resemble nothing so much as Soviet-style price controls. President Clinton favoured government regulated "managed price and quality competition" among private health insurance plans that would manage health care through direct interference in the doctor-patient relationship with controls on utilisation and clinical practice guidelines. This idea was nipped in the bud by political enemies who panned it as a government takeover of American health care and as paternalistic, cookbook medicine.

At some point, of course, Americans must confront in earnest the annual growth of US health spending, which has outpaced the annual growth of the rest of GDP (gross domestic product) by an average of 2.5% over the past four decades. In 2006 the US health sector will absorb one sixth of GDP, a share projected to reach 18.7% by 2014³ and, by my calculation, 40% by 2050, if the 2.5% growth differential persists until then. Yet for all this enormous spending, some 45 million Americans (17.8% of people under 65) are now without health insurance of any kind,⁴ as employers such as the large car building companies, who have provided generous health insurance to their employees, increasingly stagger under the load of ever increasing premiums for that coverage.⁵

President Bush would effectively bribe Americans to embrace the leaner health insurance by allowing them to make annual, tax deductible deposits of up to \$10 500 per family into a personal health savings account (HSA). The balance in such an account could then be used to finance the family's higher out of pocket spending for health care and premiums for catastrophe insurance bought directly by families.¹ Health insurance provided by employers has long enjoyed such a tax preference, because the premiums are tax deductible business expenses for employers but are not part of the employees' taxable income. Under a progressive income tax structure, of course, this tax preference makes health care cheaper, in dollars received after tax, for Americans on high incomes facing high marginal tax rates than for Americans on low incomes facing low marginal tax rates. It reflects a uniquely American social ethic.

The theory underlying consumer directed health care is that high deductibles will induce "consumers" to

shop around carefully among competing physicians and hospitals for high quality, cost effective health care and that they will also reduce their "consumption" of marginally beneficial health care. An experimental study in the 1970s showed that rates of visits to doctors and hospital admissions per capita tend to decline with higher sharing of cost by patients, although for low income families such cutbacks reduced their use of beneficial as well as unnecessary services and was estimated to have increased rates of death from preventable illness.⁶ How readily, however, can the ambitious infrastructure for information envisaged by the president be constructed?

Policy makers and leaders of health care outside the United States should study these ideas carefully. Long before Americans will have put them into workable practice, if they ever do, the usual American missionaries—management consultants, US foreign aid agencies, and the World Bank—will descend on the rest of the world to market this "new, new thing," just as, only a decade ago, they eagerly marketed to the world the then new and now discredited thing called "managed care."

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A new direction for NHS community services

The white paper tackles the right issues but may be hard to implement

The government's new white paper on the future of primary, community, and social care heralds more emphasis on preventive care, a greater choice of services from general practitioners; reduced health inequalities, and better support for people who need long term care.¹ The plan also promises more convenient access to general practices, together with an expanded range of other sources of primary care, such as walk-in centres. The NHS will seek new providers from the independent sector to tackle longstanding problems of poor access to health care in deprived areas, and perhaps elsewhere. In addition, many

services—including up to half of all outpatient care for some specialties—will be shifted out of hospitals and into community settings.

Patients will gain more power within the NHS. They will be offered greater choice over where and when they receive primary care, more information about their health and health services, more direct control over social care resources, and the ability to trigger fundamental service reviews of local health services. Furthermore, the white paper promises that patients' views of services will be assessed independently and acted on.

This comprehensive vision for primary care has been broadly welcomed by professional and patient interest groups.² However, questions remain over the means by which the plan will be implemented. Implementation will depend heavily on competition, strengthened commissioning, and new financial incentives.

Patients will be able to make more informed choices based on performance data when selecting general practices. In addition, primary care trusts will strengthen patients' rights to register with practices and will have to ensure that there are sufficient local providers. This emphasis on greater competition among general practices may enhance responsiveness to patients' demands, but it may not prove compatible with the aim of reducing inequalities.³ Moreover, competition within primary care will require more general practitioners. It remains to be seen, however, if the independent sector will succeed in recruiting new doctors in places where traditional general practices have failed.

Commissioning, particularly by general practices, will bear much of the responsibility for bringing about the changes set out in the white paper. Practice based commissioners are expected to widen the range of community based services and to focus on disease prevention. Primary care trusts must develop ambitious strategies to shift resources out of the acute hospital sector. They are also charged with using new techniques to identify patients for whom early intervention may prevent the need for hospital admission.

Commissioning in the NHS is currently underdeveloped, however. Primary care trusts are in the midst of a reorganisation that will probably reduce their effectiveness for some time to come.^{4 5} Practice based commissioning has barely got off the starting blocks, and the associated incentives are by no means certain to enthuse general practitioners.⁶

By the government's own admission, without the counterbalance of strong commissioning, "payment by results," the new financing mechanism for hospital care, together with the introduction of foundation trusts will suck resources towards hospitals.⁷ The development of substitutes for hospital care and, better still, preventive strategies to avoid the need for referral to specialists, require strong, skilful, and motivated commissioners. The reform agendas for hospitals and for commissioning seem dangerously out of synchronisation.

The white paper also signalled some potentially important changes to current structures for providing financial incentives within the NHS. Funding for general practice will be reviewed to ensure that more money will be linked to the number of patients registered per practice, to the accessibility of primary care services for patients, and to patient satisfaction surveys. Equally importantly, the payment by results system will be refined in the coming year to reduce the financial incentive for hospitals to increase emergency admissions,⁸ and in future hospitals will stop receiving a payment based on the average current cost of treatment. Instead, costs will reflect new pathways of care that are based on best practice and have a greater component delivered in the community. This new range of financial incentives should support the

government's objectives, but it will take time for it to be developed and implemented in full. As with all financial incentives, great care must be taken to avoid perverse and unintended consequences.

The government's plans also raise questions about the relative priority of competing policy goals. In particular, what value should be given to increased access and convenience for patients, particularly when many NHS organisations are facing financial deficits?

The range and volume of services provided in the community by general practitioners with special interests and by hospital consultants are set to increase. These service models are popular with patients, but evidence so far indicates that they increase costs for the NHS despite the government's hope that they will prove cheaper.⁹ Similarly, international and UK research suggest that walk-in centres tend to attract a relatively affluent population and offer treatment for mainly minor illnesses.^{10 11} The proportion of NHS resources directed towards these innovations and their cost effectiveness should be carefully monitored.

The white paper sets out little that is wholly new, relying largely on refining existing policies, offering financial incentives, and extending current pilots. However, its breadth of ambition marks it out as an important attempt to tackle a longstanding agenda. It is, after all, a quarter of a century since Sir Donald Acheson set out a closely detailed prescription to deal with the problems of primary care in the inner city.¹² The key question is whether this government will succeed where others have failed. The financial and managerial climate is not encouraging, but perhaps there will be sufficient political will to drive through many of these much needed reforms.

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