The New NHS: commentaries on the white paper

From command economy to demand management

The white paper on the NHS in England, *The New NHS*, published last month by the government, has generally been favourably received, but many of the proposals lack detail. We asked several policy analysts, public health doctors, and clinicians to comment on various aspects of the white paper, and in this week's issue and the next two we publish their commentaries. This week we also publish Donald Light's view from America (p 217), in which he argues that Britain hasn't learnt hard won lessons on the need for purchasers to be large and powerful

Financing the NHS

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BMJ 1998;316:212-6

The white paper sets out a bold and imaginative vision for the organisation and provision of health care. The unanswered question is whether the money will be available to turn this vision into reality.

Taking the optimistic view—the view set out in the white paper—there is no reason to believe those who argue that the NHS will be unable to cope with the demands of increasing public expectations, medical advances, and an aging population. On this reading, the proposals for improving clinical effectiveness and reducing unnecessary bureaucracy will enable the NHS to accommodate future pressures without sacrificing its commitment to universality and comprehensiveness. Moreover, by aligning clinical and financial responsibility, the government's plans will empower doctors and other health care professionals to improve services from the patient's perspective, particularly by reducing variations in performance.

Taking the pessimistic view, there is nothing tangible in the white paper to show that the NHS will be adequately funded to deal with the pressures under which health authorities and trusts are currently working, let alone enable them to respond to increasing demands in future. In this respect, there is a remarkable similarity with *Service with Ambitions*, the white paper issued by the former Conservative government,¹ which also promised to increase the NHS budget in real terms but did not specify the size of the increase. Those holding this view would argue that handing over control of resources to primary care groups is less a means of empowering professionals than a way of devolving responsibility and blame for unpopular rationing decisions.

Which of these views becomes reality depends on the outcome of the comprehensive spending review being undertaken by the Treasury and on the realism of the white paper's estimate that cuts in administration

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will save £1bn over the lifetime of the current parliament. Justifying the latter estimate, the government hopes that the move to long term service agreements, the ending of extracontractual referrals, and reductions in management costs will deliver savings of around £250m a year. Although this figure is much lower than the claims made by Labour spokespeople in opposition, it will not be easy to release these sums unless there is a major programme of trust mergers and continuing action by the NHS Executive to bring high spending health authorities and trusts (in terms of management costs) closer to the average. Even if the government's figures are taken at face value, the additional resources available for patient care will be modest (less than 1% of the NHS budget per year) and will only partly help to fill the funding gap.

Of greater importance is the comprehensive spending review. The white paper effectively pre-empts the review by committing the government to maintain a health service available to all on the basis of need, not

ability to pay, and funded through general taxation. It also explicitly rejects the argument that rationing or charging for treatment will be necessary. This suggests that the review will focus on other issues, like the control of pharmaceutical costs and measures to increase NHS efficiency, rather than the principle of health service funding. Many in the NHS will also hope that it creates greater certainty by sketching out a funding path for health care which removes some of the instability of current arrangements.

Notwithstanding the additional funds made available to deal with this winter's pressures, health authorities and trusts are struggling to balance their

budgets, deal with emergency admissions, and achieve the targets for waiting times. While the white paper was never intended to examine the adequacy of NHS funding, these financial pressures seem certain to preoccupy ministers in the coming months. It would be a tragedy if implementation of a vision for the organisation and provision of care that has attracted widespread support were to be frustrated by an approach to NHS spending that owes more to electoral expediency than the current state of the public finances.

1 Secretary of State for Health. *The National Health Service. A service with ambitions*. London: HMSO, 1996.

A third way? England—yes; Scotland—maybe

Greg Parston, Laurie McMahon

Much of the comment on the white paper so far has ignored general intention and focused on details of employment, cash flow, and management—or rather the lack of them. Little is being said about the government's bold attempt to construct "a third way" between old bureaucratic command and control systems and the fragmentation and distortions of the internal market. This new path will effectively result in the creation of nationalised health maintenance organisations, led by clinicians but focused on population health. Yet the most commentators seem to be preoccupied with questions about "How do they expect to ...?" without much understanding of "Why?"

The English health maintenance organisation idea makes a lot of sense; moreover, the lack of detail at this stage is a positive feature. If there is anything to be learnt from the past two decades it is that changing a complex organisation like the NHS is a long and subtle process. Whatever its faults and probably more by default than design, *Working for Patients*, the white paper that introduced the NHS reforms in 1991, also lacked the detail necessary to prescribe in advance exactly how the system would work. Consequently, those in the NHS charged with implementation had the opportunity to shape the reforms to reflect NHS values. A good example was the way in which purchasers interpreted their role to encompass pursuit of health gain for whole populations. Nothing like that was envisioned in *Working for Patients*. People on the ground—clinicians and managers—added value to central policies by putting in place the details themselves.

The current white paper recognises that the relationships that general practitioners have with their patients and the public, established 50 years ago, are in need of renegotiation; that hospital dominated services suited to the technologies of the 1960s and 1970s need to be modernised; and that new ways need to be found to balance the tensions between local decision making and the centralised performance management regimens imposed in the 1980s.

By grouping general practitioners and their patients as the basic building blocks of a renewed national service, the white paper sets out to provoke new thinking and to promote innovation in determining how to make a service suited for modern times.

This is a fundamental change in which the voice of primary care professionals, particularly general practitioners, has been deliberately amplified. This is a creative change which encourages testing and emphasises learning—all in the interest of the nation's health.

Some observers think that the certainty in the uniform and rapid changes prescribed in Scotland's white paper, *Designed to Care*, might provide a better way forward for England, too. We are not convinced. *Designed to Care* re-establishes the financial supremacy of health boards. But rather than "a third way," the Scottish changes could easily become a step back towards the old command and control systems, in which decision makers far removed from patient care and service delivery determine resource allocation and thus service configuration. Given political sensitivity to budget deficits, health boards might be tempted to set aside the long term goal of improving public health and use this reinstated hierarchy of command to slip back into operational management, with trusts treated as old style directly managed units. But the biggest difference from the English approach is that Scottish general practitioners come across less as leaders of local services and more as subjugates to local planners and managers.

All this is apparently acceptable to Scottish clinicians and managers alike, but moving directly to such a uniform model will allow little learning or means for gradually resolving the differences that really do exist between clinicians and managers. We believe that the English approach allows the system to evolve and adjust over time; indeed, the white paper suggests a 10 year programme of improvement. But in Scotland today's "one best way" may well produce structures and incentives that prove too brittle when stressed with the pressures of change of the next century.

We believe that the way forward in England, Scotland, and—with their proposals still coming—Wales and Northern Ireland must entail clear national strategies mixed with large measures of local discretion and flexibility and with strong voices for doctors, nurses, and other primary care professionals. In England, this can all happen provided ministers avoid the temptation to pick up the powerful managerial reins that lie in the traces. In Scotland, with the reins already in their hand, we fear it may not.

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