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

12 January, 1998

1. Sources of information accessed

- *The new NHS : modern, dependable.* London : Stationery Office, 1997
- Journals taken from the King's Fund library (handsearched):
  - *BMJ*, 13 December 1997
  - *Community Care*, 18 December 1997
  - *The Economist*, 13 December 1997
  - *Health Service Journal*, 11 December 1997, 18 December 1997
  - *The Lancet*, 20/27 December 1997
  - *Medeconomics*, December 1997
  - *New Statesman*, 12 December 1997, 19 December 1997
  - *Nursing Standard*, 10 December 1997, 17 December 1997
  - *Nursing Times*, 10 December 1997, 17 December 1997
  - *The Health Summary*, December 1997
- Databases searched:
  - King's Fund Library Unicorn Database
  - DH-Data
  - GPGP

2. Information gleaned

- The majority of comments regarding the content of the new white paper fit the category of a qualified welcome; in many instances though clarification of the initiatives has also been called for.
- The white paper claims that the internal market is dead; however, many commentators refute this.
- Questions have been asked about the origin of the money necessary to pay for the changes. It is not thought that savings from red tape will be enough to fund the reforms.
- Many have expressed concern at the thought of management redundancies (part of the assumed savings from red tape) just at a time when skilled managers will be needed to implement the changes.
- Several commentators believe that the Primary Care Groups will in fact increase bureaucracy rather than reduce it.
- The concept of Primary Care Groups is liked in general, although the abilities, desire and time commitments of their potential members to do the job have been questioned.
- The idea of collaboration rather than competition has been praised.
- The quality initiatives (NICE, CHI, clinical governance) have been praised, but more detail about their structures and powers is wanted.
- Longer-term contract planning is liked.
- Questions have been raised from patients' associations a[illegible] involvement in the new system.
- [illegible]S Direct and the merging of GMS and Hospital and C[illegible] gets have only received limited comment but are, in g[illegible]

FOR REFERENCE ONLY

HIBG2 (Kin)

3. The reactions in detail

3.1 General attitudes to the white paper

An editorial in the *Health Service Journal* states that the "initial reactions to *The New NHS* ranged from the merely warm to the ecstatic."[19]. Although many commentators on the white paper, including managers, nurses, doctors, academics, some politicians and union representatives, were positive in their observations[1,5,8,15,19,25,31,32], several have qualified their welcome with concerns about the ways in which the initiatives will be implemented[9,16,17,18,19,23,25,31].

One of the main reactions which has been expressed in the professional press is surprise, both at the extent of the reforms and at how positively the commentators find themselves viewing them.

Those commentators who have expressed their surprise at how "radical"[19,25] the reforms are have described the contents of *The New NHS* variously as "ground-breaking"[6], "bolder and broader in scope" than was expected[2], bringing in the NHS's "biggest shake up in recent years"[8] and even as "the biggest reform of the health service since it was created"[19]. Rhidian Morris, Chair of the National Association of Fundholding GPs has described his organisation's executive as "40 gobsmacked people"[19].

Along with several of these commentators, Roy Lilley believes that it is the changes in commissioning which are the most dramatic initiatives in the white paper:

> "This long overdue bright idea can revolutionise the NHS...The transfer of care into the primary sector is going to happen. Nothing else matters. Nurses answering hot-lines to try and determine the difference between a child with the 'flu and one with meningitis will evaporate into confusion."[24]

Interestingly, however, it is the shifting of commissioning into the primary care arena which has caused some of the concern and debate in other quarters[1,9,16].

Some professional commentators have expressed surprise at how encouraged they feel by the content of the new white paper (for example, Kieran Walshe[32] and Ray Robinson[19]). Others still see *The New NHS* as simply a set persuasive yet inconsequential words on a page. An editorial in the *Health Service Journal* puts the new white paper in that category of government documents which it describes as being "like property developers' brochures: full of seductive, if rather stylised, artists' impressions of imposing structures which one day may stand where currently only rubble and rudimentary foundations are to be found."[16]

The fact that the reforms are being designed to take ten years to complete has caused some comment. The above mentioned editorial in the *Health Service Journal* says that this can be interpreted in two ways, either as "ministers admirably refusing to duck the long term" or as "a cop-out" as the government will have a ready made excuse if the results are "slow or unflattering" [16]. This editorial also points out that it is a little presumptuous for a seven-month old government to be laying plans for beyond the next election.

Despite this, several of the seasoned commentators have given a welcome, albeit cautious, to the proposals within *The New NHS*.

3.2 The end of the internal market?

The claims that *The New NHS* heralds the end of the internal market have been greeted in two ways: some commentators have cheered at this news, while others have said that this is a little premature as the internal market still exists within the new initiatives.

Those who have been cited as applauding or at least mentioning the demise of the internal market include Roger Kline, of the Manufacturing Science and Finance Union (MSF)[15], Matthew Limb, writing in the *Health Service Journal*[26], the Royal College of Nursing[12,18,30], Sandy Macara, the BMA Council Chair[19], First Division Association (which claims to represent more than half of all trust chief executives)[19], the Local Government Association[19] and, unsurprisingly Alan Milburn, writing in the *New Statesman*[27] and David Hinchcliffe MP, quoted in the *Health Service Journal*[19].

More has been written by those who believe that the internal market has not in fact met its demise in the new white paper, although the numbers of those who think that it has finished and those who believe that it has not are roughly similar.

The Liberal Democrats have been cited in three places in the literature reviewed as condemning the Labour government's "spin" that they have abolished the marketplace in the health service[14,19,31]. In a briefing given prior to the publication of the white paper, Evan Harris, Liberal Democrat health spokesman, has been quoted as saying:

> "For all Labour's spin on new models of commissioning healthcare, the basic principles of the market, as established by the Tory government, remain intact."[14]

In another article he has been quoted as going further than this, accusing the Labour administration of being less than honest:

> "It is dishonest of the government to pretend that they are undoing the Tory legacy of damaging and wasteful competition."[31]

The idea that beneath the white paper's proposals lies an internal market of competition with purchasers still "shopping around elsewhere"[13] for services is picked up by other commentators[13,24]. An editorial in *The Economist* goes so far as to suggest that "[r]ather than being scrapped, the market is being modified, in some ways for the better, in others for the worse."[11]. The author of this article mocks the changes to the commissioning system proposed in the white paper:

> "The buyers will still decide what to buy and will still be able to switch between sellers. This, whatever Mr Dobson says, is what is commonly known as a market."[11]

This article also asserts that the reforms in *The New NHS* point primarily to "keener competition", especially in relation to the league tables of performance which have been proposed. In an article in *The New Statesman* Alan Milburn denies that this is the purpose of the mooted benchmarking. He says that "[c]omparison, not competition, will be the lever for efficiency"[27].

Several commentators have highlighted the retention of the purchaser-provider split. They see this as an essential remnant of the internal market which ensures that it will continue, even if the official emphasis is to be on collaboration[33,34]:

> "Many features of the internal market will survive. For example, the separation between the purchase and provision of hospital care will be retained; cooperation, however, will replace competition."[33]

Both Bob Abberley, Unison's Head of Health and Malcolm Dean, writing in *The Lancet*, recognise the compromise manifested in the white paper proposals. Abberley claims that the government "has performed the impossible and will make a silk purse out of a sow's ear of an internal market"[5]. Dean states that this process of modification was already underway ("The most competitive parts of the Conservative model had already been modified"[3]) before the publication of the new white paper. Despite the possibility that the remaining system may not resemble the original competitive market, some concerns have still been raised over the potential conflict of interests within the new Primary Care Groups. It is possible that the Primary Care Groups will end up both as commissioners of services and as providers (see section 3.5.1).

3.3 Problems with paying for the changes

One of the most frequently asked questions among the commentators is: 'where is the money to pay for the reforms to come from?'. The financial situation does not seem to be clear at all. Evan Harris of the Liberal Democrats has claimed that the white paper has been completed prematurely as it has been published prior to Labour's NHS spending review[31].

The claims in the white paper that the money to fund the projects will be found by cutting bureaucracy have caused consternation and disbelief in some quarters. Jonathan Baume, general secretary of the First Division Association emphasises the need for adequate funding:

> "Studies of the kind of commissioning bodies proposed by the government show that the changes cannot work unless the management structure is properly financed."[19]

This sentiment is reiterated elsewhere in the professional press. Malcolm Dean paints a bleak financial picture by comparing these Labour reforms with the introduction of previous, Tory ones:

> "Some proposals, such as 3-year service agreements, will only work if ministers replace the present stop-go funding with a clear, generous spending programme. The Tories launched their reforms with a 7.2% real increase in funds. Next year, the NHS is scheduled to get only a 1.5% increase - 3% is needed just to maintain existing services."[3]

The white paper claims that the £1 billion necessary to finance the changes is to be made from cuts in red tape. How this will work in practice does not seem to be clear. Andrew Lansley, Conservative MP for Cambridgeshire South and a member of the health select committee has described the white paper as "the NHS according to Pangloss"[19]. He points out that it claims that "[e]verything is going to be for the best but it does not provide for the resources to deliver the best.". An editorial in the *Health Service Journal* describes the less than concrete funding source for the changes as simply "promises of savings"[16].

The vagueness of these plans has provoked others, such as Rhidian Morris[19] and Sandy Macara[18], to question them. Morris is keen to know the details of how the proposals will be financed ("If this is going to work properly it is going to require real money."[19]). Stephen Thornton, Chief Executive of the NHS Confederation, has welcomed the collaborative aspects of the reforms but deliberately points out what should happen next:

> "The next step, and it is an important one, is to get the resources and capital investment to go with it."[25]

This concern about the funding of the reforms has engendered a fear that GPs in the Primary Care Groups "will become scapegoats for an underfunded NHS" (Limb and Chadda writing in the *Health Service Journal*[4] and repeated by Sandy Macara[18]). The financial situation seems bleak to many commentators.

The source, as well as the possibility, of these savings has also caused alarm. Doubt has been expressed that savings from "red tape" are feasible "at a time when skilful management will be more in demand than ever"[16]. Stephen Thornton, Claire Perry, Chief Executive of Bromley Health Authority[25] and an unnamed Liberal Democrat spokesperson[8] have all expressed scepticism that the claimed £1 billion can be saved on bureaucracy over the next five years[25]. Jaki Meekings of the Healthcare Financial Management Association identifies "a credibility gap between the pink and fluffy picture we are being given and what is happening here."[19]. She states that "[f]rom the financial point of view" a reduction in management costs at a time when tough decisions need to be taken is "untenable". Thornton has also asked the question about who would pay for all the redundancies that these savings will create[25].

The question of how to pay for the changes has made some commentators concerned that rationing will continue unabated. The MSF believes that without extra finance the NHS will continue to be about "rationing and managing shortages"[15]. Stephen Pollard, writing in the *New Statesman*, implicitly agrees with this. He states that "[i]f we want to increase the amount spent on healthcare, we have to do it privately"[29]. Without this, he says, "rationing and adequacy (rather than excellence)" will always be with us.

Some other commentators have criticised the absence of any new policies in the white paper which refer to rationing (Malcolm Dean[3] and Simon Hughes MP[19,31]). An editorial in *The Economist* implies that, even if the word "rationing" has been omitted from the document, the concept of rationing has been included in the reforms via the National Institute for Clinical Excellence (NICE):

> "[M]ost NHS staff are unlikely to be fooled by the way the white paper dodges the questions they most want answered...What treatments will be rationed - because if it is to be worth having, NICE will have to be nasty and say which patients should be denied expensive drugs."[11]

Very few commentators believe that management savings can be found; however, Malcolm Dean is one who suggests that this is possible. He submits that the supposed reduction in competition would also curtail the "paper chase" in which, he cites, "one authority spent 8% of its budget dealing with 60,000 invoices"[3]. This would save some money at least, although Dean admits that, even so, a proper funding programme will be necessary.

It is clear from these comments about the lack of any mention of rationing and about the money needed to fund the reforms (and the scepticism that the management cuts will provide the £1 billion) that finance is one of the details in the white paper needing clarification. As with all white papers, many commentators have uttered words along the lines of "the devil will be in the detail" (Karen Caines[25], Judy Hirst[21], Kieran Walshe[32]) and with this white paper it seems that it is the financial detail which is of the most concern.

3.4 Problems with managing the changes

3.4.1 Potential loss of management jobs

Several of the criticisms regarding the cost of implementing the reforms refer also to the need for good management skills during a time of change. Alan Milburn has been quoted as saying that "[s]ome people will lose their jobs. But that is the price to pay for increased efficiency."[26]. He has also, however, said that "[m]anagers at all levels have a crucial responsibility to help roll out these changes"[26]. Roy Lilley believes that Milburn "will have ruined the Christmases of a few thousand managers who are likely to be stuffed, along with the turkey"[24]. Milburn has certainly caused some confusion. The job losses of which he has spoken and which are intended to find the £1 billion savings from bureaucracy, have been assumed to be via cuts in management posts; however, at the same time, managers, in his own words, are supposedly "crucial" to the implementation of the reforms. This paradox has raised the question: how are the changes to be implemented when those people best qualified to do this work may well lose their jobs?

An editorial in the *Health Service Journal* points out the complexity of the task which is facing the NHS:

> "[I]t is one thing to state, as *The New NHS* blithely does, that, 'the government intends to establish primary care groups across the country' and quite another to organise the individuals involved into coherent and workable organisations which meet the national criteria."[17]

Gill Morgan, President of the IHSM, agrees that the "multiprofessional-led commissioning groups" will take time to organise. She warns that this delay, accompanied by the reduction in management costs, might mean the loss of that "cohort of effective primary care management" built up over the past few years[25]. This in turn could hinder the implementation of the reforms.

Peter Homa, the IHSM Chair, fears that the changes may be even more difficult to achieve due to the demoralisation which will accompany the cutbacks. This will not create a good working environment:

> "If you have individuals in the NHS who are worried about their jobs, that is very demoralising at a time when they are most needed to implement the changes the government wants."[25]

Rhidian Morris looks at the demoralisation issue from the general practitioner's point of view and makes the comment that GPs will be concerned if they have to make some of their staff redundant[19]. Karen Caines, also from the IHSM, questions the NHS's ability to reorganise itself according to the initiatives in the white paper, even without the demoralisation which may accompany this restructuring:

> "It puts great faith in complex organisational arrangements inside the NHS and beyond. Making them [the reforms] work and maintaining accountability will be challenging."[25]

Caines makes the point that there is a huge need for both effective management and staff training to ensure that the changes will work. Carole Lawrence-Parr of the Association of Managers in General Practice agrees with this; she is, however, more positive about the "excellent" management opportunities the reforms could engender. She thinks that there may be places for managers in the Primary Care Groups even if there will be immediate "casualties" among fundholding staff[19] - something about which she is not so pleased.

Another major point which has been raised in relation to the implementation of the reforms and the feared cuts in managerial jobs concerns the management skills of that group of health service staff who look likely to take over many administrative roles in commissioning services: the GPs. Several commentators have expressed doubts about the abilities of GPs in this area (see section 3.5.1 for more detail).

Rhidian Morris, quoted in an editorial in *The Economist*, sums up the view that cuts really should not be made via managers' jobs:

> "Stop attacking the grey suits. We need managers in the NHS, and if you get good managers they are worth every penny."[11]

The commentators in the main believe that managers fulfil a vital role and that cuts in their jobs would be nonsensical. Without them the changes may well be funded adequately; however, they would not be implemented effectively.

3.4.2 Increase in bureaucracy?

Far from reducing red tape, as is the stated intention in the white paper, several observers have claimed that the reforms will in fact result in more bureaucracy. Both Evan Harris, a Liberal Democrat spokesperson on health and the author of an editorial in *The Economist*[11] suggest that red tape will be increased by giving GPs commissioning powers[14]. *The Economist* editorial also points out that the introduction of the Primary Care Groups will in fact bring in "an extra layer of management to the NHS". Barry Elliott, Chair of the Healthcare Financial Management Association Education and Development Committee and Finance Director of Royal London Hospitals Trust, agrees with this. He views the problem from the practical angle of the provider's dealings with potentially many commissioning bodies:

> "I can see my trust having to deal with 20 Primary Care Groups. If we have to deal with them specialty by specialty, as it suggests in the white paper, that will mean something like six by 20 service level agreements to draw up."[19]

Professor George Alberti, President of the Royal College of Physicians, points out that, from the other angle, that of the new commissioning bodies, a lot more clerical support will be needed if the Primary Care Groups are to work. Without this additional management, he is concerned that the standards of services could fall:

> "These [the new commissioning arrangements] will require considerable administrative support for GPs and could lead to downgrading of quality of care if the cheapest options are always sought or too many services provided in the community without specialist cover."[19]

One of the only comments which accepts that the management cuts may be fruitful financially and culturally comes from Labour MP, David Hinchcliffe. He points out how new partnerships between social services and health professionals could "abolish the awkward and wasteful bureaucracy we've been plagued with in recent times"[21]. Many other commentators would see this desire to streamline the system as wishful thinking in light of the proposed changes.

3.5 The initiatives

3.5.1 The Primary Care Groups

Very few adverse remarks have been made about the concept of the Primary Care Groups. The fact that the idea has been accepted is shown by an advertisement which appeared in the *Health Service Journal* on 11 December, only three days after the publication of the white paper. It promotes a series of one-day workshops, the purpose of which is "to explore the development agenda for local health groups"[20]. An expectation at least exists that people in the field will want to embrace the reforms.

The fact that a number of models has been proposed is generally liked. Ray Robinson explains that this is a good idea because "[a]s far as purchasing is concerned...we have no evidence that one model is better than another"[19]. The *Health Service Journal* agrees. While criticising the fact that, as with fundholding, "the government is making GPs an offer they cannot refuse", it seems pleased that the various models "will allow the more reluctant a gentle introduction to commissioning"[16].

Only two commentators so far have predicted a possible problem with the diverse nature of the different Primary Care Groups. The first is from a *Nursing Standard* editorial:

> "Some groups may only want to take an advisory role. Others will want to set themselves up as independent trusts, running their own community hospitals. Critics of the plans have said this could lead to confusion."[5]

The second criticism of the four Primary Care Group models refers to the problems of GPs holding a budget. Chris Ham is keen to see an accountability framework between the Primary Care Groups and health authorities:

> "If you are going to devolve lots of budgetary authority to primary care groups, there has to be a *quid pro quo*."[19]

Ron Singer, spokesman of the National Association of Commissioning GPs, is also less than happy about the budgetary responsibilities being given to GPs. Although he believes that the aims of his organisation have been "vindicated more or less 100 per cent" by the white paper[19], he is concerned about levels two to four of the commissioning models which give the practitioners a budget:

> "There is no other health service in the whole world that gives practitioners the budget. We think that's problematic. We have been very keen to point out that if you give groups like this a budget, 90 per cent of their attention will go on managing it, and we have always said what is missing is planning and thought about what's needed."[19]

Rhidian Morris, on the other hand, is concerned that the reforms may not be giving GPs enough power[19]. He states that "only two" of the previous reforms worked (the 1966 GP charter and fundholding) and that the reason for these successes was that GPs in their surgeries were given more power to create change. He is not sure that the currently proposed changes will do this and worries therefore that they will fail. He is also concerned that Primary Care Groups' management spending is to be immediately capped at £3 per head when he estimates that fundholding practices currently spend around £4.50 per head[19]. He and his colleagues think that the new system can work but only if it gives GPs "real power to

make changes" and if "investment in premises and practice-based staff and quality management" are also introduced[19].

Other admirers of the new system include the MSF[15], the British Association of Medical Managers who applaud the collaborative working the Primary Care Groups will be undertaking with trusts[15], Karlene Davis, general secretary of the Royal College of Midwives who is pleased that midwives will be involved in the Primary Care Groups[5,18] and Norah Casey[1] and Jack Shamash[30], both writing in the *Nursing Standard*, and who both particularly like the idea of nurses working alongside GPs and other health professionals as commissioners.

Other bodies are also anxious to become involved. Judy Hirst, writing in *Community Care*, reports on the social services' keenness to sit on the Primary Care Groups and to collaborate with their colleagues in the health service[21]. She cites Ian White, Hertfordshire Social Services Director and Roy Taylor, President of the Association of Directors of Social Services, who are both eager for health and social services to decide priorities together and for access to social services to be provided via the Primary Care Groups. Hirst also quotes Chris Vellenoweth, Community Care Spokesperson for the NHS Confederation who sees opportunities for sharing responsibilities between the two agencies:

> "[I]t's possible to imagine the Primary Care Group becoming the agency which commissions some elements of social care for social service users, such as frail, elderly people, who have additional health requirements, while social services departments could concentrate on those who do not."[21]

Another body keen to join in is the Chartered Society for Physiotherapists. Its members are concerned that the composition of the Primary Care Group boards will be too narrow and questions "whether GPs and community nurses alone" could make complex purchasing decisions[19]. It advocates further involvement from the professions allied to medicine.

Many of the writers in the nursing press have shown their enthusiasm for nurses' roles within the Primary Care Groups. The general opinion, as described in a *Nursing Standard* editorial and reiterated elsewhere, is that the reforms are "good news for nurses"[5,17,28,31]. There have been a few fears that the nurses might be overshadowed by the doctors[5,6] or that community nurses who are not attached to general practice might find it hard to play a proper role in the groups[17].

These possibilities have been refuted in several other places. Margaret Jay has written that the reforms, especially NHS Direct, include a "new leadership role for community nurses"[22]. Jack Shamash reports that a ministerial aide has said that health authorities will have to ensure that nurses have reasonable power and that "[t]okenism will not be permitted"[30]. In another article a Departmental spokesperson has been quoted as advocating balance in the groups:

> "We have not set an explicit figure for community nurses but certainly would not want to see a group in which 99% of its members were GPs and there was one token [nurse] appointment."[6]

This sentiment has been repeated by Alan Milburn[5]. Sandy Macara has also emphasised the need for teamwork in order to try to counter the possibility of nurses being sidelined in the Primary Care Groups[6]. Unison reads the white paper as an affirmation by the government of the value of the views of nurses and other health staff "working at the sharp end" through the plans to give them a key role in decision-making[5], as does Heather Ballard, professional

officer at the Community and District Nursing Association[19]. Indeed, a ministerial source has been quoted as saying that nurses' partnerships with GPs in the Primary Care Groups "is a recognition of the distinctive professional perspective they bring"[31]. Christine Hancock implies that giving nurses a "key role in planning and commissioning services" is a logical step as they "have so much experience in providing" them[5]. Both the RCN and the Community Practitioners' and Health Visitors' Association are already discussing how to encourage their members to take a proactive role in the commissioning process[6].

The GPs' new roles have been touched upon also by Stephen Thornton. He points out that the GPs' entire status will alter; they will become embraced wholeheartedly within the workings of the NHS:

> "It has never been entirely clear whether GPs were really part of the NHS. This makes it very clear that they are - and I will be interested to see the considered view of the profession when this sinks in."[19]

It is really only the involvement of GPs in particular in the management of the NHS and in the commissioning of services which has drawn several commentators' criticism of the Primary Care Groups. Frank Dobson has been quoted as believing that most doctors and nurses have the "touching old-Labour faith in cooperation and goodwill" that he himself was accused of displaying[10]. Unfortunately, not everyone agrees with this. Michael White, writing in the *Health Service Journal* points out that a lot of this "goodwill" will be needed within primary care for the reforms to succeed[34]. Many disparaging comments have been made concerning the lack of GPs' management skills and also concerning their potential unwillingness, inability and lack of time available to collaborate and communicate with each other. "Goodwill", it seems, is not considered to be part of a stereotypical GP's general characteristics.

An editorial column in the *Health Service Journal* highlights, among other issues, three problems surrounding the GPs' new roles: their need for training ("Few have any training in commissioning...They will need to be schooled in how their actions will impact on the service as a whole, which might take time"); their attitudes to being given this extra responsibility ("[H]ow happy will GPs be to have so much influence showered on them?"); and the possibility that the partnership idea will break down when the GPs have to communicate with consultants ("So the deep-seated antagonism between GPs and consultants will feel another sharp prod, possibly jeopardising alliance-building and ambitions for a seamless service in some places.")[16].

More comments have centred on the GPs' abilities to communicate among themselves and with their colleagues in Primary Care Groups rather than with other groups. John Maples, shadow health secretary, has been cited as fearing that there may be problems with different GPs in the groups wanting to spend money in different ways[19]. A *Nursing Standard* editorial quotes him as foreseeing "political infighting with people battling to get more power"[5]. Collaboration between GPs is not regarded as realistic. The *Health Service Journal* predicts that "furious rows" will ensue once GPs realise that "some degree of their independence has been taken away" and that *The New NHS* "spells the beginning of the end of contractor status and separate practices"[17]. *The Economist* cannot envisage teamwork taking place within primary care:

> "Given GPs' reputation for being independent-minded, it is easier to imagine them squabbling over which treatments to buy."[11]

This same article goes on to quote Stephen Thornton, who expresses the opposite worry. He is concerned that in practice co-operation might simply mean that each primary care trust will be a "local conspiracy to mediocrity"[11], where doctors do collaborate, but only inasmuch as to agree not to embarrass each other by trying too hard to innovate.

Representatives of other primary care workers have been more positive about collaborating with GPs. Jackie Carnell, Director of the Community Practitioners and Health Visitors Association, has said that community nurses are very keen to be part of the team in the Primary Care Groups and are looking forward to "forging a genuine partnership with GPs[19]. The fears of several of the other commentators that GPs may not necessarily want to forge genuine partnerships with anyone else at all means that this may be a little optimistic.

The time taken for the GPs and other primary care professionals to do all this extra work - and to be trained so that they *can* do all this extra work - has also alarmed several commentators. Karen Jennings, the professional officer of Unison, expresses the need for those nurses who will be involved in running Primary Care Groups to be allowed time away from work for training purposes[5]. The extra work might be such that many GPs will not want to take part. Karen Caines worries that the lack of incentives for GPs to join the groups will mean that the system is vastly different in different parts of the country:

> "It is not clear...what will happen if some GPs do not want to take part. You could end up with a very hybrid system."[19]

An editorial in *The Health Summary* also refers to the extra work the changes will bring for primary care staff. It questions, however, not the new responsibilities for the commissioning but the existing, front-line caring, asking: "where will the *work* go?"[9]. This brief article is concerned about the effect that giving primary care staff responsibility for commissioning services will have on their current tasks of caring for their patients. The author puts this point into the context of GPs' questionable teamwork and management expertise:

> "How many GPs have the time, inclination or skills to manage primary and secondary care, renowned as they are for their lack of teamwork and tact?"[9]

Perhaps the most disturbing comment on the subject of the extra work the reforms will give GPs comes from a GP himself. Vaughan Smith from Somerset was quoted in the *Daily Telegraph* and then in the *Nursing Times* as fearing that "[t]his scheme may finally drive me and like-minded colleagues out of the NHS altogether"[18].

Another major potential problem concerning the Primary Care Groups is the possibility of a conflict of interest with the groups potentially both commissioning and providing services. Even though the government claims to have abolished the internal market, the notion of competition certainly has not disappeared from the interpretations of the white paper by the commentators. An editorial from the *Nursing Standard* describes the likely situation thus:

> "Some primary care groups will be able to set themselves up as trusts and run their own community hospitals. These hospitals might find themselves in competition with existing facilities."[13]

A *Health Service Journal* editorial suggests the answer to this and other problems is for England to follow the system laid out in *Designed to Care*, the Scottish health white paper[17].

The question of the structure of the Primary Care Groups is unresolved. Chris Ham praises the white paper and describes it as a "slow-burning fuse", emphasising that the NHS will attain a much greater "primary-care orientation"; however, he asks that thought is given to the structure of the groups to ensure that they reach out to people in the community and are "not just clubs for local GPs"[19]. He would also like to see them as "community health agencies" because "they will be doing a lot more than just running community hospitals and things like that"[19].

Ray Robinson is worried about the structure of the groups in relation to the population each covers. He is concerned that the government "has gone for very large units"[19]:

> "The idea that the total commissioning/primary care group must cover a population of 100,000 people makes sense in terms of transaction costs, but the evidence from the total purchasing pilot sites is that the smaller units have been the most innovative."[19]

The problem of larger units lacking imagination also concerns Edward Peck, Director of the Centre for Mental Health Services Development:

> "If you look at the big multi-funds we have now, they are more conservative than the smaller ones. There is a danger of getting the lowest common denominator in these groups. They will not do things to destabilise their local hospital, but they may not do much to upset friends or colleagues either."[19]

The main worries over the Primary Care Groups surround the management and communication issues between those members of NHS staff who will sit on the boards. Although the concept of primary care led commissioning is generally welcomed, much concern has been voiced over the make-up of the groups, their ultimate powers, their structure and how they will be made accountable for their actions.

3.5.2 NHS Direct

The nurse-run telephone hotline has received mixed reactions. The nursing press is wholeheartedly in favour, as is the nursing community (via the Community and District Nursing Association[19] and the RCN[31]) Representatives of the social services can also see the opportunities which the hotline will bring. Roy Taylor views it as another medium through which health and social services can work more closely together as access to some social services could be developed via NHS Direct[21].

Christine Hancock seems delighted and told BBC Radio 4's *Today* programme that the RCN has "been arguing for this for some time"[31]. She highlights the success of similar hotlines which are being piloted in Southampton and King's College Hospital. In the same article, a research fellow at King's College Hospital's A&E primary care services, Brian Dolan, adds a warning that the scheme should not be used as a cost saving exercise:

> "The scheme needs to be well resourced and adequately staffed by nurses who are experienced. It has to be a quality service and not just a way of cutting costs."[31]

Other commentators are scared that this is just what the scheme might be: a way of saving money which, unless properly funded, will have no real value to patients. Virginia Bottomley has dismissed the hotline as simply "bells and whistles"[34]; Roy Lilley wonders who will pay for it[23]; Professor George Alberti does not believe that the hotline will decrease emergency admissions[19].

The *Nursing Times* is keen on the idea, as a way that nursing care can be reengineered, but has not accepted it unquestioningly. It is concerned about three aspects of the scheme: the lack of physical contact with the caller could be problematic as "a face-to-face encounter is usually the only way to differentiate between these patients [the worried well] and the genuinely and seriously ill"; patients may think they are being "fobbed off" if they are not assured that "quality of care will not slip" and that "this service is not being piloted simply because doctors feel that many patients waste their time"; and the problem of inappropriate use of health services will still exist. This scheme should not detract from educating the public about their own health and the ways in which they contact the health service[7]. This article states that unless answers are found to the questions of why patients call out their GP or visit A&E "for all the wrong reasons" then "NHS Direct runs the risk of becoming the three-hour wait at A&E in another guise.".

3.5.3 Collaboration not competition

Many commentators applaud the partnership approach to health and social services and to primary and secondary care adopted in the new reforms (Stephen Thornton[25], British Association of Medical Managers[15], Rita Stringfellow, Local Government Association Social Affairs and Health Committee Chair[19], Bob Abberley[18], Roy Taylor[21], Margaret Jay (naturally), writing in the *Nursing Times*[22]).

Others, however, can see potential problems. An editorial in the *Health Service Journal* describes the new statutory duty of partnership as a "magic wand" designed to improve relationships between different agencies. This article also explains that breaking down barriers "does not always make for harmony and unity":

> "[I]t can as easily provoke warring factions, whose new-found proximity exacerbates opportunities for squabbling when co-operation proves difficult - as it inevitably will in many places."[16]

This is also recognised by commentators from the social services. Judy Hirst, writing in *Community Care* acknowledges that in developing a collaborative framework "[t]here will be a lot of baggage to discard in terms of old rivalries, suspicions and vested interests.". Ian White is concerned that the language used by health and social services is quite different in some areas and that this might cause problems:

> "Social services departments are very familiar with rationing and eligibility criteria as the basis on which to prioritise, whereas this is not as yet the language of the NHS."[21]

Perhaps this comment indicates the vast gap of understanding which exists between the health and social services: although eligibility criteria do not enter into health services, rationing is a topic which is certainly hot at the moment, as is evinced by the many comments which criticise the white paper for not mentioning it.

Despite these differences in knowledge, understanding and culture however, the idea of partnership is generally applauded in the reactions to the new white paper.

3.5.4 Longer-term contract planning

Although not commented on in many places, this initiative has received congratulation wherever it is mentioned. Stephen Thornton describes it as going "with the spirit of the times" and mentions also that the next important step is to "get the resources and capital investment to go with it"[25].

Christine Hancock has also been quoted as approving this change. She links it to nurse jobs, saying that replacing the annual contracting round with a three-yearly cycle could also "put an end to the trend of short-term employment contracts for nurses, which are so damaging to nurse recruitment"[18].

3.5.5 Quality initiatives (NICE, CHI and clinical governance)

Many commentators have broadly praised the new quality initiatives (e.g., Claire Perry[25], Stephen Thornton[25], Bob Abberley[5,15,18], the UKCC[8], Karlene Davis[5], Jackie Carnell[5,25], Simon Hughes MP[25]).

A few commentators have likened the quality initiatives to the education reforms instituted by the previous government. Michael White states that "the comparison with education is quite explicit here: standards, not extra cash, are seen to be the key"[34]. An article in *The Economist* describes the white paper as "one of several examples of New Labour repackaging old Toryism"[11]. This article compares the initiatives introduced in both sets of reforms: it links the league tables of health bodies' performance to the league tables of schools' exam results; it links the Commission for Health Improvement (CHI) to Ofsted; and it links the National Institute for Clinical Excellence to the schools' national curriculum.

Other commentators have praised the proposals but questioned the way in which they will work. These comments are not criticisms *per se*, but seem more like probing questions from interested parties. Most of them concern the powers of the new bodies and the ways in which their recommendations can be enforced. Despite lauding the white paper for ensuring that "quality improvement was a major, recurring theme" and despite admitting to finding this "genuinely surprising and even exciting", Kieran Walshe, for example, is being cautious to ensure that the quality initiatives will be worthwhile[32].

Regarding NICE, he indicates that if it "sorts out the nonsense of all HAs making their own separate decision about whether or not to buy new technologies...then all to the good"[32]. He would be even more pleased if NICE were to mean that "new healthcare interventions (not just pharmaceuticals but also things like surgical procedures) will need to have demonstrated clinical and cost-effectiveness before they can be used in the NHS. His concern is directed at the power which could be wielded by the Institute; it will need statutory force:

> "If all NICE can do is advise, exhort and persuade, then past experience suggests its recommendations will often be ignored."[32]

The opposite view is expressed by the Association of British Pharmaceutical Industry who welcome NICE but argue that it is "absolutely essential that evidence of clinical effectiveness is provided as a guide to doctors, not a diktat"[19].

Walshe is similarly in favour of, but concerned to see more details about the proposed CHI. He describes this as "an ambitious, but ambiguous remit". As with NICE, he asks whether it

will only be able to offer advice but will be "impotent" if clinicians and managers ignore that advice, or whether it will have powers to "remove, reorganise or redeploy individuals or teams which fail to address serious deficiencies in clinical performance"[32]. He sees it as possibly becoming one of two sorts of organisation: either a health service inspectorate which monitors and improves quality (this, he says, could "stimulate worthwhile improvements...but also demands significant resources [and] we are told CHI is to be financed from existing funds"); or a body which will be largely focused on investigating and dealing with clinical disasters (this he says is "less attractive and sounds like being the official locker of stable doors"[32]).

The structure and decision-making powers of both the CHI and NICE are also questioned by the Healthcare Financial Management Association[19], Karen Caines[19] and Stephen Thornton[19]. Caines describes the "flavour" of this part of the white paper as "very interventionist". Thornton believes that some in the medical profession think "and probably hope" that these bodies will be making lots of difficult decisions, a scenario which he doubts will occur. He thinks the decision-making will still lie with the health authorities but that those who do make the decisions will have better information on which to base them.

On clinical governance, Walshe is much less equivocal in his praise. He calls it "perhaps the most innovative quality improvement idea"[32]. Stephen Thornton is "warming to the idea", but wants to know what levers will be provided to ensure that physicians comply with the protocols[19]. Karen Caines supports clinical governance and sees it as being analogous to corporate governance[19]:

> "[T]rusts will have to have the right standards and processes in place to ensure service quality. I think that is an excellent idea, and a real change."[19]

Caines's approval of the quality proposals are reflected in the words of many of the other commentators. Walshe's last comments in his article show that any questions he may have about the quality initiatives are sitting on top of his ultimate enthusiasm for them:

> "For a long time, the NHS has been sorely in need of a coherent approach to quality improvement. Despite warm words of encouragement, we have never had a lead from the very top that shows by its actions that quality really matters. If the early promise of *The New NHS* is fulfilled, we may have got that at last."[32]

It is safe to say that the general reaction to the quality initiatives was one of surprise, hope and praise.

3.5.6 The merging of budgets

Little has been written in the professional press about the merging of budgets. A few commentators, such as Evan Harris MP[14], have regretted the fact that the white paper did not merge the health and social care budgets. Chris Vellenoweth agrees here but believes that the pooling of the two budgets may not be far away and might even appear in the forthcoming social services white paper[21].

A little more comment has been made over those budgets which the white paper does intend to merge: those for primary care and for hospital and community health services. Karlene Davis believes that this unification of budgets will mean fairer rewards for midwives. Her approval is not reflected everywhere though. Trevor Jones, Director-General of the

Association of British Pharmaceutical Industry, is concerned that the restructuring of the budgets "should recognise the potential for increased expenditure on the medicines bill to bring substantial reductions in other budget areas or to treat more patients for the same money"[19].

Roy Lilley is even more concerned than this. He describes the unification of these budgets as a "slow-burning fuse" and as "a bomb that has been put under the NHS that is every bit as explosive as the 1990 reforms"[24]. He likens the potential scenario of "the army of doctors and nurses" who will be "commissioning, managing, running, regulating, operating, planning, forecasting, predicting, calculating and estimating the health needs of groups of around 100,000 people" to an old district health authority. This he describes as "constipated, moribund, stagnant, motionless and at times [a] confrontational nightmare". He believes that "[h]ospitals will become like Swiss cheese with holes holding the chewy bits together" as great "lumps" are carved out of secondary care. Despite all this, he also describes the reforms as a "long overdue bright idea [which] can revolutionise the NHS"[24].

3.6 Concerns over the lack of public involvement

A few commentators have expressed their concern at the lack of public involvement indicated in the reforms. These include the Long-term Medical Conditions Alliance[19], the Association of Community Health Councils of England and Wales[19], the National Consumer Council[18] and Evan Harris MP[31].

Other commentators, such as Claire Perry[25] and Jackie Carnell[5], believe that patients have been put at the centre of the reforms, especially through the new quality initiatives. Christine Hancock also believes that patients could benefit from the proposals:

> "The new primary care groups, where collaborative working is the key, are an excellent opportunity to bring health services closer to local communities and improve public health."[5]

Although public or patient involvement is not mentioned in the white paper and this has caused some anger in the patients' representatives, a few of the other commentators see the reforms in general as bringing health services closer to patients and trying to act to improve them for their benefit.

4. Conclusion

The reforms included in *The New NHS: modern, dependable* have been generally welcomed. Questions have been raised about the detail of several of the initiatives, including in particular the Primary Care Groups, NICE and the CHI. The main criticism homes in on the white paper's assertion that it has abolished the internal market. Many commentators say that this just is not true. Despite this, the majority of the reactions recorded in the professional press towards the white paper have been surprisingly positive.

King's Fund
54001000715816

BIBLIOGRAPHY

1. Casey, Norah. Editorial. *Nursing Standard.* 10 December 1997, p .1.
2. Crail, Mark. News focus: modern times? *Health Service Journal.* 11 December 1997, pp. 10-11.
3. Dean, Malcolm. End of sharp-elbowed internal market for NHS. *The Lancet.* 20/27 December 1997, p. 1829.
4. Editorial. *Medeconomics*, December 1997, p. 9.
5. Editorial. A 'brilliant start' but more detail needed. *Nursing Standard.* 17 December 1997, p. 10.
6. Editorial. Call to stop GPs seizing control. *Nursing Times.* 17 December 1997, p. 8.
7. Editorial. Comment: nurses have always been central to the health service. It has just taken some time to convince the government. *Nursing Times.* 10 December 1997, p. 3.
8. Editorial. Co-operation put at centre of new NHS. *Nursing Standard.* 17 December 1997, p.9.
9. Editorial. Disingenewous. *The Health Summary.* December 1997, p. 1.
10. Editorial. Dobson 'proud' of good faith. *Nursing Times.* 17 December, 1997, p. 8.
11. Editorial. Dobson's choice. *The Economist.* 13 December 1997, pp. 33-34.
12. Editorial. In brief. *Nursing Standard.* 17 December 1997, p. 11.
13. Editorial. Internal market may not be dead. *Nursing Standard.* 17 December 1997, p. 11.
14. Editorial. Labour has not killed market, say Lib Dems. *Health Service Journal.* 11 December 1997, p. 4
15. Editorial. "NHS needs cash to deliver on promises". *Health Service Journal.* 11 December 1997, p.4.
16. Editorial. Opinion: papering over the cracks. *Health Service Journal.* 11 December 1997, p. 17.
17. Editorial. Short-lived season of goodwill. *Health Service Journal.* 18 December, 1997, p. 17.
18. Editorial. Unions welcome demise of the internal market. *Nursing Times.* 17 December 1997, p. 9.
19. Editorial. White Christmas. *Health Service Journal.* 18 December 1997, pp. 10-13.
20. Health Services Management Unit (University of Manchester) & Dearden Management. Advertisement for The NHS White Paper: One-day workshops to explore the development agenda for local health groups. In: *Health Service Journal*, 11 December 1997, p. 39.
21. Hirst, Judy. Primary concerns. *Community Care.* 18 December 1997, pp. 8-9.
22. Jay, Margaret. Comment: the white paper recognises that nurses have a critical contribution to make. *Nursing Times.* 17 December 1997, p. 3.
23. Lilley, Roy. Breathing fresh life into the NHS. *The Health Summary.* December 1997, pp. 1-3.
24. Lilley, Roy. Leaks and gales. *The Health Summary.* December 1997, pp. 3-4.
25. Limb, Matthew and Chadda, Dolly. Managers welcome white paper's radical direction. *Health Service Journal.* 11 December 1997, p. 4.

26. Limb, Matthew. Standards and management costs are top targets in "bold" white paper. *Health Service Journal*. 11 December 1997, p. 3.
27. Milburn, Alan. The NHS is safe in our hands. *New Statesman*. 19 December 1997, p. 25.
28. Payne, David. Primary movers. *Nursing Times*. 17 December 1997, pp. 12-13.
29. Pollard, Stephen. Radical treatment for the NHS. *New Statesman*. 12 December 1997, pp. 10-11.
30. Shamash, Jack. White Paper puts community nurses on commissioning boards. *Nursing Standard*. 10 December 1997, p. 5
31. Sylvester, Rachel. White paper boosts nurse power...but doesn't go far enough, say Lib Dems. *Nursing Times*. 10 December 1997, p. 5.
32. Walshe, Kieran. NICE ideas on quality. *Health Service Journal*. 18 December 1998, p.20.
33. Warden, John. White paper puts GPs in the driving seat of the new NHS. *BMJ*. 13 December 1997, p. 1561.
34. White, Michael. Ghost of Labour Past rattles his paper chains. *Health Service Journal*. 18 December 1997, p. 21.

KING'S FUND LIBRARY
11-13 Cavendish Square
London W1M 0AN

Class mark	Extensions
H1B52	Joh
Date of Receipt	Price
4/2/98	Donation