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### White paper More brickbats than bouquets?

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# More brickbats than bouquets?

We asked a range of commentators from clinicians to academics to comment on the white paper on health *Equity and Excellence: Liberating the NHS*. Has the NHS become “a huge laboratory for some dodgy experiments,” will the white paper divide the medical profession, or will it empower doctors?



**John Appleby**  
 chief economist, *The King's Fund*  
 The underlying argument seems to be that although choice, competition, plurality of supply, and devolved decision making were the health policies eventually reached by New Labour, they had never really been tried out properly. The market had always been constrained and a bit half hearted. Choice was never a reality for most patients, and as for primary care trusts as commissioners—total (and expensive) failures at their jobs. A harsh diagnosis perhaps, but what to do to achieve an NHS that “achieves results that are among the best in the world”?

Much of the prescription is essentially to retain the economic architecture—for example, choice and competition—but to shake up the organisational structure: out with primary care trusts, strategic health authorities, targets, and ministerial “meddling”; and in with compulsory GP commissioning, an independent NHS board, and “outcome goals.” Whether you see this as evolution, revolution, devolution, or just the same old solution depends on your point of view—although views seem unconventionally split; there are

ex-Labour health advisers supporting the proposals<sup>1,2</sup> and right of centre think tanks opposing them.<sup>3</sup>

The crucial question is whether these reforms are a cost effective way to achieve better health outcomes and more productive use of every NHS pound. The main danger is that efforts to improve productivity as money gets tight will be diffused, and the cost of change outweighs the value of the benefits. Is this a gamble worth taking?

**Kambiz Boomla**  
 senior lecturer, *Centre for Health Sciences, Queen Mary University of London*  
 The coalition promised us protection of NHS budgets with continuing growth, and no more major reorganisations. Both pledges now seem in tatters. We now face the largest structural reorganisation the NHS has experienced alongside NHS chief executive David Nicholson asking primary care trusts to find £20bn (€23bn; \$30bn) of savings next year. But GPs are being wooed with the prize of being in charge of 80% of the budget. Is this a gift we should be seizing with both hands, or would we be wise to heed the words of the Trojan priest Laocoon: “Beware of Greeks bearing gifts?”



It would have been hard for this government, without any democratic mandate to do so, to have privatised chunks of the NHS in one go. But if you combine the promise of “any willing provider,” which means private sector companies can bid for any contract, with “no bailouts for organisations which overspend public budgets,” it becomes clear where these reforms are heading. It is unlikely that GP consortiums will be so much more efficient than primary care trusts in commissioning that we will be able to prevent provider trusts from overspending their budgets, or indeed, stay within our own budgets. Perhaps that would have been possible before the credit crunch, when there was real growth in the system, but not now. With Monitor as the watchdog, a failure regime is being established that will allow chunks of the commissioning and provider side to be handed over to the private sector as the public sector fails. This has already started in education. Heed the words of that Trojan priest.

**Professor Peter Davies**  
 consultant chest physician, *Liverpool Heart and Chest Hospital*  
 I believe the reorganisation is irrelevant to the needs of the health service. Its introduction will cause temporary harm in the short term as managers and clinicians try to find out what they should be doing, and in the long term it will make little difference. I believe we have lost the plot when it comes to NHS organisation. Once it was designed as a top down almost



paternalistic system with the district health authority as the basic building block. Money came from central government and was distributed to hospitals and practices by the district health authority according to need on the basis of population and pathology. It worked, but was grossly underfunded. Fire services are organised in this way.

In 1990, under Kenneth Clarke, we changed from a “fire service” method of organisation to a “grocery store” type. The district health authority was abolished. In its place GPs became purchasers and hospitals became providers. The internal market arrived and was supposed to improve services as competition improves grocery provision. We had GP fundholding practices for a while, but they were inefficient and wasteful.

Dealing with patients with diseases is not as simple as selling apples and cornflakes. Undergraduate, and particularly graduate, teaching and research do not fit this model.

When increased funding came, as it did under Labour, much of the benefit was wasted propping up this inappropriate model. After 20 years no political party will admit they are wrong and end the failed experiment of the internal market.



**Jacky Davis**  
co-chair NHS Consultants' Association

The white paper is guaranteed to do at least three things. It will accelerate the commissioning and delivery of NHS care by the private sector. It will direct blame for the inevitable cuts and closures away from politicians towards GPs. Finally, it will divide the profession.

The government has been astute. It knows that doctors are tired of bureaucracy so the phasing out of primary care trusts and strategic health authorities is attractive, as is the prospect of GPs having charge of the commissioning budget. Knowing this, they have set up a bear trap baited with GP commissioning. Unfortunately, it seems that the bait is so alluring that the profession is walking straight into the trap.

Commissioning will end up in the hands of private companies who will buy care from other private companies under the “any willing provider” agenda. GP consortiums will be vulnerable to being bought up by the health corporations, as they have been in the United States. Hospitals will have to become social enterprise bodies outside the NHS, with loss of national terms and conditions and pensions for their staff in a short time. NHS staff on national terms and conditions will rapidly become an endangered species. End of the NHS, anyone?

The private sector has already acknowledged that this cannot happen without GP cooperation. But the proposals have no electoral mandate, no supporting evidence, no consultation, and no pilot. The profession should answer “no thanks.”

**Andy Haines**  
professor of public health and primary care, London School of Hygiene and Tropical Medicine, London  
GPs will assume much of the risk at a time when, as the government ac-

knowledges, “there are some difficult decisions to make.”

Success will be judged not by the performance of the best consortiums, but by whether the reforms as a whole deliver improved outcomes with greater efficiency and increased equity. Fundholding by general practices produced relatively modest returns.<sup>5</sup> Can a more comprehensive involvement yield greater impacts while reducing current management costs by an arbitrary, but prescribed, 45%? Given the likely increased transaction costs from engagement of large numbers of commissioning consortiums this is a challenging goal. These legitimate questions can be answered only by rigorous evaluation<sup>6</sup> which, given the welcome commitment to research and to evidence based practice, should be built in from the outset. The capacity of Monitor to ensure transparent pricing and financial accountability as well as the NHS Commissioning Board to promote quality and support GP consortiums will be key to progress.



Proposals for the integration of public health into local government should provide an opportunity to influence the social and environmental determinants of health through intersectoral action as well as much needed coordination of health and social care. The proposal to create a new public health service that includes the responsibility for vaccination and screening, however, risks separating these from primary care.

Finally, it is essential that training and education are not subject to the vagaries of short term commissioning by providers who do not have a strategic view of workforce requirements.

**David Haslam**  
national clinical adviser, Care Quality Commission, president elect, BMA  
It’s probably a case of “be careful what you wish for.” For years, primary care leaders have banged the drum

for an increased focus on their corner of the medical world. And now it feels as if general practice is being told, “Okay, if you’re so smart, you sort it out.” Not only do GPs have to deal with most of the problems of most of the population most of the time, but now in England they have to run the NHS too.



The white paper should be applauded for many things. Patients, not the needs of the system, should—must—be at the centre of all that we do. At last there is an attempt to describe what the NHS is for. After all, if you can’t define what you are trying to do, you can’t tell if you are succeeding. And not before time it seems that quality, and the description, demonstration, and measurement of quality, is central to policy.

Although the aspirations are noble, the devil—as ever—will be in the detail. In particular, what might the unintended consequences be? In the same way that drugs may be prescribed with noble intent and yet turn out to have unpredicted side effects, so can noble policies cause unpredictable problems. For instance, if experienced GPs, with their ability to manage clinical risk, spend more of their time on commissioning, will referral and prescribing costs escalate as inexperienced colleagues see the patients?

I wish the white paper well. It offers potential for genuine improvement, but—as with any form of prescription—an understandable desire for rapid results may increase the degree of risk. Identifying and minimising risk isn’t being negative. It’s absolutely essential.

**David J Hunter**  
professor of health policy and management, Durham University  
The changes to the English NHS leave no part untouched. Once again, it has become a huge laboratory for some dodgy experiments. A few good things are in prospect, including the



move of public health to local government and an expanded role for NICE (National Institute for Health and Clinical Excellence). But these stand to be eclipsed by other hasty and ill conceived proposals. Handing responsibility for commissioning to 500 or so GP consortiums is high risk. There is no evidence that a reckless shift of power and resources on this scale will succeed. The evidence from the past 14 NHS “redisorganisations” suggest otherwise. Like GP fundholding in the early 1990s, GP commissioning may prove to be more of a wild card than a winning hand. To claim the changes are about culture and not structure is disingenuous and flies in the face of what is happening as primary care trusts wind down.

Putting patients at the heart of everything may improve care for some, but probably not for all with the “inverse care law” becoming more entrenched. The principal beneficiaries of the changes, apart from some enthusiastic GPs, will be private healthcare companies already circling and ready to swoop to make a killing from the NHS’s ringfenced budget and, in the process, fragmenting services, “gaming” the system to cherry pick patients, and driving up transaction costs.

**Bart Johnson**  
chief executive, Assura Medical, part owned by Virgin Healthcare  
It is easy to be distracted by the obvious headline grabbers. But taking the white paper as a whole, it is clear that the government’s strategic reform is focused on developing a system of health care where patients



are empowered to make informed choices about which GP they want to register with.

That registration comes with a budget for the patient’s entire care, indicating that there will be rapid evolution of a free market that is based on fair and open competition, quality and service, with the principal aim firmly targeted on improving patient outcomes.

Although much of the commentary has focused on commissioning, it is probable that the most dramatic and permanent changes will be around provision. Existing and new providers will have opportunities to deliver services in novel ways, and it is fair to expect an increasingly competitive marketplace to emerge in which, among others, GP led provider organisations are ideally placed to progress.

Not all GPs will find the transition easy. Some will be looking to exit partnerships and secure salaried positions. Consortia will look inside and outside the NHS for help in their new roles. Well established companies like Assura Medical, who are already working in partnership with GPs are likely to be the type of organisation GPs turn to.



**Robert Lechler**  
executive director of King’s Health Partners

Several features of the white paper are to be thoroughly welcomed. These include the empowering of doctors and patients to influence the design of clinical services, the commitment to reduce the tiers of management with their associated costs, and the greater emphasis on public health. Perhaps the most important shift of emphasis is from targets (inputs) to outcomes (outputs). Although targets have led to improvements in the performance of the NHS in several areas, they are no substitute for measuring what matters most to patients—namely, the outcome of their health care. The

white paper also makes reference to the importance of biomedical research as an engine of innovation in the NHS; given the substantial investment in health research through the National Institute for Health Research, the creation of a few biomedical research centres, and the competitive accreditation of five academic health science centres, these centres of excellence need to be further supported and looked to for leadership and quality improvement across the spectrum of health care. Two crucial dimensions, however, are not explicit in the white paper. The first is the importance of designing specialist services on the basis of evidence, benchmarked against the best outcomes in the world. This will often lead to the concentration of activity in major centres, creating the volume of activity that allows the highest quality results. This approach has guided the rationalisation of several major specialist services in London during the implementation of the Darzi reforms.

The second is the development of models of integrated health care, dissolving the primary-secondary care divide. Such integration has the potential to improve outcomes, particularly for patients with chronic diseases, to improve patient satisfaction, and to reduce costs. Most importantly, if funded by a capitation based model, integrated care systems transfer the incentive to keeping people healthy and promoting population health, rather than rewarding clinical activity.



**Judith Lindeck**  
general practitioner, Cambridgeshire  
My initial thoughts are that this could be good and that the proposed consortia feel like the old primary care groups or primary care trusts, which seemed to work well in Bristol where I used to work.

But here in Cambridge will it change anything? We have one large

“multinational” hospital in town—effectively a monopoly provider.

The experience with a local practice based commissioning group was that our hospital was unlikely to help us set up alternatives to their service unless it suited them. After all it would reduce their funding, and without secondary care cooperation a community service might be unsafe or unusable.

Negotiating contracts with a monopoly doesn’t work. They will certainly not reduce their prices if they have a guaranteed workload. If the consortium doesn’t pay the patients won’t get treated. If the consortium goes into the red, then what? No health care for Cambridge? The white paper doesn’t explain.

If patients have the choice of where they go and who they see, most will choose the local hospital. Why travel 17 miles when you have a “world class” hospital on your doorstep? The primary care group has set up alternative endoscopy and radiography services in a neighbouring town, but the patients won’t travel that far, even if parking is free.

In Bristol there are four hospitals within easy reach, and patients are happy to travel between them so I can see how in big cities these reforms could work well. In small cities and towns it’s hard to see how any commissioning consortia could do more than tweak the edges. We might save a little here and there, but not enough to make the amount of time that is lost worth while.

**Allyson Pollock**  
professor of international public health policy, Edinburgh University

The NHS in England is to be dismantled and instead health care will be run on US healthcare lines. If this paper is enacted then for the first time in 60 years the citizens of England will experience a return to fear. The hallmark of our health service is public funding raised through general taxation; public ownership, and public accountability for services; and area based planning and allocation of resources for services delivered on the basis of need and not ability to pay. But unlike Scotland and Wales, which have reversed market oriented changes, successive English



governments have eroded the foundations of the NHS in England, paving the way for market and profit oriented health care to introduce private “for profit” elements into clinical care.

And now, with neither an electoral nor a moral mandate, the legal duty of the secretary of state to provide universal care to the whole population on the basis of need and not ability to pay is to be abolished. The NHS will be reduced to simply being the government payer and patients and staff exposed to the full weight of market forces. GPs do not have professional training or experience in health service planning let alone commissioning; meanwhile the private for profit sector and multinational healthcare companies are lining up to take control of the £80bn (€95bn; \$123bn) of NHS resources. The BMA and all doctors must not let the NHS go undefended—and neither should the citizens of England.



**Ann McPherson**  
medical director, DIPEX Health Experiences Research Group, University of Oxford

Much in the white paper cannot be questioned. The positives are: it gives high value to patients’ views of the services, it says that it upholds the values and principles of the NHS, it continues to support quality standards developed by NICE to inform commissioning, and it has the ambition to provide a world class service. It also highlights the need to increasingly take account of patient experiences. One thing is certain—yet another reorganisation will use

money that could be better spent on patient services, and waste a huge amount of professional clinical time which could be better spent on patient care.

But why this endless concentration on “choice,” which I think is a distraction and a “catch all” word? As a long time GP requiring considerable personal medical care myself—choice has been low on my list of priorities. What I have certainly wanted, and what my patients have told me that they want, is good evidence based, quality care that is near home. This means well informed and understanding GPs and a good local hospital with short waiting lists (something that targets have achieved).

I am sceptical that 500 or so GP consortiums commissioning services will save money or result in better patient care, let alone provide more efficient planning of appropriate services. They will probably further open the door to private enterprises, which will initially offer services cheaply as lost leaders, along with inducements to GPs to commission their services, and then tighten the financial screws to ensure they make greater profits. Is this where the NHS should be going?

**Gayathri Rabindra**

general practitioner trainee, Sidcup, London Deanery

GPs currently do some commissioning, and a few consortiums are around. As a GP trainee I find the proposed changes both exciting and terrifying. In theory, we do know more than the managers about what our patients want and need. We are not trained as experts in commissioning and planning services, however, so is it right to give such a big responsibility to us? Having worked in a primary care trust, I have seen the amount of work and time that goes into this: researching the diseases in a population, what the current services are, what



national guidelines are, what the population wants. Can all this really be scrapped and GPs expected to do it on top of their usual jobs? Won't it take GPs away from patient care? The main thing that patients always want is more access to their GP.



**Simon Stevens**

president of global health at UnitedHealth Group, and a trustee of the King's Fund

What's not to like about the new NHS white paper? Certainly there are risks. Can local GP commissioning consortiums be effective in every part of the country—and, if not, what's the fall back plan? How will the transition of all NHS hospitals to the foundation trust “liberated zone” fare? Will the proposed regulatory division of labour between Monitor, Care Quality Commission, and the new commissioning board work?

But history suggests it is budget crunches, not system reforms, which generate the NHS's existential crises—in 1951, 1968, 1976, 1987-8, and 1999.<sup>7</sup> This parliament will see an unprecedented NHS funding deceleration—with Labour unusually arguing that the centre-right coalition should impose deeper NHS cuts.<sup>8,9</sup>

So the key judgment call is: which policy regime is best suited to safeguard and improve patient care under these new conditions of austerity? Central diktat, or an approach that increasingly relies on patient empowerment, local professional judgment, and greater provider dynamism?

Some people will assert the latter path is a ploy to “destroy the NHS.” Similarly apocalyptic, but ultimately spurious, prophecies date back at least three decades.<sup>10-13</sup> The inconvenient truth is that on most key indicators the English NHS is probably performing better than ever.<sup>14-17</sup>

Others would simply prefer a halt to further structural change. The paradox is that it is the NHS tax funded status and consequent

national political control, which NHS loyalists admire, that in turn cause the stop go budgeting and top down reorganisations, which they lament. Sixty years of accumulated evidence indicates that praising the NHS, while attacking these intrinsic realities, is as futile as fishermen cursing the sea.

**Richard Thompson**

president, Royal College of Physicians

Andrew Lansley is not a timid man. To secure his reforms he proposes to overhaul, at tremendous speed, the entire basis on which the NHS is organised. Placing responsibility for commissioning with GPs, and scrapping many of the centrally managed performance targets brings numerous risks and costs, but also opportunities.

Any hospital doctor who has spent time trying to explain their service to a non-clinically trained commissioner will rejoice at the thought of being able to talk directly with their new GP commissioner. Conversely, GPs are well placed to evaluate services. So long as the relationships are characterised by the courteous scepticism that only members of the same profession can display towards one another, this has the potential to be an important lever for quality.



Nevertheless, we should not underestimate the task facing our primary care colleagues. Few will start the job with experience of developing whole-population strategies, nor be fully prepared for the necessary change in mindset. It is also disappointing that more is not said in the white paper about integrating primary and secondary care. Effective management of the growing chronic disease burden will require GPs and their specialist colleagues to collaborate more closely if their shared patients are to see the right person, in the right place, and at the right time.



**Jonathan Waxman**

professor of oncology, Imperial College London

The white paper is a finely written piece of prose redolent with allegory and metaphor that comes straight from a copywriter's posterior. It proposes joined up, radical change to the way the NHS is managed and will empower the professionals . . . well some of them, the GPs. The trouble is that the white paper doesn't seem to be written by an empowered joined up professional, and so lacks insight into the way the NHS works. It shows little understanding that health care is complex and doesn't just involve one group of doctors, but many professional groups working together.

It seems that the notional cost of introducing these proposed changes is £1.7bn (€2bn; \$2.6bn). We know that government costing estimates are born in ya ya land, and usually out by a factor of 10 or 100, or whatever. We have seen the £15bn disaster of the NHS computer costs. The primary care trusts were introduced without trialling, and they have been a mess that costs £5bn a year to administer. The NHS is a £100bn business. What type of business introduces change of the order that the government is proposing without trialling? Don't you think we should think about things before we leap off the white cliffs into the savage sea and on to the razor rocks?

The current white paper sets one group of health providers against another. It claims to be joined up, but it is divisive and potentially destructive. Please minister, think again.

See **EDITORIAL**, p 211  
**OBSERVATIONS**, p 232

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