the Health Development Agency and following the formula of the Cancer Collaborative. A leadership programme is promised for health visitors and community nurses to help them work with local communities to improve health. Local government will have new powers to scrutinise the NHS locally, with NHS Chief Executives required if requested to attend scrutiny sessions run by elected local councillors at least twice a year. On the downside, convergence of HImPs and Community Plans was included in a late draft but omitted from the final document.

Diet and nutrition receive a welcome amount of attention: there are ambitious but uncosted plans to reduce drug dependency (by 50 per cent by 2008 for under-25s reporting use of Class A drugs) and it is promised that the 'NHS will provide a comprehensive smoking cessation service'.

Most of the money will, unsurprisingly, be spent on the recruitment of staff and downstream health services: by 2004, 7500 more consultants, 2000 more GPs, 20,000 more nurses, 6500 therapists and other health professionals; more training and medical school places; £1 billion invested in primary care; an extra £570 million a year for cancer services; £230 million a year for heart disease services ... and so on. Within this context, however, reducing inequalities is to become a 'key criterion' for allocating NHS resources, to address the problem of the 'inverse care law' whereby the poor get the poorest services.

The Plan promises to establish, for the first time, 'national health inequalities targets, to narrow the health gap in childhood and throughout life between socio-economic groups and between the most deprived areas and the rest of the country'. This has to be a welcome development now that targets play such an important role in determining the allocation of resources. The challenge lies in finding viable targets where there can be some confidence that investment will lead to measurable outcomes – without stifling innovation or scaling down objectives until they become meaningless. There are no resources attached specifically to meeting any national inequalities targets, although the Plan says they are to be 'delivered by a combination of specific health policies and broader government policies, including abolishing child poverty, expanding Sure Start and action on cancer and coronary heart disease'. An additional £500 million is pledged for Sure Start, and £450 million for a new 'Children's Fund'.

Local NHS action on health inequalities and equitable access to health care is to be measured and managed through the NHS Performance Assessment Framework. And there is to be a new 'health poverty index', combining data on health, health services, environment and lifestyle, which should help to track progress on inequalities and, more generally, provide a useful stimulus to the development of policy and practice in future.

Just how far the new NHS billions will impact on health improvement and inequalities remains to be seen. The strength of the Plan, from the public health perspective, is that it seeks to put tackling inequalities on a more equal footing with cancer, CHD/stroke, accidents and mental health, and to establish some means of measuring results. The weakness lies in the apparent lack of intent to spend any more money on public health initiatives, beyond Sure Start and the Children's Fund (whose purpose remains mysterious).

CONCLUSION

New Labour's health policy shows a better understanding of what needs to be done to improve health and reduce inequalities than that of the previous Conservative Government. It is committed to fighting poverty and social exclusion and to investing in the social and economic infrastructure in ways that should help to redistribute opportunities for good health and long life. It recognises the need for cross-boundary working and has put some wheels in motion to encourage health-promoting partnerships at local level. But its commitment to public health is tempered by other priorities: responding to consumer demands for better and quicker health care, maintaining middle-class electoral support in order to win a second term and, to that end, demonstrating results in the short term. These are all reputable objectives, but they pull in different directions.

Much depends on sustained, energetic leadership at senior level. In 1999 Yvette Cooper replaced Tessa Jowell as Minister for Public Health, but as a Parliamentary Under Secretary, not as Minister of State, and with massive additional responsibilities – her portfolio includes cancer, heart disease and smoking. The Health Development Agency has had its budget slashed – and is not due to receive an extra penny under the NHS Plan. Secretary of State Alan Milburn, like all his predecessors, is entirely preoccupied with the NHS. While it would be a mistake to imagine that relocation alone would solve the problem of health being perpetually eclipsed by health care, there is a case for moving the public health portfolio to the Cabinet Office, alongside the Social Exclusion Unit, where there may be a better chance of finding strong, central leadership for a key issue that depends heavily on cross-boundary policy and practice.

There are no signs yet that Government policy has had an impact on the 'health gap', although it would be unreasonable to expect any at this stage, as the effects of inegalitarian Conservative policies are still feeding through into health statistics. It may well be that we shall not see positive results until Labour is out of power again. The test of a great Government must be that it will invest in long-term health improvement, even though it suspects that it will not be able to collect the credit.

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Fit for purpose? Re-designing medical self-regulation

Current moves to re-design self-regulation will mean significant changes to accountability and professional autonomy.

Steve Dewar and Alison Hill

INTRODUCTION

At first it may have appeared to be coincidental, but it soon became clear that, for the Labour Government, high-profile cases of poor performance justified making the self-regulation of health care professionals a prime target for modernisation. Three years later several of the professional regulatory bodies are about to undergo their modern makeover and the General Medical Council (GMC), shaken by a vote of no confidence from the profession and asked by the Government to contemplate radical change, is about to undergo a transformation.

The old systems of professional self-regulation are buckling under pressure from politicians, professionals and public. The need to re-design medical self-regulation has never been so stark, nor the political consequences of reform so precariously balanced. While the Government might benefit from appearing tough, would it risk a fight with such a strong professional lobby less than a year from possible re-election? The threat to take away professional self-regulation may be real – but would any government really want responsibility for a new system? Change is required, and change will happen, but when it comes to working out exactly what changes will allow medical self-regulation to survive all players are engaged in a game of call my bluff.

The Government has proposed tests for a new system.[1] It has illustrated its thinking with new regulatory proposals for nurses, midwives and health visitors[2] and the new health professions[3] (encompassing all those who endured the outdated label 'professions supplementary to medicine').

Meanwhile, the Chief Medical Officer is planning for local systems of regulation that link revalidation with local accountability for quality assurance.[4] Alongside these developments the Government has indicated its intention to establish a new overarching body to develop common approaches across the disparate systems of professional self-regulation for health care.[5]

With so many of the jigsaw pieces scattered on the table, what sort of picture can be seen? What are the concerns of all the major stakeholders? What are the approaches to change? And, finally, to what extent might reform assuage concern?

CONCERNS OVER CURRENT MEDICAL SELF-REGULATION

There are three major stakeholders in the current system for medical self-regulation: the profession; patients and public; and government. The concerns of each are considered in turn.

Stakeholder concerns: the profession

Different parts of the medical profession have voiced different, though overlapping, concerns. These can be summarised in four aspirations: maintaining professional power; building confidence in medical self-regulation; ensuring fair and quick responses to potential poor performance; and clarifying the role of the regulatory body in the local working environment.

The wish to maintain professional power is a key concern. The institutional expression of medical regulation is *the* measure of its professional power.[6] During a BMA debate on the GMC, members told council, 'we are not in the business of giving away medical influence ... if we give up self-regulation today there is no going back'.[7] Without self-regulation, the profession is not able to determine its own professional identity let alone negotiate with the public or the state in favour of its own, or its interpretation of the public's, interests.

Maintaining confidence in medical self-regulation goes hand in hand with the status of the regulatory body and the status of all the bodies representing the medical profession. Establishing and maintaining such status empowers the profession. The perceived failure of the regulatory system to protect the public from poor performance or even criminal intent is correctly identified in the *BMJ* as being at the heart of concerns felt by all doctors.

> *The biggest – but least well defined – complaint is to do with public relations. Doctors are fed up with their bad press.*[8]

Doctors do not wish to be depicted as villains because of the inability of the regulatory body to manage incompetent or criminal practitioners. They want to distance themselves from a regulatory body that they feel is discredited and to avoid being associated with the bad press on medical regulation. Many doctors attribute their perception of some combination of these problems to poor leadership or bad decision-making within the GMC, and lack confidence in the organisation as currently constituted to respond to these concerns.[9]

Doctors wish to see a fair, effective and quick response to potential poor performance. Given the proven ineffectiveness of the current system, a number of different diagnoses have been put forward. Uppermost is the notion that the procedures used by the GMC for fulfilling their regulatory responsibilities (particularly where fitness to practice is concerned) are inefficient and slow. For these critics, reform of the GMCs structures and procedures are seen as the crucial area upon which to focus attention.[10]

An alternative analysis places much of the blame for recent notorious cases of professional incompetence at the local level. This has led to fierce debate over the GMC's plans for revalidation and the way in which they might link to local management systems. Overall, the BMA has welcomed revalidation, and some parts of the profession (particularly in general practice) have embraced work to take the proposals forward.[11] But some doctors see the role of the GMC in these plans as inappropriate for a national professional regulatory body. Revalidation may turn out to be radical step that the profession is not ready to take – as a *BMJ* editorial put it, '[revalidation] may be ahead of other countries, but it may also be ahead of what British doctors are willing to accept'.[12] Others within the profession do not argue with the principle but believe that current plans for implementation are ineffective and wasteful. The Chairman of the BMA's joint consultant committee has criticised the proposals on both grounds as 'at best unachievable and at worst misguided'.[13]

Stakeholder concerns: patients and public

Patients meet health care professionals one to one. When they meet, they expect professional conduct as well as clinical competence.[14] They also want to trust the wider health care system. If they think something has gone wrong, they want health care professionals to be accountable for their actions and an effective system of redress to be open to them.[15]

The patient wants to be – and to feel – safe. Patients want to be listened to and to have their concerns taken seriously. The health care system should work so that if something goes wrong patients get an explanation and an apology. The system should learn from mistakes so that they are less likely to happen to others.[14–16] These are all characteristics that the NHS has failed to exhibit when the local circumstances for some of the most recent and notorious cases of poor performance have been put under the microscope.[17]

Regulatory bodies promote themselves as protectors of the public; the GMC's logo proclaims that it is 'Protecting patients, guiding doctors'. But these expectations are increasingly difficult to fulfil.[18] The system for public protection needs mending. Recent cases have exposed the many ways in which the system has failed. There is plenty of evidence to demonstrate the consequences of a lack of clear local accountability for quality and performance, alongside cultures that do not encourage local clinicians or managers to act on concerns.

But what would a system to achieve public protection and attract public confidence look like? Public expectations are dynamic and vary among different groups. They also change with changing social and political norms.[19] Public expectations are now more rooted in individual rights and consumer experiences than deference to professional status. Have recent crises, such as the poor performance of the Bristol heart surgeons, just provided 'suitable vehicles' for the articulation of these new public expectations? Commentators such as Professor Salter[20] believe so:

> *As citizens come to see themselves as active consumers of health care, rather than the passive recipients of authoritative clinical decisions, so they are in effect redefining their welfare citizenship, their health care rights, their expectations and their political demands.*[21]

Stakeholder concerns: the Government

To understand the role of government, it is helpful to review the complex triangular relationship between government, profession and public. The three are locked together in a way that means government concerns cannot be separated from those of the public and the professional. Professor Salter clearly describes the nature of these relationships:

> *In return for the statutory right to self-regulate its own knowledge territory, medicine acknowledged its duty to ensure that in terms of both education and practice its use of that knowledge would be in the public interest ... Provided the profession retains the trust of the public then it also fulfils the terms of its contract with the state and self-regulation can continue unhindered. But if the profession fails in its task, then Parliament must act to protect the citizens on whose behalf it originally ceded the privilege of self-regulation when it established the GMC. Not to do so would constitute a failure by the state to fulfil the terms of its own contract with civil society ...*[22]

One of the advantages of this 'contract' between state, public and medicine is that it dilutes state responsibility by establishing the profession as the first line of accountability. But, in return, the government has to act (and be seen to act) on the public's behalf.

Government is, however, on the horns of a dilemma. It may be tempted to influence the reform process so as to reduce the power of medical self-regulation and thereby decrease the overall power of the profession. It may do this in the belief that such an outcome would increase its ability to implement health care policy. The *BMJ* puts the argument succinctly:

> *The Government probably does not want the job of regulating the profession but all politicians would be happy to see the political power of doctors reduced. It would make it easier for them to implement their policies, no matter how ill considered.*[23]

However, decreasing the power of professional regulation also opens up the possibility of an increase in direct government accountability for the health care system. A rational government concern would be to try to achieve reform that meets the Government's obligation to act on the

public's behalf to improve the efficiency of the regulatory mechanism; reform that reduces the professional power of medicine – but reform that also ensures a degree of distance between government and the direct workings of the health care system. Professor Salter captures the nature of this problem:

> *Under pressure from their citizens, governments face a dilemma. Public trust in the authority of doctors needs to be maintained ... to rely on the profession to manage its own process of organisational change to achieve that trust is gambling against history. On the other hand, the introduction of regulatory reform for which the state takes responsibility means that it, rather than the profession, then becomes the target for citizen discontent with the standards of health care. The political advantage of medical self-regulation to the state has always been the distance it places between itself and its citizens.*[24]

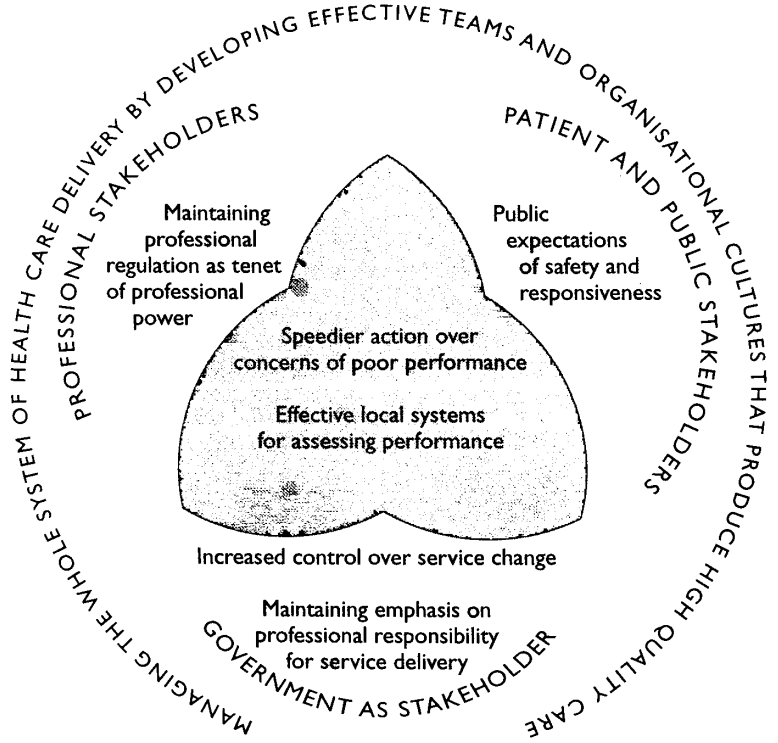
COMMON AND SPECIFIC STAKEHOLDER CONCERNS

The different concerns of these stakeholders share common elements as well as reveal distinct perspectives (see Figure 1). The common concerns of all major stakeholders are speedier action over potential poor performance and the need for effective local systems of assessment and action to protect patients and public.

More specifically, patients and public have new and changing expectations of the safety of the health care system and the responsiveness of regulatory and quality assurance systems. Government has a specific concern to increase its ability to direct new service delivery if it is to deliver the scale of NHS change and improvement that it promises the electorate. The Government also wishes to ensure a good share of the responsibility for delivering change still lies with the health profession. The medical profession specifically wishes to maintain

Figure 1

MAPPING CONCERNS OVER PROFESSIONAL SELF-REGULATION



professional ownership of regulation as a tenet of professional power.

These concerns, both common and specific, represent criteria against which the approaches to regulatory re-design can be matched. The next section lays out three main approaches to the re-design task.

APPROACHES TO RE-DESIGNING MEDICAL SELF-REGULATION

In the re-design of medical self-regulation, three approaches are emerging. The first of these is the reform of the regulatory body: the Government offers a new model for increased 'lay' input into the regulatory bodies, alongside smaller and more efficient decision-making councils, and greater transparency. Proposed changes to the regulatory bodies for non-medical health professionals provide an insight into Government thinking.[25,26] The NHS Plan makes it clear that the GMC is expected to follow suit or face centrally imposed reform.

The second approach is local self-regulation. This is focused on the regulatory system rather than the regulatory body. The local system is where professional, personal and managerial responsibilities combine to establish functional (or dysfunctional) ways of accounting for clinical practice. The GMC's commitment to revalidation will have a big impact at this level, while the GMC's audit tool for local medical regulation stakes out the territory for medical and non-medical managers.[27,28] The CMO's plans for integrating managerial systems of appraisal and clinical governance with professional responsibilities also stand out as a key feature in this particular landscape.[29]

The third approach is inter-professional regulation. The NHS Plan intimates that the fledgling UK Council of Health Regulators will serve as a forum for cross-professional collaboration – and in the event of any perceived failure of uni-professional reform might be asked to take on additional regulatory roles.

At the same time, the implications of incorporating human rights legislation into UK law means that all regulatory bodies will have to address the problem of effectively separating the role of managing and prosecuting cases against poorly-performing professionals from the fair determination of the evidence. This potentially fragments single and cohesive uni-professional regulating bodies and raises significant questions about whether the standards of determination should be consistent across professional boundaries.

REFORM OF THE REGULATORY BODY

The key components of the Government's agenda for modernising the regulatory bodies are increased accountability, greater clarity of purpose and faster redress against potential and actual professional incompetence. The NHS Plan establishes three tests for the reform of professional regulation:

> *As a minimum, the self-regulatory bodies must change so that they:*
>
> - *are smaller, with much greater patient and public representation in their membership*
> - *have faster more transparent procedures, and*
> - *develop meaningful accountability to the public and the health service.*[30]

In an attempt to meet these criteria, the GMC is consulting on a revised structure.[31] The GMC will look to develop an inclusive conference of stakeholders alongside a much smaller GMC board. It has acted to speed up the processing of cases concerning potential poor performance as well as establishing, with the Government, new powers to protect patients while decisions are pending.[32] How will their proposals fare against these tests?

Ironically, one of the strategies for political management employed by the current Government has been the conscious inclusion of stakeholders in shaping and implementing policy. The GMC proposes adopting a similar approach to help it maintain the substantive involvement of medical, public and health

service professionals through a large GMC conference. The alternative risks sacrificing the representation, role and influence of a large number of stakeholders at a time of poor standing with the profession and the public. This would court further detachment and alienation – to be followed surely by a swift demise.

The proposals for both the Health Professions Council and the Nurses and Midwifery Council suggest decision-making bodies of up to 30 members, with professional majorities limited to one. The GMC also proposes a board of less than 30 and acknowledges that the current council of 104 is an unwieldy decision-making group, which leads to power being vested in the presidential role and the work of a Presidential Advisory Committee. These are seen as opaque and unaccountable mechanisms for setting strategic direction. Given that changing social, political and health care expectations are setting a substantial agenda, the GMC will need an accountable and small 'board' with dedicated time, brainpower, and professional authority if professional self-regulation is to meet the expectations placed upon it.

These proposals for simultaneously growing bigger and reducing to a decision-making core are the GMC's attempt to square the circles of greater accountability and increased effectiveness. Greater patient and public representation raises similar problems of accommodating greater accountability while ensuring the relationship between regulatory body and doctors stays strong. The two are not mutually exclusive. Indeed, it is the accountability of the regulatory body to all three major stakeholders – the profession, patients and public, and government – that needs strengthening – not any one at the expense of another.

The second government test concerns the speed and transparency of decisions – this is an issue that resonates with sections of the profession. The GMC is working hard to address shortcomings. To promote faster working, Parliament has, at the GMC's request, considered (and approved) an amendment to the Medical Act 1983 to introduce changes to the functions of the GMC, including the ability to appoint more members to professional conduct committees and power to act on the suspicion of poor performance by temporarily suspending doctors from practice.[33] However, this is against a background of escalating workload: in 1993, the GMC received 1000 referrals or complaints against doctors but by 1998 this had trebled.[34]

The third test concerns accountability arrangements to the public and health service. In its proposals for the new Health Professions Council, the Government raises a fundamental question about this line of accountability:

> *... it is questionable how far the aims of improving public understanding and transparency are served if the Secretary of State answers to Parliament for the professions, but the professions report to the Privy Council.*[35]

It is hard to imagine any professional group arguing for the historical accident of accountability to a body as anachronistic and nominal as the Privy Council. But the nub of the issue is the implication that since the Secretary of State answers to Parliament, the professions should answer to the Secretary of State. The GMC argues that accountability to the public, via the democratic process, lies with Parliament rather than an individual Secretary of State.

LOCAL SELF-REGULATION

This is the second approach to professional regulation. Regulators have to justify their claims to protect the public by playing a part in local systems to identify and respond – quickly – to potential poor performance. With this approach, the regulatory bodies are only one stakeholder in a complex network of cross-professional and cross-agency approaches to public protection. The issue is no longer focused on the registration of the practitioner – rather, it is the speed and relative fairness of local action in the face of legitimate concern.

Provisional judgements – which may be sufficient to stop a practitioner practising – might be reached from any of a series of interlocking mechanisms that collate information on clinical performance. In such systems, great care will be needed to establish appropriate thresholds for legitimate action. However, appropriateness may be in direct proportion to the speed of decision-making required in order to protect the public. Can such a system be fairly devised?

Justice for the practitioner remains, with recourse to the higher standards of proof currently applied at the level of the national regulatory body. But there is a tacit acceptance that some practitioners may need to be taken out of frontline practice, even if their performance is later proved to be sound, in order to ensure a reactive system with an in-built bias in favour of public protection.

So what role would the GMC play? The answer is two-fold. First, through re-validation, the GMC will keep one of the central processes of information gathering and judgement within the control of the profession, while acknowledging that its findings will sit in the annual appraisal process alongside the assessments of colleagues in managerial roles. Second, the GMC will seek to influence implementation with its own standards and tests for these new emerging systems. Currently, this is in the form of a professional audit tool to help local stakeholders test their local systems.[36]

Both strategies seek to influence; both seek to establish the GMC in the new way of working. But ironically, the GMC suffers a similar dilemma to government: if it doesn't get involved, it will be viewed as out of touch. And by getting involved it risks being seen as the responsible body for the achievement of objectives that can lie only in the attitudes and decisions of others. This problem is acknowledged in the GMC's report on local medical regulation:

> *Our role is national and centrally-based. It is concerned with the regulation of the profession as a whole. However, the delivery of medical regulation – in other words, good standards of care and protection from unsafe practice – is, for most doctors, a local activity related to individual performance and conduct and usually subject to contractual arrangements.*
>
> *At a local level, we have no executive responsibility. However, if we are to fulfil our responsibility to foster good medical practice then we need to understand how local regulation of medical practice works. We also need to be assured that systems of local medical regulation are effective, both in promoting high standards of care and in identifying potential or existing problems with medical practice.*[37]

Whether in relation to revalidation or influencing local medical regulation, the GMC needs to avoid becoming a media scapegoat for cases of clinical poor performance or misconduct. Such a position would offer many opportunities for those who may have a desire to weaken (for ideological or political reasons) the independent professional power of the medical profession – symbolised and made manifest through the GMC.

Responding to this latest approach to re-designing the regulatory system represents a real challenge to GMC survival. The process of adaptation will be a very serious business and it is not only external predators that might encircle the GMC but the diverse centres of power within the medical profession itself. Political concerns about the boundaries between different types of medical bodies, both representative and regulatory, are not uncommon in other countries and the issue is highlighted in a recent King's Fund review of international approaches to medical regulation:

> *... with the move by the GMC towards the introduction of revalidation in 2001 there is a need for separate institutional contributions to form part of a single system rather than an unco-ordinated set of informal arrangements. For the UK this is sensitive and as yet uncharted political territory ...*[38]

INTER-PROFESSIONAL SELF-REGULATION

The third approach to changing regulation for health professionals centres on the arguments for regulating different health professionals together. There are three main reasons for a renewed emphasis on using this inter-professional approach to address regulatory re-design.

First, there is a need for a more rigorous regulatory system to show a consistent approach to different professions. Although changes to the Council for Professions Supplementary to Medicine (CPSM) and the United Kingdom Central Committee (UKCC) are similar, parallel structures will breed difference. From a consumer's perspective this may not be acceptable – as a recent consumer review of regulation suggested, '... such uni-professional incremental reform is unlikely to address the problem of inconsistency that currently typifies the policies of professional self-regulation'.[39]

Indeed, the consultants employed by the Government to provide the recommendations upon which current proposals are based themselves questioned this uni-professional inconsistency. As well as pointing out the irrationality of such a situation they stressed the positive benefits that joint regulation could bring: a sharing of experience, more cost-effective arrangements, as well as the advantages of greater clarity and impact with the public, the employer and other stakeholders. JM Consulting reached the following conclusion:

> *It is reasonable to ask why nurses, doctors and other health professionals should each have a different regulatory scheme. These professions work together in multi-professional teams and the public would expect common standards of protection to apply.*[40]

The second reason for looking to common regulation arises from the simple observation that it is the work of a team that often has the greatest impact on health rather than the actions of one individual. If work on regulation is to support the quality improvement and assurance of clinical teams, then joint regulation might be seen as a good starting point.

Third, joint regulation offers a political opportunity. The need to end what are seen as old-fashioned demarcation practices is viewed as central to the implementation of a plan for a more effective NHS – even with a rapidly expanding budget. Professional self-regulation stands in the way of such a strategy because it is a manifestation of independent professional power. Winning the argument on inter-professional regulation could be one way to undermine objections to changing the boundaries of inter-professional working.

All three reasons for change are evident in the Government's proposals for a UK Council of Health Regulators, but it is the use of joint regulation as a threat to independent professional power that leaves the strongest aftertaste. In the Plan, the following justification is made for the proposal:

> *... a UK Council of Health Regulators will be established, ... In the first instance the new body would help co-ordinate and act as a forum in which common approaches across the professions could be developed for dealing with matters such as complaints against practitioners. Were concerns to remain about the individual self-regulatory bodies, its role could evolve.*[41]

HOW DO APPROACHES TO CHANGE MATCH STAKEHOLDER CONCERNS?

The concerns of those with a stake in effective medical regulation are only partially met by any one of the three approaches to change (see Table 1).

Reform of the national regulatory bodies focuses on the decision-making capacity, efficiency, speed and transparency of the national regulatory body. Change may be required for the sake of achieving these ends – and change may allow the national organisation to play its traditional roles more efficiently. However, these changes will not of themselves allow the GMC, or any other regulator, to fully meet concerns of

Table 1

MODELS OF CHANGE ALONGSIDE COMMON AND SPECIFIC CONCERNS

	Approaches to re-designing the regulatory system		
Common and specific concerns	**Reform of regulatory body**	**Local self-regulation**	**Inter-professional regulation**
Context			
• Managing whole health care systems through the development of effective teams and organisational cultures	Little direct impact on clinical practice or health services	Sympathetic to whole system thinking	Offers a sympathetic perspective
Common concerns			
• Speedier action over concerns of poor performance • Effective local systems for assessing performance	Only if effective internal GMC governance is a prerequisite for future change	Real locus of activity for development of fast, local systems	Uncertain
Specific concerns (patients and public) • Public expectations of health care safety and regulatory responsiveness	May not be met by changes to regulatory governance	Would need to be addressed by an effective local system	Uncertain
Specific concerns (the profession) • Maintaining professional regulation as tenet of professional power	Yes	Would represent a sharing of power on the question of performance	Only if professional identity is re-defined

public safety and responsiveness – these can only really be met by an effective regulatory system rather than an effective uni-professional regulator.

The GMC is working at the interface between regulator and local stakeholders. It is proposing ways of auditing local medical regulation and attempting to establish the respective roles of managers, regulator and professionals in the interlocking systems of re-validation, appraisal, national audit and clinical governance. This approach to establishing local self-regulatory systems meets more of the common and specific concerns of those with a stake in a good regulatory system.

It is broadly more sympathetic to the organisational and team context for performance and performance assessment. It is more closely connected to the local intelligence where concerns about performance first surface and should be addressed. It also recognises that while there is an issue of professional power in the wider regulatory system – particularly when it comes to defining entry and exit from a professional register – the real issue of performance assessment has to be shared between the profession, day-to-day managers, patients and clinical teams.

The third approach to regulatory re-design takes an inter-professional view of regulation. Government currently threatens joint regulation as a way to proceed if the national regulatory bodies do not undertake sufficient reform. The development of performance data for clinical teams, the inspection of clinical teams by bodies such as CHI, the need for near misses to be investigated as system failures, clinical governance frameworks that stress partnership and organisational culture – all these approaches point towards teams rather than single professionals. However, approaches to joint professional regulation are still in their infancy – more the stuff of political bargaining than a real proposal. While this remains the case, it is hard to assess the extent to which real approaches to inter-professional regulation might address stakeholder concerns.

CONCLUSIONS: FUTURE CRISIS AND FUTURE CHANGE

All three approaches to re-designing the regulatory system will make their respective marks. They are all responses to genuine concerns. The national bodies have been slow and opaque in the way they address poor performance. And some local systems of managers and clinicians have allowed performance problems to continue unchecked.

Currently, plans to change the composition and governance of the regulatory bodies attract much attention. But an analysis of concerns suggests that the effective discharge of their statutory roles is only part – and probably the smaller part – of the problem. The real locus of concern and action needs to be in the local working environment, where the need to create a regulatory system across professions and organisations is driving together a whole range of initiatives: clinical governance; appraisal; re-validation; and the proposals outlined in the Chief Medical Officer's reports on supporting doctors[42] and developing an organisational memory.[43] These sticks of dynamite have been placed under local inaction and complacency but it is unclear what will happen after they blow.

When the dust settles the question is what role will the regulatory bodies and particularly the GMC have left? As re-validation, appraisal and audit coalesce, the role of local doctors in practice, in education and in management will predominate. Real responsibility and real decisions will be in local hands. If local processes pass basic hurdles of fairness and challenge then their recommendations will become strong enough to guide the GMC.

While the regulatory bodies have rightly been directed by both the Government and their own members to review internal procedures and practices, new local regulatory systems are incubating. When these new and inevitably complex systems emerge, a new form of regulation may eclipse old debates of professional ownership, and prompt new challenges to the accountability, speed, and transparency of the local networks necessary to assure clinical quality and professional practice.

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The war on waiting

The Government's pledge to reduce numbers waiting by 100,000 has – with difficulty – been met. Now, even more ambitious maximum waiting times targets have been set.

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Labour came to power pledged to reduce the numbers waiting for hospital treatment to a level 100,000 below the level they inherited from the previous government. *The New NHS: modern, dependable* added further targets for access times for hospital out-patient appointments for cancer patients and for extending the number of patients offered booked appointments. In the first part of this article, we consider how well the NHS has performed in relation to these targets.

Although the first of these was achieved by the time that work began on the NHS Plan, long before that there was general recognition that a reduction in the in-patient waiting list was not a sensible target to aim at in the first place. The emphasis on numbers was misplaced: the time spent waiting was more important. As the 100,000 target formed one of the 'pledges to Britain' made by the Prime Minister during the Election campaign, it was a commitment from which the Government could not renege until it was met. However, during the three years between publication of *The New NHS: modern, dependable* and the NHS Plan, some of the elements of a more sensible policy towards access to elective care began to emerge, albeit in a piecemeal way. We look at these in the second part of this article.

In the third part we describe the proposals made in the NHS Plan and assess their merit and their feasibility. We conclude with a brief discussion of the issues that remain to be resolved.

MEETING THE TARGETS, 1997–2000

Treatment

Although the numbers waiting for hospital treatment rose rapidly after the 1997 Election, they began to decline during 1998. That decline continued, albeit slowly, during 1999 and, by the end of March 2000, the Government was able to announce that the target of a reduction of 100,000 in the numbers waiting had been achieved. Within that total, waits over 18 months were virtually eliminated, but there were still around 50,000 waiting for over 12 months when the NHS Plan was announced.

The Government's success, however, was undermined by general recognition that the target it was pursuing was inappropriate. Both the medical profession and outside commentators argued[1,2] that time spent waiting was more important and that sticking to the targets risked distorting clinical priorities. By linking reductions in numbers with reductions in times, the Government quietly accepted this point, even though, as we have shown elsewhere,[3] these two aspects of waiting do not necessarily move together in the same direction.

Out-patients

The previous government had recognised the importance of waiting for an out-patient appointment and from 1995 onwards the numbers waiting at this point were recorded, albeit in an imperfect form. The numbers waiting over three months – the Patient's Charter target – rose sharply in the period 1997 to end-1999, at the same time as numbers waiting for hospital treatment were falling. In

March 2000, the numbers recorded as waiting over three months fell, only to show an increase by the end of June. On that date, 440,000 were waiting more than 13 weeks after a GP referral, of which 130,000 waited more than 26 weeks, compared with 402,000 and 132,000 in the previous quarter. The inference was obvious – gains at one stage of access were at the expense of losses at another. It was, therefore, not clear that access times overall had improved.

As noted already, the waiting list target was criticised for its emphasis on numbers rather than times and for its effect on clinical priorities. This criticism was partly met by the initiatives targeted on cancer, where delays may be critical to successful treatment. The 1997 White Paper gave a guarantee that everyone with suspected cancer would be able to a see a specialist within two weeks of their GP deciding that they need to be seen urgently, as follows:

> *... we will improve prompt access to specialist services so that everyone with suspected cancer will be able to see a specialist within two weeks of their GP deciding they need to be seen urgently and requesting an appointment. We will guarantee these arrangements for everyone with suspected breast cancer by April 1999 and for all other cases of suspected cancer by 2001.* [4]

Extra funds of some £10 million were injected into these services immediately and the process by which the target was to be met set out in the following year.[5] In September 1999, however, the Government announced[6] that the target should apply to all cancers, with initial emphasis on leukaemia, lung cancer and paediatric and adolescent tumours. £10 million was allocated from the Modernisation Fund to support projects designed to help achieve this target.

The initial pledge was followed up with the development of guidelines for referral. Those for breast cancer appeared first but a wider programme was instituted for other cancer sites. A Steering Group was set up in May 1999 and a series of working parties was established for each cancer area, involving a wide range of professionals. The draft guidelines were then circulated for consultation between November 1999 and January 2000.

During that process, doubts about the wisdom of the targets emerged. The published guidelines noted in their summary of the response to the consultation that:

> *Concern was expressed about the capacity of hospitals to respond to an overall increase in workload and the potential prolongation of waiting times for cancer patients referred non-urgently, and for those with problems other than cancer.*
>
> *These concerns highlight the need for an effective dialogue between primary care and secondary care regarding the appropriate referral of patients with suspected cancer. It is hoped that these referral guidelines will form the basis for such a dialogue.*[7]

Evidence emerged subsequently that the referral process was proving problematic. In July 2000 a report appeared in *Pulse*,[8] that suggested that between 30 and 60 per cent of breast cancer cases were not being referred urgently to breast cancer specialists within two weeks. In response, the Department of Health[9] said:

> *The survey in Pulse has identified that not all urgent cases are being picked up by GPs and therefore some women who should be seen within two weeks are having to wait longer. This demonstrates that it is vitally important for GPs to use the referral guidelines carefully. There should also be a clear dialogue between GPs and their local breast cancer specialists to support GPs in using the referral guidelines, getting the most urgent cases seen within two weeks. We will be carrying out a national audit of the referral process and will report back to cancer networks.*

Others argued that, yet again, this was the wrong target. An audit of times carried out in 1997, before the targets were formally introduced, found that over 70 per cent of patients had been seen within two weeks. But longer delays occurred further down the line during the diagnosis stage. In its critique of cancer research policy, for example, the Select Committee of Science and Technology[10] argued time from

symptom detection to treatment would be a better target (Recommendation 9b). Furthermore, hospital consultants argued that they were better at determining who was or was not urgent than GPs, who would see only a few cases a year of any given cancer.

Booked admissions

No precise target was set for levels of booked admissions in 1997. Instead the Government proceeded via a programme of experiment and collective learning. The National Booked Admissions Programme was launched in 1998. Twenty-four pilot sites were selected for a programme running from October 1998 to March 2000. The initial emphasis was on booking for day cases.

The second wave, running from 1999 to 2001, provided for replication of the experience of the 24 sites to 60 sites, 43 collaborative projects in nine cancer centres or networks and a programme of continuous improvement of booked admission in 19 sites.[11] The third wave,[12] running from 2000 to 2002, was intended to extend booking, with the aim of ensuring that all acute trusts had started to book day cases for at least two specialties or high volume procedures by March 2001. It also provided for the development of booking where it was already practised and for improvements to the process of care delivery for patients with heart disease. In April 2000 the Government announced that £40 million would be allocated to extending pre-booked appointments and operations to about 5 million people by March 2002.[13]

Supporting measures

Although achievement of the 100,000 target was the main focus of Government policy, it also instituted a number of other initiatives designed to improve access to treatment by supporting efforts to improve the organisation and management of the provision of elective care.

In 1998 the National Patients' Access Team was established, with three main roles in respect of waiting lists:

- *providing experienced, practical help for NHS Trusts and Health Authorities to achieve agreed reductions in in-patient, day case, and out-patient waiting*
- *identifying and disseminating good waiting list and elective care management across the NHS*
- *supporting NHS staff and patients to re-design and implement improved elective care through, for example, booking systems.*[14]

Much of the Team's work was carried out at trust level. Drawing on this work, in November 1999, it published a report on out-patient performance.[15] Its main conclusion was that out-patient management systems were archaic and needed updating – many were found to date back to the 1950s. The report was followed up in July 2000 with advice[16] as to how hospital trusts might improve the management of out-patient services and extend booking systems.

The NPAT also launched a series of initiatives bearing on particular procedures or specialties. The initial focus was on cataracts. In February 2000, *Action on Cataracts*[17] was published, which was 'intended as a toolkit to help staff locally to design and manage services better'. Other 'action on' projects include orthopaedics, dermatology and ENT. The Team also supported a programme of service re-design while the (separate) Waiting List Action Team[18] produced a guide to improving the processes by which patients gain access to elective care.

Managing the process

Soon after the publication of *The New NHS: modern, dependable*, the then Secretary of State made it clear, in a series of private meetings, to trust chairs and chief executives that they were required to meet the waiting list target. This message was reinforced by the introduction of financial allocations linked to waiting list performance. In 1998, part of the extra funds announced by the Chancellor for the NHS was allocated to the reduction of waiting lists.[19] In August 1999,[20,21] the waiting lists and times performance fund made available £30 million to 'reward good performance and tackle poor performance in reducing waiting lists and times'.

However, the Secretary of State also had to acknowledge that hospitals were experiencing other pressures, particularly during the winter months when demand for emergency beds was high. At national and local level, there had to be a balancing act between the two objectives of reducing numbers waiting and ensuring that everyone who needed treatment had a bed.

In an attempt to reduce this tension, hospitals were urged to reschedule their waiting list work away from the months of peak emergency demand and to adopt a series of measures to manage that demand better, including measures outside the hospital itself. Modernisation Fund monies were made available[22,23] to support measures introduced to cope with emergency admissions, e.g. for reductions in delays at discharge from hospital and the development of alternatives to hospital admission.

How effective all this activity was is impossible to say. With one exception, the Government did not institute any monitoring of the policies described here. The exception was booked admissions. A monitoring and evaluation programme was commissioned from the University of Birmingham, the first report of which was published in autumn 1999.[24] We draw on it below.

Overview

Earlier King's Fund work[25] argued that a better monitoring framework was required to assess the extent to which access to care was being improved. Unfortunately, official reporting of progress remains as limited and unsystematic as ever, making it extremely hard to determine what the impact of the Government's policies has been. In particular, the claims that clinical priorities were being systematically distorted by the need to meet the national targets went unexamined.

Furthermore, despite the pressure that the Government put on the service, it had found it hard to raise the level of elective activity significantly. Although the number of operations did increase substantially in 1998/99, the figures published in August 2000 indicated that the level of waiting list activity was no higher than in the corresponding previous year. As waiting lists fell during this period, the implication must be that this was achieved by further administrative culling of the existing lists and/or by reducing the numbers coming on from the out-patient stage.

On the plus side, progress had been made in improving the processes through which people gain access to care. But as the reports from the National Patients' Access Team, the Waiting List Action Team and the University of Birmingham state, a great deal remains to be done before the process of accessing elective care works properly. The University of Birmingham report concludes in the following terms:

> *To exaggerate only a little, if booking is to become the accepted way of providing care in the NHS, then major changes will be required in how consultants, nurses, managers and other treat patients.*[26]

The same message is implicit in the advice disseminated by the National Patients' Access Team and the Waiting List Action Team (see Box 1).

BOX 1: WAITING LIST ACTION TEAM HANDBOOK

Theoretically, the patient is at the centre of the treatment process. However, the reality can be quite different. Both NHS staff and patients can face a situation where:

- the treatment process is very complex
- the treatment process is managed by a number of agencies
- the way these agencies work internally is very complex
- the way these agencies interact with each other is complicated
- information systems are often fragmented and communication with the patient deteriorates
- perverse incentives can come into play.

Source: Department of Health, NHS Executive. *Getting patients treated: the waiting list action team handbook*. London: DoH, 1999: 20.

THE NHS PLAN

The NHS Plan[27] sets a series of commitments to reduce the times people spend waiting for treatment:

BOX 2

By the end of 2005:

- waiting lists for hospital appointments and admission will be abolished and replaced with booking systems giving all patients a choice of a convenient time within a guaranteed maximum waiting time. As a first step towards this all hospitals will by April 2001 have booking systems in place covering two procedures within their major specialties
- assuming GP referrals remain broadly in line with the current trend in the growth of referrals, then the maximum waiting time for a routine appointment will be halved from over six months now to three months – urgent cases will continue to be treated much faster in accordance with clinical need. As a result of delivering this policy we would expect the average time for an out-patient appointment to fall to five weeks
- the maximum wait for in-patient treatment will be cut from 18 months now to six months. Urgent cases will continue to be treated much faster in accordance with clinical need. As a result of delivering this policy we would expect the average time for in-patient treatment to fall from three months to seven weeks.

Source: Secretary of State for Health. *The NHS Plan: A plan for investment, a plan for reform*. Cm 4818-1. London: The Stationery Office, 2000.105.

The Government believes, drawing on the evidence of the patient survey carried out prior to the announcement of the Plan, that people dislike waiting for care. The report of the public consultation states that seven out of ten people think waiting lists and waiting times are too long. These findings are confirmed by the first NHS National User Survey[28] and other results (see Jo-Ann Mulligan's article on pp.15–16).

THE RIGHT TARGETS?

The way the targets have been set indicates that the Government has learned from its experience with the Election pledge, i.e. it is time spent waiting not numbers waiting that count. Whether it is has fully learned that lesson is not clear. The text of the NHS Plan refers to 'all stages of waiting' but elsewhere this appears to refer only to waiting for an out-patient appointment or for treatment, i.e. it is not defined so as to include the whole care pathway. So whether delays during the diagnosis stage will be targeted remains unclear.

The commitment to an extension of booking should be beneficial to users, for whom the certainty that booking offers is undoubtedly a benefit.[29] But it raises issues for the management of hospital services as a whole. The Plan, following the University of Birmingham analysis, argues that the widespread introduction of booking will in itself be a catalyst for reforming the processes involved in the provision of elective care. Whether that holds true remains to be seen. But it presents management difficulties for hospitals, which still have to cope with variations in emergency demand. Given the modest initial targets set for the extension of booking, this difficulty will take some time to make itself apparent, but if it does become the normal way of working, then the trade-off between offering certainty to elective patients and the quality of hospital care for emergency patients will become apparent.

ARE THE NEW TARGETS ACHIEVABLE?

The Government has allowed a substantial period of time for the achievement of the new targets. But the Plan gives no data on the expected cost of meeting them, nor the volume of the extra activity that the Government thinks will be required. Can they in fact be achieved, even within the relatively long timescale?

DEMAND

The Plan notes that the targets are attainable given the continuation of current trends in referral. But the greater the success in moving towards the target times, the less likely the assumption is to hold.

As we argued elsewhere,[30] the historical evidence shows two things. First, as waiting times shorten, more people seek treatment, more

are referred by GPs to hospital out-patient clinics and more are accepted for treatment. In particular, if NHS waiting times fell drastically, some people would use the service instead of the private sector. That could increase demand for operations like hip replacements, many of which are currently provided privately. As the Plan recognises, waiting in other words acts as a barrier to entry – in effect a rationing device that reduces the demand for care, rather than just delaying access to it. However, it does not indicate how large the Government believes this effect to be.

Second, new procedures are continually being introduced. These increase the number of treatments carried out and, where they are less invasive, the number of people benefiting from them. The Plan contains no explicit allowance for this effect, which may itself also depend to some degree on the availability of resources for elective surgery, i.e. if waiting times do come down for existing procedures and more resources become available for elective care, the case for introducing procedures on an experimental basis or developing new ones may seem all the stronger to those in a position to do so.

Furthermore, the more the Government quite rightly pushes to eliminate differences in the degree of access enjoyed by different groups of people, the more as yet untapped areas of need will be identified. A good example here is the low rates of heart surgery in some parts of the country relative to those living near major treatment centres,[31] but there are also variations in access to more routine treatments: *Action on Cataracts*, for instance, points out that activity needs to be increased substantially in some areas to make up for the low levels of the past.

The scale of these effects cannot be predicted with confidence. The Government has commissioned no research into the responsiveness of referrals from GPs to the length of time people spend on the waiting list. But even if the results of such research were available, it would remain impossible to predict what new medical techniques will become available in five to ten years' time and how many people will be able to benefit from them. The number of operations currently carried out is much higher than ten years ago, but the numbers waiting have gone up all the same. It is not a matter of catching up on a backlog – more of trying to reach a target that is itself moving.

Two things follow from this. First, elimination of waiting implies that a substantial increase in the number of operations will have to be sustained indefinitely. In Scotland, for example, where waiting times are on average lower,[32] the level of activity is substantially higher.

Second, the Government cannot know exactly what it is committing itself to if it takes on a commitment to reduce waiting to three months simply by paying for more operations. If demand proves unresponsive and if new clinical developments are modest, then it will be quickly achievable. But if these effects prove to be significant, as they may well do, it will find that the target proves elusive.

Increasing supply

We have already indicated that the growth of elective activity has slowed down. If the targets are to be met, the rate of growth must be increased.

In the first instance, much can be done to reduce waiting at very low cost. Better organisation and scheduling of testing and diagnosis or the offer of alternative treatments, such as physiotherapy for those waiting for orthopaedic care, can all contribute to reducing waiting times and in some cases costs as well. The measures promoted by the National Patients' Access Team mentioned above have been largely of this kind and, as we have seen, by historical standards, the volume of effort devoted to improving the process of care delivery is very high.

Even if these efforts are successful, however, some extra resources will be required if extra activity is to be carried out – particularly theatre and operating time, along with the associated support services. The Plan indicates in general terms that more resources will be available to

hospitals but not how they will be allocated to particular categories of work. But as John Yates has pointed out,[33] the productivity of orthopaedic surgeons and their teams has been falling in recent years. In the two regions he studied, one-fifth of surgeons were operating below the minimum recommended by the British Orthopaedic Association. By using existing theatres for more of the day and by persuading surgeons to operate for more sessions, a large increase in output could be achieved within existing physical and human resources. Even so, extra expenditure will be required.

The Plan does, however, propose dedicated centres carrying out only waiting list cases to be built and operated in conjunction with the private sector:

> *4.8 ... In partnership with the private sector we will develop a new generation of Diagnostic and Treatment Centres to increase the number of elective operations which can be treated in a single day or with a short stay. These Centres will separate routine hospital surgery from hospital emergency work so they can concentrate on getting waiting times down. As a result of this NHS Plan there will be:*
>
> - *20 Diagnostic and Treatment Centres developed by 2004. By then, 8 will be fully operational treating approximately 200,000 patients a year.*[34]

In principle, these centres would avoid the interruptions from emergency work that leads to cancellations and hence in themselves can be welcomed. Even if the eight centres are operational by 2004, it is clear that their direct impact will be limited – 200,000 operations represents only a few per cent of the current total. However, they would offer the opportunity to re-think working practices, to modify contracts, particularly those of surgeons, and to modify the mix of skills employed, such as using nurses for some anaesthetic procedures. In this way, they may be able to promote a form of competition with existing trusts.

But the emergency side of the hospital would still require the capacity and flexibility that the availability of surgical beds – and, more importantly, the nurses who staff them – currently provides to deal with winter peaks in demand. So additional resources would be needed here as well unless other measures proposed in the Plan, such as the expansion of community-based measures, reduce the extent of those peaks.

There would be wider implications if the proposed centres took on a major role or, if resurrecting further the internal market, existing hospitals with efficient delivery processes were encouraged to carry out more work. The centralisation of work would mean people had to travel further to be treated. In the early 1990s, specialist treatment centres were set up in Wales to drive waiting lists down.[35] But they found it difficult to attract patients because of the travel costs. Experience in England[36] shows that many people would travel to avoid waiting, provided the travel was 'part of the package'. That would imply the NHS organising and paying for it.

But if patients did travel in this way, the effect would be to further undermine the local hospital. There is already pressure to move emergency work away from smaller district general hospitals. Significant transfer of elective work would add to the case for closure which, as the recent demonstrations at Kidderminster and elsewhere show, is likely to be strongly resisted. What looks like a popular policy may turn out to be politically unattractive when its implications become apparent.

OUTSTANDING ISSUES

The Plan acknowledges that it is important, despite the hope that long waits will be eliminated, that clinical priorities are respected. However, it sets out no plans for their better determination. Unless this is done, the risk remains that the achievement of maximum waiting times will be achieved only by deferring the urgent for the less urgent, particularly if shortening of the lists and reduction in waiting times encourage those with less urgent or serious

conditions to come forward for treatment. The only way to limit the risk of this is through the introduction of referral guidelines and treatment thresholds. Here NICE has made a start with the production of reference cues.[37]

Second, the focus on those waiting neglects those who never join the queue. Some patients are identified late, even for common conditions such as cataract, partly because they are reluctant to come forward and partly because their GPs do not recognise the severity of their condition. The NICE programme of work on referral criteria will help, but it will be some time before all the most important conditions are covered in this way and longer still before they are followed in practice. If, as the Plan confirms, the Government remains committed to both equity of access and a reduction in health inequalities, these broader questions will have to be addressed.

Finally, as Justin Keen points out elsewhere in this issue, the broader equity posed by the co-existing of short waiting times for privately paid for treatment and, even if the Plan targets are set, those in the publicly financed NHS, remains unresolved.

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Reforming long-term care finances: a continuing saga

Not all of the Royal Commission's recommendations have been accepted; it remains unclear what support younger generations can expect when they are old.

Janice Robinson

LONG-TERM CARE FUNDING AS A LONG-STANDING PROBLEM IN COMMUNITY CARE

Throughout the history of community care, governments have wrestled with two major problems concerning the organisation and funding of services. First, it has proved difficult to achieve integrated care and support for individuals when responsibility for service delivery lies with different agencies. Second, having two distinct funding systems – where NHS services are free at the point of delivery and social care services are means tested – has led to inequity and inefficiencies in community care. This dual system of funding has disadvantaged people with chronic illness and long-term disability. It has also been confusing to operate, as it has often been difficult in practice to distinguish health from social care. Furthermore, the system has contained perverse incentives for the NHS to engage in cost-shunting and for local authorities to continue to place large numbers of older people in care homes – despite policies intended to maintain people in their own homes as far as possible.

Difficulties created by the funding system have led to disputes between care organisations and legal challenges on the part of service users. They have also hindered the partnerships required to achieve service integration. However, as the story of long-term care funding shows, efforts to reform the funding system have been conducted separately from policy developments designed to achieve better service integration. The failure to link these two aspects of policy has led to much frustration on the part of governments (who have tended to blame local agencies for poor services) and of health and local authorities (that have had to work within a disjointed policy framework).

As the following account shows, the continuing saga of long-term care funding has featured:

- increasing demands for the reform of a system that has its roots in the post-war settlement governing health and welfare services
- a determination by the Labour Government to create a better system of funding long-term care, culminating in proposals for change that failed to address major shortcomings in the current system
- mounting calls for a clarification of the respective rights and responsibilities of the individual and the state in funding the care and support required in old age.

THE DEMAND FOR REFORM

Demands for the reform of long-term care finances have been building up over a decade or more. The dual funding system has its roots in the 1940s legislation that created the National

Health Service, and a system of national assistance and income support for people who could no longer look after themselves because of increasing frailty. Various finance problems arose early on, with the implementation of policies designed to re-settle residents of long-stay hospitals into the community. But public discontent with the funding system increased dramatically in the late 1980s and early 1990s. The law relating to the funding of long-term care had not changed since the original post-war settlement, but conditions in the NHS and in local government had changed in ways that increasingly placed the costs of long-term care on service users and their families.

During the 1980s, hospitals were under pressure from government to become more efficient, managing higher volumes of patients by achieving faster bed throughputs. This could not be achieved while older people with chronic conditions, who needed longer periods of time to recover, occupied a high proportion of beds. It was at this time that the NHS began to divest itself of 'continuing care' beds and to direct older people towards residential care or nursing homes. This shift was possible because changes in social security had made available benefits that could be used by residents to defray the costs of living in a care home. The uncapped social security budget, with the expanding market for residential care, resulted in a dramatic growth of care homes in the independent sector. Fears about uncontrollable public expenditure were then played out in subsequent reforms of community care.

The NHS and Community Care Act 1990 was intended to contain the high level of expenditure on residential care. It made local authorities responsible for allocating public money on a means tested basis to individuals assessed as being in need of care and support. In the process of these changes taking place during the 1980s and 1990s, health care needs had been redefined, by default, as social care needs. Increasing numbers of people found themselves being moved out of free hospitals and into means tested care homes. Despite the legislation, the incentives remained for both the NHS and local authorities to move people into care homes. NHS costs were moved on to another sector and the net cost to local authorities was lower than the comparable costs of providing care in people's own homes (because of the income generated from house sales).

The requirement to take the value of assets into account when applying the means test for residential care had been a feature of the original post-war settlement. However, with greatly increased home ownership by the 1990s, the requirement was affecting more people than ever before. This was at a time when the then Conservative Government had been encouraging home ownership and extolling the benefits of wealth being passed down through the generations. A public furore ensued with much talk of older generations being 'betrayed' and younger generations robbed of their inheritance. It was also during this period that local authorities routinely began to levy means tested charges for home care and other services. This was in response to pressure from the Government to raise more income from service users to augment funds raised through taxation.

Despite Government efforts to clarify NHS responsibility for 'continuing health care', disputes about the respective financial responsibilities of the NHS and local government continued to take place. There was also increased litigation on the part of disabled people of all ages, who challenged the legality of costs falling on them. By the mid-1990s, neither the Government nor the public was happy with a system of care that was very expensive, but which was failing to use resources efficiently and effectively. In view of the widespread disquiet about long-term care, it is perhaps not surprising that various inquiries were mounted to consider the matter.

A wide range of problems surrounding the provision and funding of long-term care were aired by the House of Commons Health Select Committee in 1995/96,[1] and by the Committee of Inquiry set up by the Joseph Rowntree Foundation[2] in the same year. By the time the Labour Government came into power in 1997, it

had promised to sort out the system that was attracting so much criticism.

NEW LABOUR'S APPROACH TO COMMUNITY CARE

At the beginning of its term of office, the Labour Government made it clear that it was resolved to tackle problems concerning both service integration and the funding of long-term care. In line with a pledge it had made in its manifesto, it set up a Royal Commission to consider the future provision and funding of long-term care. It then proceeded to 'break down the Berlin Wall dividing health and social care' by requiring the NHS and local government to work in partnership. In the NHS Act 1999, both were given a statutory duty to collaborate in planning, commissioning and providing services. They were also given new freedoms to pool budgets and to delegate responsibility to lead agencies for commissioning or providing particular services.

The Government's plans for improving the way health and social services worked together were laid out in its White Paper *The New NHS: modern, dependable*.[3] No mention of long-term care finances was made in this document. The scene was set for developing organisational and managerial solutions for the problem of service fragmentation, while ignoring the underlying problems caused by the dual finance system.

The Royal Commission duly delivered its report on time at the beginning of 1999, recommending (among other things) that personal care provided in all settings should be made free at the point of delivery, bringing it in line with the funding of nursing and medical care provided by the NHS.[4] It was some 18 months later that the Government gave its formal response to the Royal Commission's report.[5] This delay – portrayed by the Government as perfectly normal – frustrated many campaigners and others who had supported the Commission's recommendations. It also increased suspicions that the Government was experiencing problems in deciding what to do or – as time went on – that it had already decided not to accept some of the key recommendations of the Commission.

The Government put forward its own proposals for change in the funding of long-term care at the end of the Parliamentary session in summer 2000. It did so on the same day that it announced its much-heralded National Plan for the NHS.[6] In the press, immediate reactions to its long-term care proposals contrasted markedly with those relating to wider changes in the NHS. The latter attracted a good deal of support from health professionals, patient and consumer groups, and from independent commentators, even though some reservations were expressed about the feasibility of achieving many of the improvements in the time suggested. In contrast, the long-term care proposals were widely criticised and were greeted with varying degrees of disappointment.

The Government made no claims that its proposals represented a radical reform of a system that was widely regarded as confusing, unfair and inefficient. Instead, it presented its proposals as targeting some of the most problematic aspects of the current system. This amounted to:

- removing one of the most glaring anomalies by making nursing care free in residential settings (as it is in hospitals or in people's own homes)
- reducing the costs falling on less well-off individuals by increasing the capital limits that determine who is and who is not expected to contribute towards the cost of their care
- delaying the point at which the value of a person's home would be taken into account when calculating the contributions to be paid towards residential care. Thus, for the first three months in a care home, the value of a resident's home would be disregarded from the means test
- reducing variations in the charges made by local authorities for care provided in people's own homes
- preventing unnecessary use of care homes by investing in prevention and rehabilitation

services that enable more people to remain in or return to their own homes.

This amounted to tinkering with a flawed funding system by changing some of the rules governing the means test and the levying of charges, while leaving the basic principles and structures essentially untouched. The refusal to remove personal care from the means test (as recommended by the Royal Commission) revealed a disinclination to create a fair and transparent system that would cease to penalise people with chronic ill health and long-term disabilities. Furthermore, the proposal to review private insurance and savings products for people 'who may continue to worry about possible care costs' constituted a failure to remove the uncertainty regarding protection for individuals against the future costs of care.

A CLOSER LOOK AT THE REFORMS

The Government maintained that it had had to choose between making personal care free for all or improving services. It claimed that the costs of the first would use up all the money it had found for the second. No argument was put forward as to why it was neither desirable nor practicable to fund both – something that had been discussed quite openly in the Minority Report of the Royal Commission. Certainly it is not self-evident that these two options are alternatives, where a choice has to be made between resourcing one or the other. No such choices had been made in the NHS Plan, for example, which showed how millions of pounds would be used to improve health services and how this would be done without expecting people on higher incomes to contribute towards the cost of their care through private insurance, charges and the like.

In the absence of any explanation by the Government, it has to be assumed that it was seen as reasonable to leave all but the poorest paying towards their care, while making a gesture towards those whose assets are at the threshold that triggers the means test. Were assumptions being made that demand would increase dramatically if personal care was made free or that families would stop supporting their relatives and opt for 'free' care? What was the philosophical basis underlying the continuation of a system that so clearly failed to pool the risks associated with chronic ill health? Whatever the thinking behind the decision, it was clear that the Government believed that free personal care was not affordable either now or in the future – at least when assessed against competing demands on the public purse.

Some of the proposed measures were an improvement on the current system, while others represented little or no advance.

A FAIRER SYSTEM?

The proposal to reduce variations in the charges made by local authorities for home care was welcome. It represented a clear recognition that it is no longer possible to justify the fact that people in some parts of the country are paying very high charges, while others elsewhere are paying little or nothing. However, it remains to be seen what levels of charges the Government will regard as reasonable, and who will be the winners and losers as the range of charges is compressed.

Other measures made little change to perceived inequities in the system. Thus, there was no indication that changes in the means test would benefit substantially low income or middle income groups. Researchers studying the reform of the means test[7] had calculated that the poorest groups would benefit most if more of their income (rather than capital) was disregarded. Middle income groups and house owners would benefit if savings and capital limits were raised substantially. None of the rule changes proposed revealed any attempt to target resources on the least well off. Furthermore, the proposal to increase the upper capital limits from £16,000 to £18,000 was insufficient to achieve any substantial reduction in the number of people having to pay the full cost of their care.

Last, the decision to maintain the means test for personal care meant that people with chronic and acute health conditions would continue to

be treated differently. Those with chronic ill health and disability – who need help to eat and drink, to wash and use the toilet – would still be expected to pay towards their care.

A more transparent system?

Making nursing care free in all settings would, in principle at least, result in the division between means tested social care and free health care being simpler and easier to understand. However, in practice, distinguishing nursing care from personal care is likely to result in continued confusion.

A more efficient system?

In terms of perverse incentives causing inefficiencies in the system, the proposal to disregard house values during the first three months in a care home would do much to prevent premature decisions to sell property and to enable individuals to return home after a period of recuperation and rehabilitation. This change addressed a key inefficiency in health and social care, whereby authorities have made increasing use of expensive residential long-term care and have neglected to develop shorter-term options designed to promote independence.

The Government claimed that the introduction of free nursing care in nursing homes would remove the perverse incentive for the NHS to discharge people too early into care funded by social services. That remains to be seen, for much will depend on the definition of nursing care, where the costs of such care fall within the NHS, and the trade-offs that hospital trusts are willing to make in order to reach their waiting list targets. Equally, a new perverse incentive may have been introduced, which will encourage care agencies to exaggerate the dependency of residents and to provide more of the drugs, therapies and equipment than may be needed. Meanwhile, the perverse incentive for local authorities to place people in care homes will persist as long as people's savings and assets can offset so much of the cost.

Better services?

The decision to commit more funding to improve services was a clear advance on the current situation. Previous inquiries into long-term care had been unanimously critical of variations in the availability of services and of poor standards of care in both residential and domiciliary settings. The Government had, in fact, already set in train a number of measures designed to improve community care services. These included the development of National Service Frameworks for Mental Health and for Older People's Services; the creation of long-term care charters setting out standards that service users could expect of local services; new arrangements for regulating residential and home care; and a requirement on the NHS and local authorities to show how rehabilitation services for vulnerable people would be developed in their joint investment plans. However, the proposal to allocate £900 million over three to four years to rehabilitation and related services to promote independence and improved quality of care for older people meant that investment plans for service development could be implemented.

All in all, though, proposals to change the funding system (as opposed to the amount of funding) constituted only a rather modest step forward. The refusal to make personal care free has only served to reinforce the battle lines around long-term care. A stand-off had been reached, reflecting the lack of consensus about public expenditure on (mainly) older people and about the respective rights and responsibilities of citizens and taxpayers in an ageing society.

Time for a re-think?

Given that the problem of long-term care funding looks set to continue, the quest to find a solution that will attract widespread support becomes all the more urgent. In this respect, it would be helpful to re-examine some of the assumptions influencing decisions to reform the funding system.

First, the policy requiring people with means to pay towards the cost of their care is presumably

based on the assumption that the 'better-off' can pay and experience no hardship in doing so. This requires further scrutiny in order to reveal the facts of the matter. Several public opinion surveys show widespread acceptance and approval of the better-off paying towards their care. However, it is not always clear whom the public regards as being better off (or indeed whether they count themselves as among that section of society who should pay for care). Furthermore, there is a great deal of ignorance about the relatively low levels of savings and assets that result in people having to pay the entire costs of care themselves. Few people know that the means test is applied to people who would not normally be regarded as particularly well off. For instance, people owning a house worth £16,000 or more can expect no public funding to help with the costs of their residential care. Support for the current system might be very different if there was increased public understanding of where and how the means test is applied.

Very little is known about the hardship experienced by people compelled to pay for their own care. Small-scale studies have shown a surprising range of health and social care goods and services being purchased in part or full by people with long-term care needs.[8] These studies show that the people concerned resent having to pay for essential elements of care, running down their savings and using modest incomes derived from pensions and welfare benefits. However, comparatively little is known about the financial hardships that result and the aspects of domestic and social life that have to be foregone. Increased understanding of the financial disadvantages associated with chronic ill health might well increase support for a funding system that more effectively pools the risk.

Second, some new insights into the reform of long-term care finances might be gained by stepping back from the narrow world of health and social care and examining the wider welfare state. All critiques of long-term care funding have assumed that the problem is essentially one of the fit between free health care and means tested social care. All efforts to solve the problem have centred on moving the boundary between the two and changing the rules governing the means test.

This approach takes no account of the impact and inter-relationship of other policies such as pensions and income support. Policy decisions related to these areas have a direct impact on people's ability to pay for their own care, and on the provision they are able and willing to make to cover the potential future costs of care that might be needed in old age. There are real questions as to whether policies designed to increase low incomes through the Minimum Income Guarantee, or through stakeholder pensions, are effective means of protecting the poorest groups of older people. Consideration also needs to be given to the trade-offs that occur as public expenditure is transferred from one sector to another – as when benefits funded by the Department of Social Security are transferred to the NHS or local government to offset the costs of long-term care. Greater understanding is needed of how the whole system works, and how decisions in one policy area have a knock-on effect elsewhere. This would provide better insights into the total costs of financial support for people with long-term care needs and the merits or otherwise of increasing public expenditure in the different funding streams. It would also indicate whether it would be more cost-effective to invest more in some services, such as health and housing, in order to reduce expenditure in others, such as social care.

HOW WILL THE STORY END?

The Government's plans for reforming long-term care funding have barely begun to address major shortcomings that were exposed by the previous committees of inquiry. If the proposed new arrangements are implemented unchanged, the system will continue to be complicated and confusing, both for service users and their families, and for staff assessing need and providing services. Major inefficiencies will also remain, stimulated by incentives to make greater use of high-cost institutional care than is necessary or desirable.

The future management of this system does not look bright. First, the distinction between nursing and personal care is by no means clear and attempts will have to be made to identify tasks that can be undertaken only by a registered nurse (or delegated and supervised by her) and those that can be undertaken by a care assistant. The Department of Health can be expected to issue guidance on how the means test should be applied, and on how people should be charged for aspects of care that may change on a daily or weekly basis as their own health fluctuates. But whatever happens here, stories of absurd bureaucracy and distressing, undignified procedures are likely to be featured in the press, fuelling pressure for further reforms.

NHS and local authority partnerships will continue to have to administer a dual funding (and charging) system. The difficulties in doing that will not be resolved by compelling organisations to pool their budgets nor by creating new integrated care trusts, as suggested in the Government's NHS Plan. On the contrary, these problems will merely have to be managed by the organisations concerned, as they strive to create better-integrated services.

However, another scenario may unfold. The Government has yet to flesh out the detail of its proposals and to show how the new arrangements will work. Primary legislation will need to be passed before free nursing care can be provided in care homes. There is still scope for critics of the Government's plans to challenge and to lobby for detailed amendments. It is not too late to take a fresh look at long-term care funding and to identify ways forward that are capable of commanding widespread support.

During the course of 2000 and beyond, there will, no doubt, be further scrutiny of the Government's proposals examining how far the new arrangements meet the concerns of different interest groups, how far they are sustainable in the longer term and how they fit with other changes in the wider welfare state (such as pensions and income support). This, in turn, will stimulate further debate and various forms of lobbying aimed at influencing the Government's plans. Opportunities to voice critiques of the proposed new arrangements will be grasped every time a new measure related to long-term care is announced, such as the White Paper on the quality of social care, new guidance on eligibility criteria and charging for social care, and the introduction of a National Service Framework for Older People' Services.

The story of reforming the funding of long-term care looks nowhere near to coming to a satisfactory end. The Government, like others before it, does not appear to have resolved fundamental tensions in the system. Furthermore, it has not answered those critics who believe the system is unfair to the current generation of older people and unclear about the preparations that younger people should make for care they may require in their future old age.

Given the uncertainty and controversy surrounding the funding of long-term care, it would be helpful to both critics and supporters of any new settlement if the Government were to clarify the rights and responsibilities of individuals to make provision for the care and support they may require because of long-term illness or disability. This statement should also set out what can be expected from the state or other collective provision designed to pool risks across the population. It would be all the better if any re-stating of these rights and responsibilities were to take place within the context of a new social compact for old age. Not everyone will like what they hear, but younger generations would be clear about what to expect and what will be expected of them.

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Managing the NHS

The Government believes the 'third way' outlined in the NHS Plan will solve problems of NHS management. But can lasting change be achieved without a genuine understanding of the varied structures of the service?

David J Hunter

INTRODUCTION

A constant theme running through successive NHS reorganisations from the mid-1970s has been the search for improved management.[1] All governments have wrestled with the dilemma of how most effectively to manage what is possibly the most complex public service organisation in the world. Employing around 1 million people, the NHS is certainly one of the largest organisations to be found anywhere. It is also one of the most centralised and hierarchical.

The management dilemma remains unresolved, although the Government believes it may have found a solution. This is outlined in its Plan for the NHS published in July 2000, in which it is claimed that neither a command and control model on the one hand nor market fragmentation on the other works. In their place, the Government proposes a 'third way' where 'intervention is in inverse proportion to success'. In practice, this means that central intervention will be progressively relaxed as NHS organisations demonstrate improved performance. Persistent failure, on the other hand, will be 'rewarded' with a significant degree of intervention from Whitehall. However, whether this represents a realistic way forward or is likely to result in elaborate 'gaming' by managers and others in order to achieve centrally imposed targets is open to question.

The NHS represents a particular management challenge because, for all the Government's efforts at branding the NHS as a national service, it is not a unitary organisation. Those employed in it belong to one of many professional groups, or tribes, each with its own particular culture and set of values.[2] In the case of clinicians, the most powerful tribe, their relationship with the NHS is a peculiar one. They are less a part of, and more apart from, the organisation that they effectively dominate and in which most spend their professional lives. Many resent the intrusion of management into the clinical domain, which they see as denying them access to resources or preventing them from practising as they think appropriate.[3]

Over the years governments of all hues have experimented with various management fads and fashions, ranging from consensus management, in vogue during the 1970s, to general management in the 1980s. At times, a strong central pull has been evident; at other times there have been moves to decentralise managerial authority and place it with those charged with providing local services. Both these countervailing forces are evident in the switch of Government in 1997. This article documents the nature of the shift in management style that followed the election of a Labour Government in May 1997 and considers whether the NHS Plan marks a change of direction.

CHANGE OF GOVERNMENT

The outgoing Conservative administration had since 1989, when it first proposed its internal market changes, been determined to devolve management responsibility so that the NHS would become more responsive to local needs

and preferences. The Government was ideologically opposed to state monopolies and sought to apply the disciplines of the marketplace and competition to the public sector. Some years earlier, as a result of the Griffiths management changes, the NHS Executive had been established with its headquarters located in Leeds. Although not a 'next steps' agency in the manner of the Benefits Agency, remaining instead an integral part of the Department of Health, it was an attempt to place at arm's length the operational management of the NHS. An NHS chief executive was appointed to lead the new organisation and contribute to policy and strategy at the Centre.

Although the Conservative Government had no desire to micro-manage the NHS and was generally content to leave its detailed operation to those who knew the business best, Ministers could not avoid being sucked into a series of high-profile political issues, ranging from rationing health care to rationalising acute hospital services in London and elsewhere. Given the structure of the NHS, with its firm emphasis on accountability upwards to Parliament, there were strict limits in practice on how much devolved responsibility could be tolerated, especially if a consequence of this was greater variation and diversity in the availability, and sometimes the quality, of care.

NEW LABOUR, NEW MANAGEMENT

Labour entered office impatient to act after 18 long years in opposition. Public concern about the NHS and its alleged mismanagement had been a key factor in Labour's electoral victory. The ill-advised Election pledge on waiting lists became a big stick with which to beat the NHS and its recalcitrant managers and clinicians.

It was not long before Labour Ministers revealed their programme for modernising the NHS. The Government asserted that it did not want another 'big bang' style reform because it acknowledged that those working in the NHS had had enough of this approach. What transpired, however, came perilously close to being a 'big bang' in all but name.

The Government claimed that it was seeking a 'third way' in NHS management – neither a return to the hierarchical command and control style of the 1970s nor a continuation of the competitive, quasi-market approach introduced by its predecessor. Rather, it favoured partnership, a collaborative approach based on networks. However, in practice the Government's style has come to resemble the top-down approach it allegedly rejects. The contradiction has been a source of puzzlement and confusion for those within the NHS. The NHS Plan seeks to soften the hard-line centrist approach by favouring a system of 'earned autonomy' whereby those organisations that perform well will receive light touch monitoring by the Centre. However, as is argued below, such a system may unwittingly create a perverse incentive and encourage sophisticated gameplaying as well as diverting managers' attention away from the core business of preventing and treating disease.

More than any other government since the 1970s, this administration has proved to be the most managerial and technocratic. Ministers, including the Prime Minister, speak the language of management even if they do not fully understand it, and have virtually no experience of managing a large complex undertaking.

It is a common failing, too, that new governments, especially those inexperienced in governing and running big departments of state, invariably fall into the trap of believing that Whitehall is akin to a large signal box stuffed full of levers: all a Minister has to do is pull the appropriate lever and the managers and practitioners on the frontline jump to attention and obediently change course.[4] All governments, sooner or later, come to understand that the real world is considerably more complex and that, far from being in control, Ministers and civil servants are invariably the captives of the services they oversee.[5]

This leads to a curious paradox. Charges of Ministers acting like control freaks may be well-founded if judged by the rhetoric and symbolic

posturing, but should not be confused with securing compliance on the frontline or the untrammelled ability of Ministers to effect change. Clinicians do not see the world in the way Ministers or managers, as the agents of Ministers, do. And there's the rub, for Ministers and managers are not well placed to redirect the activities and preoccupations of clinicians if those clinicians are disinclined to oblige.

When Labour's health policy was revealed in its white paper, *The New NHS: modern, dependable*, published in December 1997, there was general support and enthusiasm for the modernisation proposals. The emphasis on improving health and on narrowing the health gap was especially welcome, as was the stress on partnership working and on the removal of the worst features of the market type changes introduced by the preceding Conservative Government, which had led to dysfunctional, competitive behaviour by hospital trusts and fragmented services. There was support, too, for the emphasis on primary care and the attempt to manage this sector in a way that had not hitherto been attempted. Whereas GP fundholding had offered incentives to individual doctors, the creation of primary care groups and, in time, trusts is designed to change the culture in general practice and encourage a more corporate approach.

THE END OF THE HONEYMOON

The honeymoon with the Government, and the goodwill towards it evident among almost all who work in the NHS, is now largely over. There is little dissent over the strategic direction the Government has set, over the assault on the health gap between rich and poor, and over its diagnosis of the NHS's ills. All these features have been widely welcomed and supported. But it is the manner in which the Government has chosen to prosecute the change agenda that is giving rise to concern among clinicians and managers. The top-down, command and control style of the Government began to assert itself shortly after the appearance of the White Paper but became especially evident with Alan Milburn's appointment as Secretary of State for Health in October 1999.

MICRO-MANAGING THE NHS

Far from managers being empowered to implement Government policy in ways that best suited local circumstances, the Government began to lay down exactly how managers were to perform, on what they were to concentrate their energies, and how their performance would be monitored and managed. Managers did not quibble with the Government's right to set the strategy and put in place milestones in order to be able to judge progress towards stated objectives. Less acceptable, however, was the Government's assumption that it knew best and could manage the NHS from the Centre through a battery of new initiatives; through parcelling funds up into new schemes, like Health Action Zones, and inviting NHS organisations to compete for them; and through a vast, complex array of performance indicators, targets and Public Service Agreements. 'Initiativitis' and 'reform fatigue' became watchwords as the Government sought to stamp its priorities on the NHS. While its diagnosis of the NHS's ills was widely supported, many were critical of its prescription for achieving change and the pace at which reform was to be undertaken.

The White Paper was followed by a stream of related policy statements and guidance circulars, including the introduction of a system of clinical governance; changes in primary care involving initially the establishment of primary care groups and, subsequently, primary care trusts; the creation of 26 Health Action Zones in two waves; the appearance of a new health strategy, with its four targets in the areas of coronary heart disease/stroke, cancer, mental health, and accidents; the introduction of Health Improvement Programmes; the National Service Frameworks (NSFs) for Mental Health and Coronary Heart Disease (with others for diabetes and elderly care in preparation). In the midst of this frenetic outpouring of policy advice, guidance and new initiatives, and organisational forms, managers have been under constant pressure to deliver on waiting list targets and on tight financial targets. Unrelenting performance management is the hallmark of the Government's managerial style.

Binding many of the initiatives together are the NSFs, since in each of the key priority areas identified by the Government they will lay down the desired models of care and service standards to be attained.

National Service Frameworks

The NSFs produced so far have been widely welcomed for their adoption of an integrated care model – often known as the seamless patient journey – bringing together primary, secondary, tertiary and social care with an emphasis on primary and secondary prevention and rehabilitation as well as treatment. But for the Frameworks to be implemented effectively much will depend on changes in the way in which clinical work is conducted and on the development of effective partnerships between organisations and professions both within the NHS, and between the NHS and local government. It is still the case that, despite partnerships having been favoured for almost 30 years, few have actually been achieved on a sustainable basis. The cultures of the NHS and local government are quite distinct and little understood by each other. Managing public services remains a vertically organised activity with little movement between the silos.

Steering and rowing

Not only is policy being steered vigorously from the Centre, the Government appears to be doing much of the rowing, too. Managers of hospital trusts, health authorities, Health Action Zones (HAZs) and other NHS organisations complain of the constant demands from the Regional Offices or from the Centre itself for information on aspects of their performance. Meeting waiting list targets and ensuring financial robustness are the principal means by which chief executives' performance is assessed. Even HAZs are being subject to constant monitoring, with their strategies being modified to meet Ministers' policy objectives. This style of management runs counter to the thinking underpinning their creation. They were established to foster innovative solutions to problems that cut across agencies and professions, and to operate with minimal bureaucratic controls or fuss. The reality has been very different.

Paradoxically, too, the appearance of HAZs has actually made partnership working more complex and fragmented by introducing new interfaces to be managed alongside existing ones and creating new turf wars that would otherwise not have existed. The organisational landscape in health policy that now has to be managed coherently defies easy description and lacks clarity.

Primary care in transition

Elsewhere, there have been charges of heavy-handed pressure from the regional offices and some health authorities on primary care groups to move rapidly to trust status even in cases where a decision has been taken to remain as a PCG for what appear sound, legitimate reasons. The NHS Plan asserts that by April 2004 all PCGs will have become PCTs. It amounts to a significant and rapid change agenda since PCTs are not mere extensions of PCGs – they are quite different organisations.[6] They pose a complex management challenge, which, as noted earlier, has more to do with culture and behaviour than boxes and charts. The corporate approach envisaged in primary care runs counter to the tradition of diversity and individualism, features of the independent contractor status of GPs.

Therein lies a major policy tension. Traditionally, primary care has developed in accordance with the individual preferences of local practitioners. They have never been part of the NHS in terms of its management and strategic direction. But all that is destined to change, driven by a government intent on 'universalising the best' and ensuring that a standard level of care and service is available wherever a patient happens to live. Given the significant sums of money that PCTs will have at their disposal to commission and provide a comprehensive range of health (and possibly social) care, it seems inconceivable that the Treasury will be content to allow resources to be spent without stringent controls and performance management measures in place. At

the same time, the Government has 'sold' its primary care-led NHS policy on the grounds that GPs are close to their patients and local communities and are best placed to identify and meet their needs.

It remains unclear whether this apparent contradiction is widely perceived by those who welcome the primary care thrust of policy. Probably only time will tell who is likely to win the struggle for control. History is not on the side of those providing frontline care.

THE PRICE TO PAY FOR NEW RESOURCES?

The significant additional resources allocated to the NHS in the budget in March 2000 have been hugely welcomed after many years of under-investment but they come with strings attached, which may result in dysfunctional behaviour and less than optimal impact. Managers are under constant pressure to demonstrate good performance, compete for funds through endless bidding rounds, and then show that these have been effective in meeting targets that may take years rather than months to achieve. The outcome of this complex process has been to focus on what the Centre deems to be a priority and to ignore or sideline local priorities. Evidence from evaluation studies of regeneration projects shows that the Government's centrist approach has proved distracting and distorting and has led to ineffective and often inappropriate interventions with little local relevance.[7]

A similarly centrist approach is evident in the approach to rationing health care. From a position of denial that rationing was an issue in the NHS, the Secretary of State for Health at the time, Frank Dobson, stepped into the emotional public debate surrounding whether the drug to alleviate the symptoms of impotence, Viagra, should be available on the NHS. Following a review of the evidence, the Department of Health issued guidelines restricting its availability on the NHS. Many managers and clinicians welcomed the Secretary of State's tough stance even if some found the guidelines flawed. Others saw it as an intrusion into the clinical domain and argued that decisions about who should and should not receive treatment ought to be left to clinicians.

Another tactic adopted by the Government, not unfamiliar to many of its predecessors, has been to establish new, or reform existing, national bodies to undertake centrally determined functions that are beyond the Department of Health's capacity and/or capability to discharge. The National Institute for Clinical Excellence was established in April 1999 to review the evidence in regard to the cost-effectiveness (not only clinical effectiveness) of new and existing therapies and treatments with a view to issuing advice that local NHS organisations were expected to follow unless they could marshal good reasons for not doing so. NICE's purpose, at least in part, is to take the heat of rationing off Ministers, although its Chair has argued that its purpose is not to ration health care but to ensure that resources are allocated to procedures of proven efficacy. NICE is also an attempt to end 'postcode prescribing' and to signal to the public that the NHS is a truly national service so that wherever a patient might go in the country for treatment, the standards of care and availability of that treatment should be the same.

A problem facing NICE is when the weight of scientific evidence comes up against the 'rescue principle' to which the public is strongly wedded. A recent example concerns Beta-Interferon for MS sufferers. It is not a cure but it can arrest the progress of the disease in some sufferers and has transformed their lives and given them fresh hope. The scientific evidence suggests that the drug is not cost-effective and is therefore likely to lead to NICE recommending that the drug not be prescribed for new sufferers (existing patients will continue to receive treatment).

In the aftermath of the Bristol tragedy and other instances of management failure to deal appropriately with cases of unacceptable clinical practice, the Government has established the Commission for Health Improvement (CHI). The Commission is only just getting into its stride but its style of operation remains a serious issue. The NHS Plan refers to it as an

inspectorate akin to OFSTED in education. But it is not viewed in such terms by its inaugural director, who favours a developmental, supportive body whose task it is to work with local hospitals and other organisations to sort out their problems and not to go in wielding a stick intent upon naming, blaming and shaming.

The NHS Plan will see a doubling of the size of CHI and an increased budget for NICE. In addition, there will be new agencies established, notably a Modernisation Agency to assist with the re-design of services – it will include an NHS Leadership Centre – and a National Independent Panel to advise on major hospital changes, thereby distancing such decisions from Ministers. However, all these agencies remain directly accountable to the Secretary of State for Health, so the degree of independence they will enjoy is at the discretion of that person. Political interference cannot be ruled out and seems almost certain in areas of considerable sensitivity and public concern.

In a move seen as an attempt to secure complete control at the Centre, the posts of Permanent Secretary at the Department of Health and NHS Chief Executive are to be combined into a single post. Such a move reverts to the days before the Griffiths Inquiry into NHS management.[8] Griffiths was highly critical of the Centre's lack of management ability and the confusion between management and political control. Either the Government has learned nothing from this recent history or it believes that only by bringing these functions together can it improve its chances of securing changes at the periphery.

Low trust, high trust?

Underlying much of the Government's approach to NHS management is a lack of trust in managers to achieve its Modernisation Agenda. Significantly, few managers were involved in the development of the NHS Plan. While accepting that the NHS has been starved of resources and that under-investment has been responsible for a lamentable deterioration of the fabric of the NHS as well as the availability and quality of care, the Government is unwilling to allocate the additional resources without some control over what happens to them. Resources are accompanied by stringent conditions concerning how they are to be used.

Almost without exception, the climate surrounding the Government's style of managing is one of fear and distrust. Managers believe they are being bypassed and reduced to the status of administrators, i.e. mere agents of the Centre. But it is not just the NHS that has been subjected to this style of management. Similar treatment has been meted out to education, and local government has not escaped censure for its management performance. For all the talk in the NHS Plan about restoring a public service ethic based on high trust, it would appear that much of the last Government's dislike of the public sector lives on in New Labour. It bemoans the lack of incentives that it believes exist in private sector organisations to improve performance.

That there is an image problem with public sector management, following 18 years of being undermined in favour of private sector management and market mechanisms, is not in doubt. But the Government's reform style has done little to dispel the negative view of public sector management that prevails and that New Labour appears implicitly to support. Perhaps its new-found faith in the public sector, as revealed in the NHS Plan, will herald a new dawn for public services.

WHERE NOW?

The NHS Plan constitutes the Government's blueprint for the service over the next ten years. It is both a restatement of the Government's changes plus some new initiatives. The future of the NHS in something like its current form is wholly dependent on the Plan succeeding. Failure on a significant scale is likely to herald the end of the NHS as we know it. Considerable political capital is therefore riding on the Plan, especially given the Prime Minister's unprecedented personal involvement in the details of the NHS modernisation project.

The Government has sought to prepare the ground carefully by ensuring that elite members of the health policy community are signed up to the core values and principles on which the Plan is based. Cynics might say it is a ploy to silence potential critics. This may be a little harsh. The impressive roll call of names demonstrates the widespread support that continues to exist for the values and principles on which the NHS has operated for over 50 years. As a measure designed to restore confidence in the service, having 'the great and the good' on board may serve a useful symbolic function. However, for the Plan truly to succeed it must win the 'hearts and minds' of the NHS's employees, who feel demoralised and undervalued. The elite members of the 'tribes' may be united but their followers will need more than a handful of signatures if they are to be convinced of the Government's intentions.

The NHS Plan seems likely to ensure that the structure of the service will remain unstable for the foreseeable future, with obvious implications for its management. As PCTs take root and mature, the role of health authorities in their current form looks unsustainable. Most of their functions and resources will pass to PCTs, leaving them with a vague, nebulous 'leadership for health' strategic role. Moving the furniture around is a favourite pastime of NHS managers. Nothing is likely to happen this side of an Election but the expectation is that health authority mergers are not far off and that around 30 large authorities will remain. Interesting issues arise in the context of the NHS Executive regional offices. If large health authorities are in place is there a need for NHS regions? Most likely there will be a realignment of functions between the regional government offices and the NHS regional offices. Whether devolution takes off in England and regional assemblies emerge, even if only in some parts of the country like the North East and North West, this will also have implications for the shape and management of the NHS.

The Plan has much to say about the management challenge and affords an important insight into how the Government intends to secure improved performance in the coming years. Despite its plea for a 'high trust' NHS and a restoration of a public service ethos, which sound a little hollow when the Plan is taken as a whole, much of its thrust is directed towards what it sees as ending over 50 years of weak, or non-existent, management. Moreover, there is no let up in the emphasis on management by targets and Public Service Agreements with the Centre deciding when a local hospital or health care facility has performed well enough to be granted 'earned autonomy'. A system of red, amber and green traffic lights will apply and those awarded a red light will attract more intensive central scrutiny and more frequent visitations by external support teams and inspectors.

The entire thrust of this management style would seem to be based on mistrust rather than trust. It is central government that will decide when to grant autonomy and when to withhold it. The effect will be to politicise further the management of the NHS, with managers ever more inclined to look upwards to Ministers rather than downwards to their local communities. Such an orientation is likely to breed a dependency culture and a type of managerial infantilism that can only lead to weak management of the kind the Government wishes to remove.

Given the evidence from preceding top-down initiatives, it is unlikely that such a highly centralised, command and control approach will work. It may appear to succeed superficially as managers and practitioners resort to elaborate 'gaming' in order to ensure that they avoid the dubious honour of being awarded a red traffic light. Managerial time and talent will be diverted to 'feeding the beast' in the shape of the central department instead of being directed to improving local services and health status.

The management model in vogue is seriously flawed because it misunderstands the nature of management in a complex service that is in effect dominated by a powerful professional group. It does violence to the different value sets and cultures that exist among the various

professional groups, or tribes, that inhabit the NHS. These comprise clinicians, nurses, doctor-managers, nurse managers and lay managers. Securing a shared vision for the NHS and negotiating agreement on how best to change practice means, in the first instance, acknowledging and appreciating these different sub-cultures. They cannot be air-brushed out of the picture through an NHS branding exercise and new logo, which offer the pretence that the NHS has a shared vision and common purpose. It is a pluralistic organisation, a loose coalition of groupings all jostling for supremacy, influence and resources. For the most part, doctors continue to see the NHS as a supply of resources, which exist for them to access to achieve their professional and personal goals. Managers exist to provide them with these resources, not to challenge their clinical practices. It is often claimed that this stereotype of the clinician is no longer valid and that younger doctors view the world differently. But this is not so – the evidence suggests the stereotype remains very much alive and well.[9]

CONCLUSION

Managing the NHS is a complex and messy business and always will be. It is a source of endless fascination and frustration. If real and sustainable change is to be achieved, then the service's political masters could start by genuinely trying to understand and work with the multiple sub-cultures that exist. This will involve making them responsible for re-designing their working practices within a strategic framework set by the Centre. What is unworkable and dysfunctional is the endless stream of targets, performance indicators, inspection arrangements, incentive schemes and competitive processes in place to bid for funds. There is ample evidence testifying to the shortcomings of such instruments, yet the Government remains stubbornly and misguidedly wedded to their alleged power to effect real change.

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>>>>>>>>>>>> looking forward >>>>>>>>>>>>

Political party policies on health and health care

A look to the future, with an examination of the three main political parties' policies on health and health care.

John Appleby

To state the obvious, the health policy future espoused by the three main political parties is heavily influenced by their current (and prospective) power differences. Labour is in government – its plans for the future of the NHS and health in general are more detailed, attempt to be comprehensive and naturally carry the authority of a party in power. The opposition parties' stated health policies are less detailed, more selective and tend, again, naturally enough, to be informed by criticism of current Government policy. But despite differences between the parties, there is clearly extensive common ground over many of the basics. And while an enhanced role for the private health care sector is pushed by the Conservatives partly, it could be presumed, in an attempt to distinguish its policies from Labour's, in practical terms the argument is at the margins. Similarly, the Liberal Democrats – in agreement with the Government not just on the basics but over much of the detail as well – find it difficult to significantly differentiate their policies from Labour's.

LABOUR'S PLAN FOR THE NHS

The Government's NHS Plan,[1] delivered to Parliament by the Prime Minister on 27 July, and building on the initiatives of the White Paper *The New NHS: modern, dependable*,[2] was the end result of a peculiar inside-out and back-to-front Spending Review (SR2000).

SR2000 (historically known as the public expenditure survey – PES) was announced on 18 July. But the NHS already knew what it was to receive because the Chancellor had brought forward its particular part of the SR2000 to the March budget.[3] That budget had been the culmination of the previous month's to-ing and fro-ing between the Health Secretary, the Prime Minister and the Chancellor over looming spring and possibly summer NHS financial crises. While the Treasury was asked to find extra money in January, the Department of Health had not, by that time, got into the usual spending review detail of exactly what the money was to be spent on.

In the past, with the previous spending review (and, further back, the PES), spending departments worked up bids and entered into bilateral negotiations with the Treasury. The announcement of extra money for the NHS in March – ahead of the spending review in July – turned things upside down. But the Treasury, keeper of the public purse, was not about to hand over large amounts of taxpayers' money without any idea where it was going to go. Out of this necessity, the notion of an NHS Plan was

BOX 1: RESPONSE TO THE ROYAL COMMISSION ON LONG-TERM CARE

National Care Standards Commission to drive up care standards in domiciliary and residential care.

Piloting of a free retirement **health check**.

Extension of breast cancer screening to women aged 70.

A new service, **Care Direct**, to provide faster access to care as well as advice and support on a range of health, social care and benefit arrangements for older people.

5000 extra **intermediate care beds**, more **'rapid response'** teams designed to care for the elderly at home, additional **home care support and adaptations** to promote independence and health.

For the first three months from admission to residential and nursing home care, the **value of a person's house** to be disregarded from means tasting rules. **Capital limits** on assessing contributions to care costs to be restored to the 1996 value. **Variations in charges** across local authorities to be reduced.

Nursing care provided in nursing homes to be fully funded by the NHS.

The **residential allowance** to cease in 2002 and resources transferred to local authorities. Local authorities to become responsible for assessment, care management and financial support of those in residential homes.

Consultation on a Treasury report on regulation of **long-term care insurance**.

'Personal care' costs will not be funded by government but will remain means tested.

BOX 2: RESOURCES

Beds

- 7000 more beds by 2004
- 2100 (of the 7000) increase in general and acute wards, the rest in intermediate care
- 30 per cent increase in adult critical care beds by 2003

Hospitals, facilities and equipment

- Over 100 new hospital schemes by 2010
- 20 diagnostic and treatment centres specialising in day case routines by 2004
- A quarter of the £3.1 billion maintenance backlog to be cleared by 2004
- £1 billion to be invested in primary care facilities and up to 3000 GP premises to be refurbished or replaced by 2004

By 2004

- 50 new magnetic resonance imaging (MRI) cancer scanners
- 200 new computed tomography (CT) scanners
- 80 new liquid cytology units for cancer screening
- 45 new linear accelerators
- 3000 automated defibrillators in public places
- 450 new and replacement haemodialysis stations

Information technology

- £250 million additional funding for IT in 2003/04
- Access to electronic personal medical records in majority of hospitals
- Bedside televisions and telephones in all hospitals
- Electronic prescribing
- All GPs connected to NHSnet by 2002
- Telemedicine for medical advice by 2005

Staff

Between 2000 and 2004:

- 7500 additional consultants
- 2000 more general practitioners
- 20,000 more nurses
- 6500 more therapists and other health professionals

Increased numbers of training places:

- doctors – 1000
- nurses – 5500
- therapists – 4450

BOX 3: TARGETS, CONTRACTS AND MONITORING

Simplified **Public Service Agreement** for the whole of the NHS.

Expansion of **Performance Assessment Framework** (PAF) to cover more activities of trusts and primary care.

Commission for Health Improvement to take over responsibility for annual PAF publication.

Benchmarked **efficiency targets** to be developed to counter cost/quality trade-off. All trusts expected to reach the level of the best over five years.

'Traffic light' system of performance to identify trusts performing at acceptable/unacceptable levels. 'Green light' trusts to earn greater local autonomy and access to an annual £500 million performance fund.

New **consultant contract** designed to tie newly appointed consultants into the NHS; private work disallowed for first seven years' of contract; senior doctors to work seven sessions per week for the NHS.

Personal Medical Services contracts to be promoted. Moves towards majority of **GPs** as salaried NHS employees contracted to deliver key quality-based objectives.

National targets for reducing **health inequalities**; a 'health poverty' index to be developed.

By 2004, all patients to be able to see a health care professional within **24 hours** and a GP within **48 hours**; maximum waits in **A&E** to be cut to four hours. By 2005, all patients to be admitted via **booked admission** systems; maximum wait for routine **out-patient** appointments to be three months; maximum waits for **in-patients** to be cut to six months. By 2008, maximum waits for **any treatment** to be cut to three months.

BOX 4: NEW ORGANISATIONS, RELATIONSHIPS AND STRUCTURES

- **Modernisation Board** to advise the Secretary of State and oversee implementation of the NHS Plan.
- **Modernisation Agency** to help local organisations to implement the NHS Plan. It will encompass the existing National Patients' Action Team, the Primary Care Development Team, collaborative programmes and the Clinical Governance Support Unit.
- **NHS Leadership Centre** to co-ordinate and promote work-based leadership development for all NHS staff, non-executives and chairs.
- **NHS Appointments Commission**, an arm's length group, to select non-executive trust and health authority directors.
- **National Independent Panel** to advise on hospital mergers, closures and reorganisations.
- **NHS Local Improvement Finance Trust (NHS Lift)**: public-private partnership.
- **Task forces**: more ad hoc groups to drive forward national policies (e.g. on waiting, heart disease, inequalities, etc.).
- **Care trusts**: new level of primary care trust to commission and be responsible for all local and social services.
- **Medical Education Standards Board** to replace the separate postgraduate bodies for GPs and hospital specialties.
- **National Clinical Assessment Authority**: a special health authority to provide rapid investigations of individual doctor's performance.
- **UK Council for Health Regulators**: over-arching group to co-ordinate regulatory work of the GMC, the new regulatory bodies for nursing, etc.
- **Patients' forum** to be established in every trust and PCT to influence delivery of services.
- **Patient Advocacy and Liaison Service (PALS)** to be established in every trust to guide and support patients regarding complaints and general information.
- **Citizens' Council**: additional lay group to advise NICE.
- **NHSplus**: occupational health services provided at cost to businesses.
- **'Concordat' with the private health care providers**: national framework for the NHS contracting work out to private providers.
- **Local authority scrutiny role**: local authorities to be able to ask chief executives of NHS organisations to attend twice-yearly all-party scrutiny committees.

BOX 5: AND GOODBYE TO ...

- Community Health Councils
- The NHS Tribunal
- UKCC for Nursing and Midwifery
- Joint Committee for Postgraduate Training in General Practice
- The Specialist Training Authority

conceived, to be informed by the views of the public, frontline NHS staff and six Modernisation Action Teams constituted from key leaders in the health and health care field.

The NHS Plan set out a hard-to-dispute set of criticisms of the NHS:

- historical under-investment
- a lack of national standards
- demarcation problems between staff
- a lack of clear incentives
- barriers between services
- a lack of support and intervention
- over-centralisation
- disempowered patients.

The Government's response to these criticisms (see the boxes above) generally eschewed the short term in favour of the long view; it was also long on targets and numbers. But, crucially (and this is a criticism that can be levelled at most governments' policies, most of the time, almost everywhere), there are doubts that it can deliver on all its promises.

And while more money has been essential for the NHS, international experience suggests that spending more on health care per se does not automatically buy greater satisfaction on the part of patients and taxpayers.

CONSERVATIVE PARTY HEALTH POLICY

In a speech on 25 July 2000 at the Institute of Civil Engineers, under the auspices of the Centre for Policy Studies and just prior to the announcement of the Government's Plan for the NHS, William Hague laid out his own Party's seven-point plan for the NHS.

It is worth noting that Hague reiterated his commitment to match the spending increases for the NHS announced by the Chancellor in his March 2000 budget: 'We have pledged to match Labour's spending because we believe that the NHS is badly underfunded ... By doing so I hope we can ... move the debate away from the overall size of the health budget to the equally important issue of how the money is spent.'[4]

So, how do the Conservatives propose to spend the money if they were in power?

THE PATIENT'S GUARANTEE

- *The Waiting List Initiative would be scrapped and, starting with selected clinical areas (cardiology and cancer care), patients would be given a guaranteed maximum waiting time based on their consultant's own judgement of what is in the best clinical interests of their patient. Patients who fail to be treated within their maximum wait time can have the option of having their care privately with their local PCG footing the bill.*

There is anecdotal evidence that the Waiting List Initiative (reducing the numbers of patients waiting) did introduce perverse incentives: reducing list size within available resources and time is more easily done if the less 'complicated' patients are treated. However, similar criticisms were made of previous Conservative Governments' attempts to reduce waiting times (the Waiting Times Initiative): those waiting longest were, by definition, not those in most urgent need of admission. A guaranteed maximum waiting time determined by an individual's consultant would overcome some of these clinical priorities distortions, but its practical implementation is likely to be problematic.

The impact of the Guarantee on the NHS, the balance in provision of services and the distribution of benefits to patients will depend partly on how consultants behave. If, when setting admission dates, consultants ignore the reality of the resource constraints they, their trust and the NHS in general face, then the service could easily be overwhelmed by this

commitment. Moreover, the 'stick' of the NHS having to pay for private care has a clear opportunity cost in terms of reducing benefits for other NHS patients. Also, given that consultants with NHS contracts carry out much private work, there is a perverse incentive for consultants to set unattainable admission dates with the prospect of performing operations privately.

Freedom of referral

- *A promise that GPs' referral freedoms will be reinstated.*

Although Hague has stated that following the abolition of extra contractual referrals (ECRs) '... you and your GP can no longer choose which hospital to send you to', guidance on the processing of the new out of area treatments (OATs) specifically states that 'These arrangements are not intended to impinge on the clinical responsibility of GPs and consultants to make appropriate referrals'.[5]

In fact, under the internal market there were many examples of health authorities refusing to pay for ECRs, insisting instead that some ECR patients should be treated under existing contracts. A similar position seems to hold now, although the nomenclature has changed ('service agreements' for 'contracts', 'OATs' for 'ECRs').

Dedicated surgical units

- *Routine operations such as cataracts and hip replacements should be carried out in surgical units dedicated to such operations. These units could be run by the private sector under contract to the NHS.*

It is not clear what benefits dedicated surgical units would bring to patients and the NHS. They may be more efficient – though presumably these units would either need to be located within or adjacent to general hospitals or have the facilities to deal with surgical complications. And they would not necessarily reduce waiting times for the procedures they deal with (as Hague admits). If the units were to be privately run, who does the work? As with the stick associated with the Patient's Guarantee, most private work is carried out by consultants with NHS contracts; in the short to medium term this implies an opportunity cost to the NHS.

Exceptional Medicines Fund (EMF)

- *A fund (top-sliced from the NHS budget), the size of which would be determined by the Secretary of State and disbursed by a committee of independent clinicians and academics, would pay for certain high-profile drugs that may be subject to 'postcode' prescribing.*

Although the claim for this approach to rationing is that it would end postcode prescribing, whereby certain drugs are available in parts of the country and not in others, the need to ration still exists. One issue is where and by whom this rationing takes place. The claim for the EMF is that it ensures that politicians take overt responsibility for rationing decisions (the Secretary of State sets the fund's budget) and in particular for assessing the affordability of a health technology. In essence, this means taking decisions about allocative efficiency; a drug may be cost-effective according to assessments by NICE, but may still not be made available via the NHS because other judgements (to do with equity or the distribution of benefits) may come to bear. A previous Secretary of State's decision to restrict the availability of the impotence drug Viagra (cost-effective relative to other impotence treatments) was essentially made on the basis of value judgements about allocative efficiency.[6]

A special top-sliced fund will not, of course, guarantee that all drugs at the margins of clinical and/or cost-effectiveness will be made available through the NHS. Nor, given the job of the clinical/academic committee to decide which drugs to fund, would politicians (the Secretary of State) necessarily be clearly identified as the person responsible for affordability decisions in the NHS.

Although the EMF appears to be aimed at high-profile drugs (Beta-Interferon for multiple sclerosis, Riluzole for motor neurone disease), there are geographical variations in the

prescribing and treatment rates for nearly all interventions offered by the NHS. If standards can be set for 'exceptional medicines', why not for routine interventions such as hip operations?

Independent review of appointments to NHS boards

- *In order to 'take party politics out of management of NHS trusts and health authorities', and in response to a report from the Commissioner for Public Appointments, Dame Rennie Fritchie, which suggested an association between membership of the Labour Party and likelihood of non-executive appointment to NHS boards, a review of the appointments process is called for.*

If non-executive members of the boards of trusts, health authorities and primary care groups are to be appointed on 'merit, and merit alone ...', how is merit to be defined? Governments of all persuasions have at one time or another been accused of cronyism, of selecting those adjudged to be 'one of us' rather than 'one of them'. When it comes to implementing Government policy, from a governmental point of view there can of course be merit in appointing those who broadly agree with Government policy. Nevertheless, a review of appointments to NHS boards seems redundant in view of Dame Rennie's report[7] and the Government's NHS Plan recommendation to set up an arm's length organisation (reporting direct to Parliament) to take over responsibility for appointments.

Redefined roles for Ministers, GPs and nurses

- *The Secretary of State for Health should be confined to setting overall strategic direction for the NHS, negotiating the NHS budget with the Treasury, allocating the budget within the NHS and policing minimum standards of care. GPs should be encouraged to specialise to break down barriers between primary and secondary care. Nurses should be given more autonomy and encouraged to stay with the NHS.*

The general thrust of the Conservative's penultimate point on their health care policy more than hints at accusations levelled at the current Government of control freakery and interfering micro-management of the NHS. Sensitivity to these accusations spawned the Government's policy of 'earned autonomy' for NHS organisations; crudely put, this amounts to 'hit the targets we set and we will allow you more freedom'. Moreover, one person's political interference can be another's reasonable wish to ensure that policies are implemented. The balance of power and control between the centre and the periphery in the NHS has regularly emerged as a bone of contention, but trends over the last 20 years have been moving towards more central control (even during the internal market years).

Encouraging growth in the private health care sector

- *Greater partnership between the NHS and private providers of health care along with greater encouragement for more personal provision. Possibilities for abolishing the taxation (via the imposition of National Insurance contributions on benefits in kind, e.g. private medical insurance cover) will be re-examined, as will the ending of tax relief for private medical insurance for elderly people.*

The NHS has for many years purchased, albeit on a small scale, care for NHS patients from private providers. The Government's NHS Plan makes clear that this will be formalised through a 'concordat' with private sector providers. Again, however, the issue of a relatively fixed medical workforce split between the public and private sectors could in the short term merely lead to a zero sum game in which private provision is expanded partly at the expense of the NHS. Nevertheless, it is clear that private sector providers are keen to use their surplus capacity and the NHS is a potential buyer.

The question of tax breaks (or the abolition of taxation on private medical insurance provided as a perk by some employers) has been looked at many times in the past, not least by Nigel Lawson during his Chancellorship.[8,9] The unanimous conclusion has been that using public money to subsidise private medical insurance is inefficient and inequitable. And

recent experience of providing tax relief for elderly people showed that together with significant 'deadweight' costs, additional numbers attracted to PMI were minimal.

LIBERAL DEMOCRATS: 'RESTORING THE NATION'S HEALTH'

The latest policy briefing on health and health care from the Liberal Democrats[10] sets out policy ideas and targets that map almost directly on to those laid out in Labour's NHS Plan. Many of the criticisms of the Liberal Democrat proposals, therefore, are similar to those made for the Government. Given voter intentions and the current voting system, the key problem of whether change can be delivered, however, is unlikely to be put to the test in the case of the Liberal Democrats.

- *National Health Service Care Guarantee drawn up by the Secretary of State for Health, setting out minimum standards of care that patients could expect for every major medical intervention. Elected regional governments would amend standards to take account of 'regional conditions'.*

The devil here is clearly in the detail. What exactly will be counted as 'standards of care'? The Patient's Charter standards are already in existence – will this Care Guarantee go further?

- *More resources to be provided for NICE to enable it to appraise existing treatments rather than concentrate on new ones.*

In fact, NICE does not just concentrate on appraising new technologies but also existing treatments and interventions. However, NICE's workload is potentially enormous and increased funding seems inevitable (as the Government's NHS Plan envisages) if it is to make a sustained impact on the type of drugs, devices and interventions offered by the NHS.

- *Charges for 'personal care' as defined by the recent Royal Commission on Long-term Care to be abolished.*

This Royal Commission recommendation was rejected by the Government on the basis that it would be costly to implement and that, in any case, such personal care costs had never been fully funded within the NHS. However, there are strong equity arguments to back the Commission's original recommendation, which are only partially dealt with through arguments about trade-offs due to cost.

- *Three-month 'breathing space' between entering care and making means tested charges for living costs for the elderly to be introduced to avoid people having to sell off their homes.*

A similar 'breathing space' has been proposed by the NHS Plan.

- *National Care Commission to be set up to monitor care for older people, perform an advocacy service and encourage service innovation and improvement.*

The Government has announced the setting up of a similar commission as part of its response to the Royal Commission on Long-term Care.

- *Waiting lists to be replaced by a 'diary system'; waiting times for treatment to be cut to six months over three years with shorter maximum waits for some urgent treatments.*

Booked admissions are to become standard throughout the NHS as part of the NHS Plan and, similarly, waiting times are to be cut.

- *Medical student places to be increased by 1000 per year. 3000 more nurses, 1000 doctors and 1000 health professionals above 'current' Government plans to be recruited immediately. Longer-term commitment to increasing doctors by 5000 and the number of nurses by 20,000.*

It is not clear what 'current' means, given the publication of the NHS Plan. However, the Plan also aims to increase training places and clinical staff by numbers similar to those proposed by the Liberal Democrats.

- *Access to those most in need of dentistry to be widened.*

One notable failing of the NHS Plan was the absence of any substantial proposals on NHS dentistry. With the long overdue dental strategy still yet to emerge, and significant variations in access to NHS dentistry across the country, it seems clear that if dentistry is to remain properly part of the care offered by the NHS then action needs to be taken to improve access. However, improving access 'to those most in need' suggests the Liberal Democrats accept that there will not (or should not) be universal access to dental services regardless of ability to pay.

- *Eye and dental check-up charges to be abolished. Income loss to be compensated by a 10p per packet rise in cigarette duty.*

Free dental check-ups and eye tests were abolished in 1989 and led to an immediate 25 per cent fall in the numbers of NHS dental treatments and a 70 per cent fall in NHS sight tests. To an extent these falls have been compensated for by rises in private check-ups and sight tests. There is little evidence of the health impact the abolition of free check-ups and sight tests has had on the population and hence it is difficult to assess the cost-effectiveness of this policy.

- *Invitations for breast cancer screening to be extended to women over 65 (with consideration given to lowering the current qualifying age to 45).*

Again, the NHS Plan proposes to extend the upper age limit for screening to 70.

- *Tobacco advertising to be banned completely.*

This is one of the Government's 13 specific 1997 manifesto health pledges, and one which has not been achieved due to a legal challenge from the UK tobacco industry preventing implementation of the European Directive banning tobacco advertising.[11] Banning advertising will have an effect on consumption, but far less an impact than putting up prices.

- *The Health Education Authority to be made independent of government.*

The HEA has in fact been abolished following proposals in the Government White Paper *Saving Lives: Our Healthier Nation*[12] and was replaced this year by the Health Development Agency, which is charged with co-ordinating research into the effectiveness of public health interventions and setting public health standards.

- *All government departments to assess the health impacts of their policies.*

Health impact assessments (HIAs) were proposed as part of the Government's 1997 White Paper, *The New NHS: modern, dependable*.[13] So far, however, apart from some initial work by the Department of Health to set out how HIAs could be tackled, this idea has not been implemented.

- *Composition of primary care groups to be widened to bring in patient and local authority representation. Primary care trusts to be made more accountable to local government and NHS Regional Offices to be merged with proposed regional governments.*

It is not clear how PCTs are to be made more accountable to local government, or whether 'local government' refers to the proposed new regional governments or current local authorities. The NHS Plan suggests that local authorities will take on a scrutiny role over local NHS organisations, with NHS chief executives obliged to report to all-party committees from local authorities. If local accountability in the NHS is a problem, why not go for elected NHS officials or move the NHS (locally at least) into the orbit of local authority control?

- *Trusts' non-executive appointments to be taken out of the hands of the Secretary of State. Trust board meetings to be held in public, with speaking rights to all who attend.*

Again, the NHS Plan indicates that NHS non-executive appointments will be taken out of the hands of the Secretary of State with the setting up of an arm's length appointments board.

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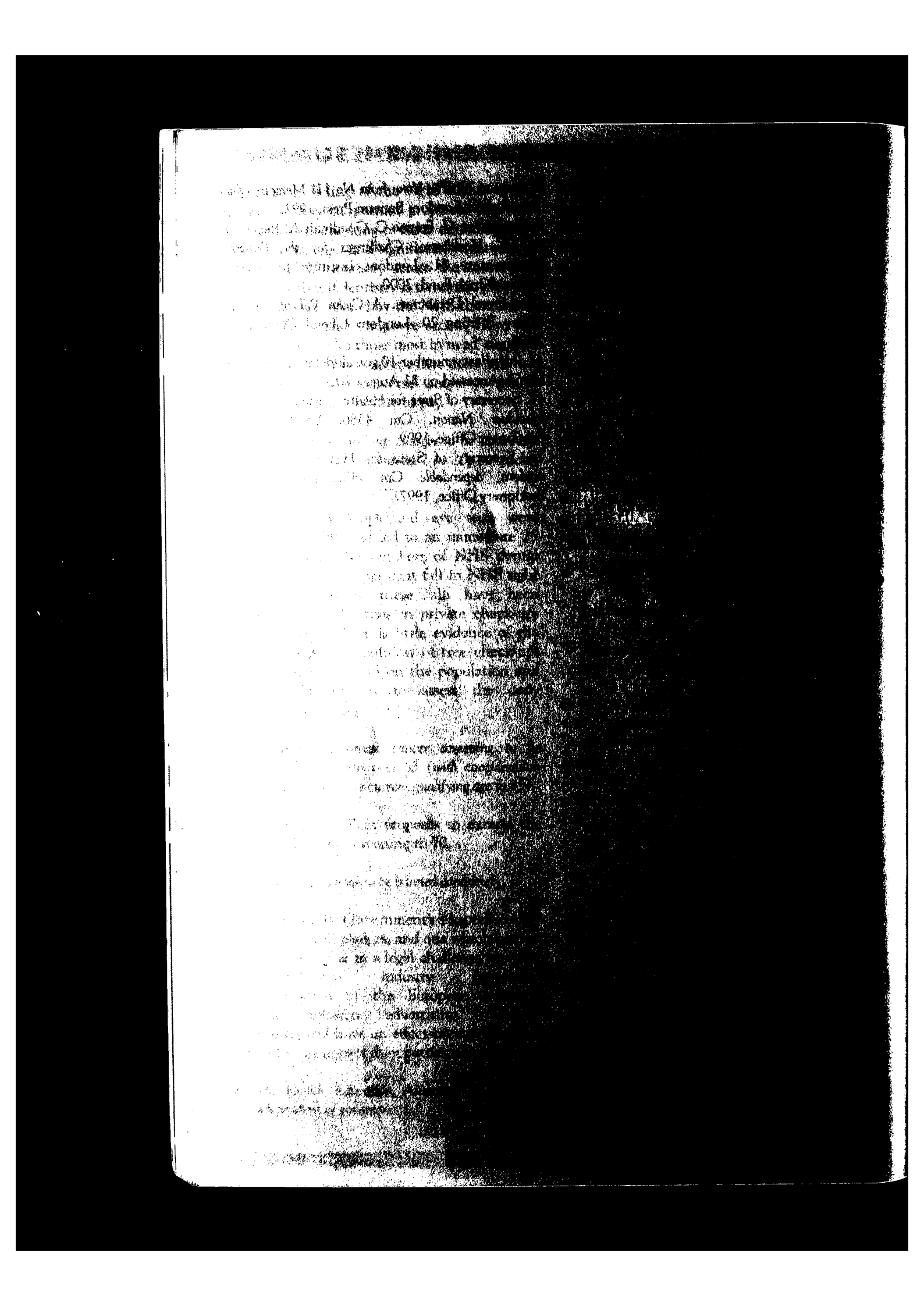

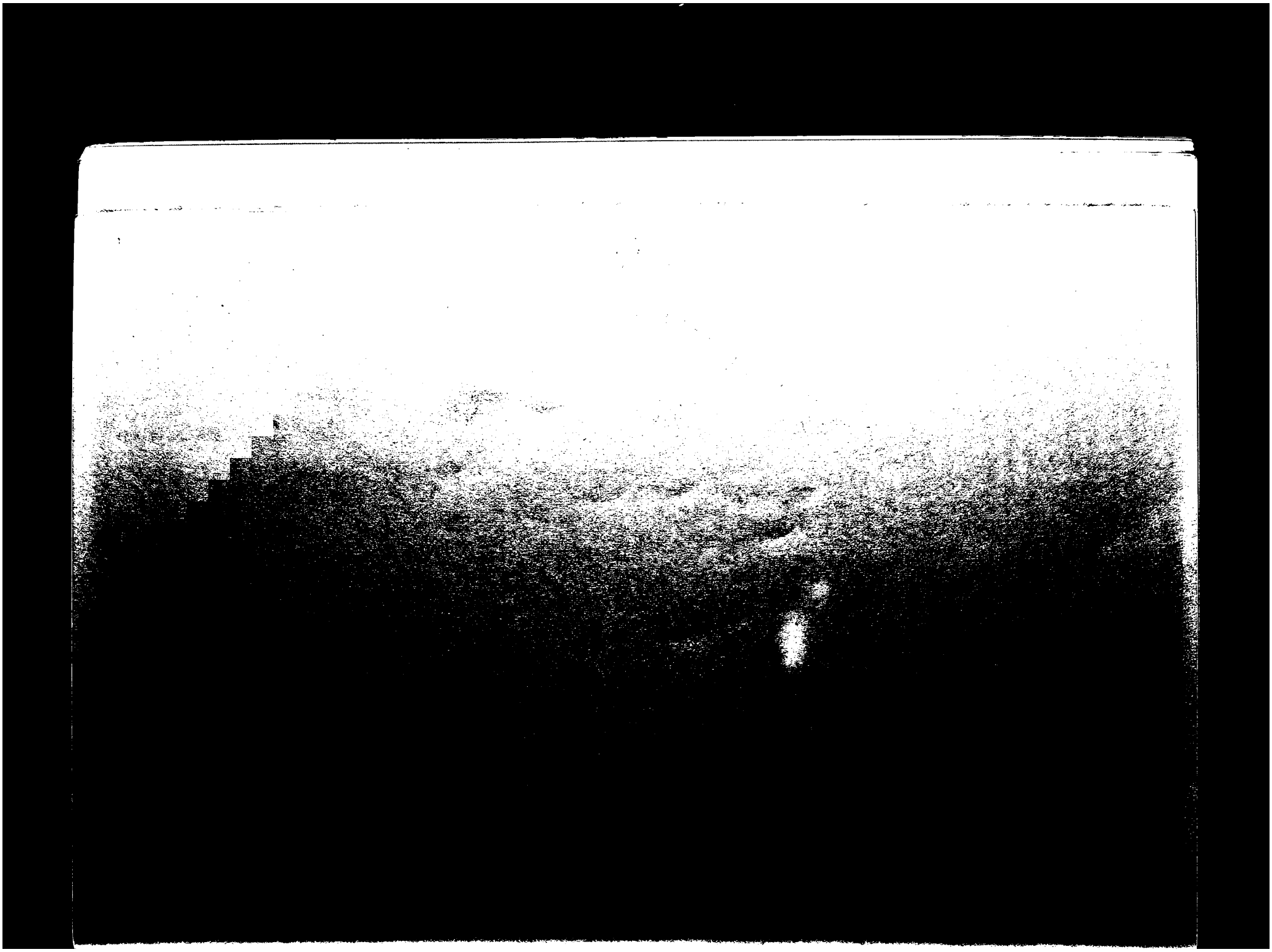

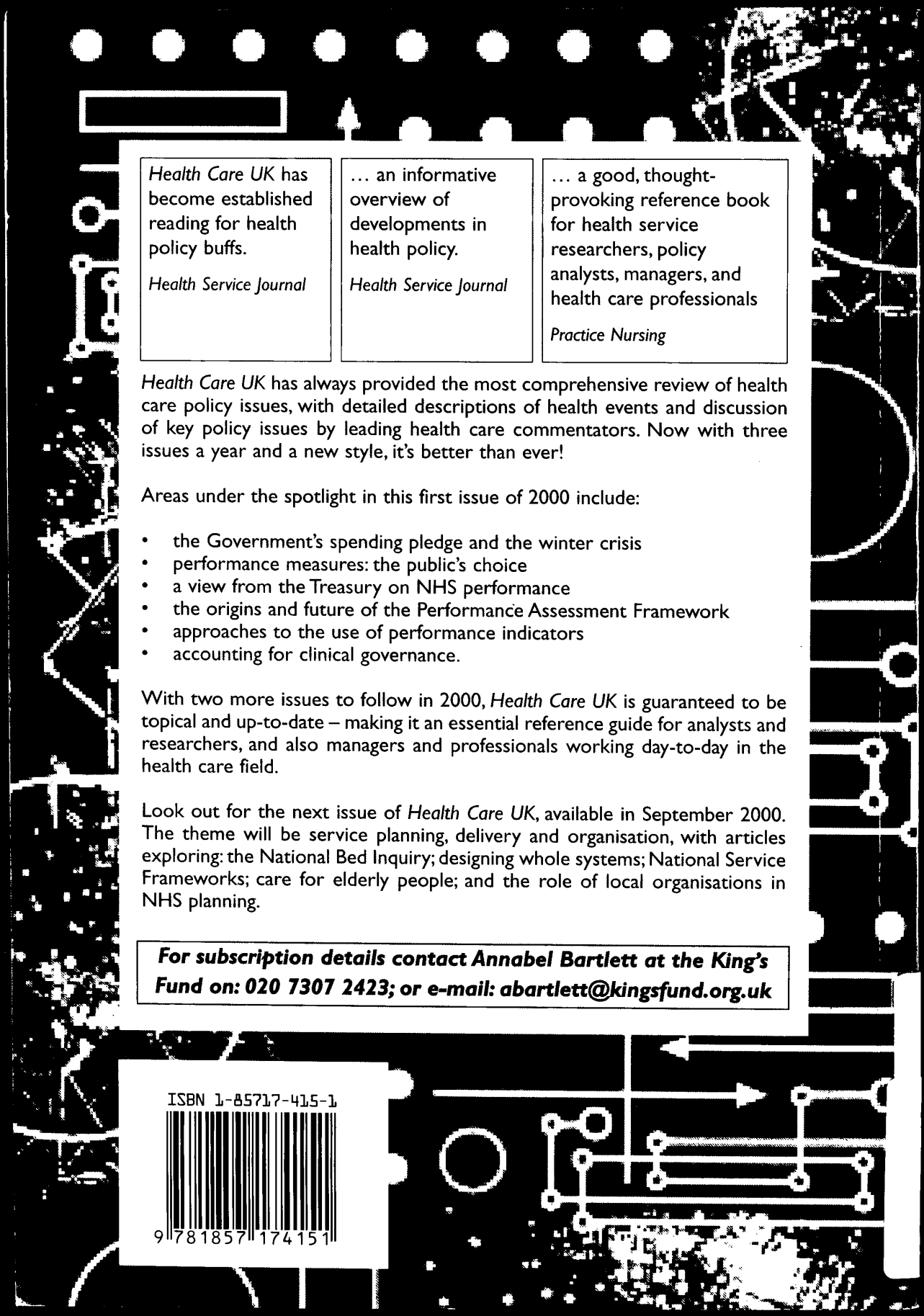

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