The new health authorities: moving forward, moving back?

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There is much to celebrate in the new white paper. The emphasis on quality and partnership both within and outside the health service is welcome. Longer term agreements will replace the stop-start demands of the annual contracting round, and the need for strategic coherence is recognised: indeed, this government is not afraid of the word "planning." But perhaps the most radical aspect of the white paper is its commitment to keep primary care "in the driving seat in shaping local health services." This will attract the most attention—not least because the "problem" of general practitioner fundholding was one of the main triggers for a review of the NHS. But it begs many questions:

- Will the new primary care groups really be in the driving seat?
- How will the groups relate to health authorities, local government, and voluntary agencies?
- What will be left for health authorities?

There are both functional and structural reasons why primary care groups may have less impact than expected. Skills in commissioning will be stretched to cover 500 such bodies. Recent work by the Audit Commission showed insufficient commissioning expertise for even 100 health authorities.¹ The problem will be compounded by capping of management costs and the aim of saving £1bn on bureaucracy. Given an additional tier and the resources needed to make the system work, such savings will be difficult to achieve.

The structural problems are possibly more profound. Serving populations as large as 100 000, primary care groups will lack the flexibility that individual fundholders had to move contracts between trusts. But neither will they have the leverage of health authorities, which have often been sole purchaser for local trusts. Primary care groups risk being neither "small enough to walk" nor "big enough to hurt."

Primary care groups may not have the power to make more than incremental changes to what and where services are provided. While they can "switch resources" between services and providers, the white paper also states they will have to "explore with health

authorities" any planned changes. This might mean a health authority veto. The contestability of services is further reduced by longer term agreements. All this adds up to reduced purchasing power. The trade off between this and greater stability for trusts lies at the heart of the white paper.

In time primary health care groups will be responsible for purchasing almost 90% of hospital and community care, so proper accountability is crucial. Health authorities will monitor their performance against targets set in health improvement programmes and will exercise some control through allocating resources and controlling the progress of groups up (and down) the four steps to complete autonomy. The precise form these powers take remains to be seen. Certainly, if primary care groups have their own budgets and accounting officers there will need to be independent financial audit.

The principle of joint planning between health and local government, backed by a statutory duty of partnership, is welcome, though this will also require careful regulation and financial scrutiny, particularly if budgets are pooled. An integrated approach between health and social services is necessary,² but given that primary care groups and health authorities will seldom be coterminous with local government bodies, it is not clear who will liaise with whom. Duplication and confusion are real risks.

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

1 Audit Commission. *Higher purchase: commissioning specialised services in the NHS*. London: Audit Commission, 1997.

2 Audit Commission. *Coming of age: improving care services for older people*. London: Audit Commission, 1997.

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NHS Direct: managing demand

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The second 50 years of the NHS will see a very different relation between the service and the public it serves. One of the four key themes of the white paper is the introduction of NHS Direct, a 24 hour nurse led helpline. After piloting it will cover the whole country by 2000, as proposed in the chief medical officer's report on emergency services in the community.¹ However, NHS Direct is not solely about telephone advice lines. It should also herald a fundamental shift in the NHS where more public participation in health care can happen closer to home and where more care

can be delivered without face to face contact. It may well be the most important development this white paper has to offer.

NHS Direct has profound implications for the shape and purpose of the developing health service in general and primary health care in particular (especially if the gateway to the NHS moves from the surgery to the sitting room). A publicly led NHS may soon complement a primary care led NHS, where NHS Direct could help enable much more graduated access to the right care at the right time in the right way by the right person.

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