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The NHS White Papers

On 9 December 1997, the Department of Health and the Scottish Office published White Papers, *The new NHS, modern, dependable* and *Designed to care,* on how the "internal market" in the NHS was to be abolished. The Welsh Office brought out the equivalent paper for the NHS in Wales, *NHS Wales: putting patients first* on 15 January 1998. This paper summarises the main proposals in the three White Papers and discusses some of the comments made by interested parties to date. Legislation will be needed to implement some of the changes, and this is expected in the parliamentary session 1998/99.

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CONTENTS

Summary

In 1991, the Conservative Government introduced major changes to the management of the NHS through the *National Health Service and Community Care Act 1990*. This Act created a "purchaser/provider split" in the NHS between Health Authorities (responsible for assessing the health needs of their local populations and commissioning appropriate health services for them) and NHS trusts (responsible for providing those services). The concept of "GP fundholders" was also introduced, allowing GP practices to hold budgets and hence have considerable independence from their local Health Authority. Health Authorities and GP fundholders were at liberty to purchase services from whichever NHS trusts, or private providers, they wished, with the aim that the competition created by this "internal market" would both drive up standards and improve efficiency. A more detailed summary of the main aspects of the changes introduced by the 1990 Act is given in Library Research Paper 93/109, *The NHS reforms - the developing agenda.*

In their election manifesto, the Labour party promised to retain this "purchaser/provider split" but to abolish the internal market which they believed had led to both waste and injustice. The Government's proposals to achieve this were set out recently in three White Papers*: The new NHS* (England), *Designed to care* (Scotland) and *NHS Wales: putting patients first*. Part II of this Paper summarises the proposals for England. Changes include:

- the creation of "primary care groups" of GPs and community nurses to take on the role of commissioning care from NHS trusts, with the ultimate aim of becoming free-standing "primary care trusts"
- Health Authorities to be given a more strategic role
- the system of annual contracts between purchasers and providers to be replaced by longer-term "service level agreements"
- budgets for hospital and community services, GP prescribing and GP infrastructure to be merged
- a new framework to be introduced to monitor NHS trusts' performance, with emphasis on quality and accessibility as well as finance
- a new "National Institute for Clinical Effectiveness" and a "Commission for Health Improvement" to be set up, the former to disseminate good practice guidelines and the latter with the powers of intervening where quality standards are inadequate
- three specific initiatives: a 24 hour telephone advice line, "NHS Direct", for patients; the connection of all GP surgeries to the NHS's information superhighway; and a guarantee of a maximum 2 week wait to see a cancer specialist after referral by a GP

Part III of this Paper describes the proposals for Scotland and Wales. Although the broad principle, that of abolishing the internal market, is the same across all three countries, there are significant differences in detail. In Scotland, GPs and other community staff will combine with NHS trusts providing community services to become "primary care trusts", but these

trusts (unlike the primary care groups in England) will not be responsible for commissioning hospital care from "acute" trusts. In Wales, "local health groups" of GPs, other health professionals and representatives from social services departments and the voluntary sector will be responsible for commissioning care but will remain sub-committees of Health Authorities and will not have the option of become free-standing bodies as in England.

Part IV of the Paper brings together some of the comments made to date on the three White Papers. In general, the response from health service professionals, academics and the general press has been positive, although there has been a lot of discussion as to how "primary care groups" and their Scottish and Welsh equivalents will work in practice. Particular issues that have been raised include the question of what incentives GPs will have to join primary care groups, how the groups will be managed, to what extent they will be accountable to their local populations and whether GP fundholders will accept their lessened independence. The merging of the hospital and community services, GP prescribing and GP infrastructure budgets has been welcomed, as have the proposals to give a greater emphasis to quality of care. Many commentators, though, have expressed concerns that the White Papers do nothing to address the question of the adequacy of the existing funding of the NHS.

I Introduction

In its 1997 manifesto, the Labour Party promised to make major changes to the NHS, stating:

> "There can be no return to top-down management, but Labour will end the Conservatives' internal market in healthcare. The planning and provision of care are necessary and distinct functions, and will remain so. But under the Tories, the administrative costs of purchasing care have undermined provision and the market system has distorted clinical priorities. Labour will cut costs by removing the bureaucratic processes of the internal market. The savings achieved will go on direct care for patients. As a start, the first £100 million will treat an extra 100,000 patients. We will end waiting for cancer surgery, thereby helping thousands of women waiting for breast cancer treatment.
>
> In recent years, GPs have gained power on behalf of their patients in a changed relationship with consultants, and we support this. But the development of GP fundholding has also brought disadvantages. Decision-making has been fragmented. Administrative costs have grown. And a two-tier service has resulted. Labour will retain the lead role for primary care but remove the disadvantages that have come from the present system. GPs and nurses will take the lead in coming together locally to plan local health services more efficiently for all the patients in their area. This will enable all GPs in an area to bring their combined strength to bear upon individual hospitals to secure higher standards of patient provision. In making this change, we will build on the existing collaborative schemes which already service 14 million people.
>
> The current system of year-on-year contracts is costly and unstable. We will introduce three to five-year agreements between the local primary care teams and hospitals. Hospitals will then be better able to plan work at full capacity and co-operate to enhance patient services."[1]

Two White Papers were published on 9 December 1997, setting out how the Government intends to fulfil these promises: *The new NHS: modern, dependable*,[2] covering England, and *Designed to care*,[3] covering Scotland. A further White Paper, covering Wales, was published on 15 January 1998: *NHS Wales: putting patients first*[4] and a consultation paper for Northern Ireland, has been promised for the near future. This Paper will summarise the main points of the English, Scottish and Welsh White Papers, together with a discussion of the responses to the proposals which have been made so far.

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1 Labour Party, *New Labour: because Britain deserves better*, 1997
2 Cm 3807, 9 December 1997
3 Cm 3811, 9 December 1997
4 Cm 3841, 15 January 1998

II The English White Paper

The Department of Health sets out six key aims which it believes underlie the proposed changes. These are set out in the White Paper, *The new NHS: modern, dependable*, as follows:

"
- First, to renew the NHS as a genuinely **national** service. Patients will get fair access to consistently high quality, prompt and accessible services right across the country
- but, second, to make the delivery of healthcare against these new national standards a matter of **local** responsibility. Local doctors and nurses who are in the best position to know what patients need will be in the driving seat in shaping services.
- Third, to get the NHS to work in **partnership**. By breaking down organisational barriers and forging stronger links with Local Authorities, the needs of the patient will be put at the centre of the care process
- but fourth, to drive **efficiency** through a more rigorous approach to performance and by cutting bureaucracy, so that every pound in the NHS is spent to maximise the care for patients.
- Fifth, to shift the focus on to quality of care so that **excellence** is guaranteed to all patients, and quality becomes the driving force for decision-making at every level of the service
- and sixth, to rebuild **public confidence** in the NHS as a public service, accountable to patients, open to the public and shaped by their views."[5]

The ways in which the White Paper envisages these principles being put into practice can be divided into three broad categories: through changes in organisational structure, through new mechanisms for improving quality and through new incentives to improve efficiency. These three categories will be considered below in turn. Three specific initiatives are also promised, as examples of how the new approach will work, and these are discussed in section D below. Finally, the various "milestones" for implementation of different parts of the White Paper are set out in section E.

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[5] Cm 3807 p.11

A. The structure of the NHS

One of the major features of the Conservative reforms of NHS structure, implemented through the *National Health Service and Community Care Act 1990*, was the separation of the roles of the "purchasers" of health care (District Health Authorities and the new GP fundholders) from the "providers" of care (hospitals, community services and ambulance services). Providers were encouraged to apply for trust status, giving them managerial independence from District Health Authorities. Formerly, District Health Authorities (which have since merged with Family Health Services Authorities and been renamed "Health Authorities") were responsible both for deciding what services should be provided within their district and directly managing those services. The new system involved an "internal market" in which purchasers and providers contracted with each other for services and purchasers were at liberty to change providers if they could find better services elsewhere. GPs could also apply to hold their own budgets and hence be mainly independent of their local Health Authority when deciding what services to purchase for the patients on their lists.

The Labour manifesto had promised to retain this "purchaser/provider split" in the NHS while abolishing the "internal market". The means through which this might be effected have been much discussed in the health service press, with some commentators arguing that it is impossible to retain one without the other: without some form of contracting mechanism it would be meaningless to speak of a genuine split between purchasers and providers. Others have argued that the significant element of a "market" is not the contracting system in use but rather the existence of *competition* between providers; hence it is quite possible for there to be a distinction between commissioners and providers of care without this necessarily entailing a market system.[6] The White Paper proposes what it calls a "third way" between the centralised "command and control systems" of the 1970s and the internal market of the 1990 reforms in which providers competed with each other for purchasers' contracts.

1. Primary care groups

The way in which the White Paper proposes to keep the purchaser/provider split while abolishing the internal market entails major changes in the functions of NHS bodies and the relationships between them. At present, in some areas of the country, Health Authorities are the main purchasers of healthcare, with GP fundholders covering only a relatively small percentage of the population. (The opposite applies in other areas, with nearly all patients covered by fundholding GPs, leaving Health Authorities with a negligible purchasing role.) The White Paper envisages that primary responsibility for purchasing (or "commissioning") health care will in future be taken over from Health Authorities by "primary care groups" of GPs and community nurses. This builds on the principle of "GP commissioning" which has

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[6] for example "Old crisis with a new dimension", *Health Service Journal*, 10 October 1996 p.20 & "Dividing the spoils", *Health Service Journal*, 28 November 1996 pp 28-29

been developing under the existing structure, but would also include nurses working in the community as well as GPs.

At present the term "GP commissioning" can cover a wide range of involvement by GPs in Health Authority commissioning: all the way from a group of commissioning GPs taking full responsibility for deciding what services should be purchased for their locality and negotiating directly with providers, to GPs offering advice to Health Authorities but with no real authority for budgetary decisions. The White Paper envisages four stages of "primary care groups" encompassing these extremes, but visualises that in time all groups will progress to the most developed stage. Stage 1 represents a minimum level of GP and nurse involvement, with primary care groups advising the Health Authority on its purchasing decisions. Stage 2 involves primary care groups taking devolved responsibility for managing the healthcare budget in their area, but the formal financial responsibility will remain with the Health Authority: in other words, primary care groups will take the relevant decisions but the financial mechanisms will still be routed via the Health Authority. Some of the more advanced GP commissioning groups are currently already at this stage. At stage 3 groups will become free-standing bodies accountable to Health Authorities; they will therefore be able to take all their own purchasing decisions without formal reference to the Health Authority, but will be held accountable for these decisions. Finally, at stage 4, primary care groups will take on additional responsibilities for providing community services (such as district nursing and health visiting) to their local populations. This final stage will effectively constitute a merger between GP services and services currently provided by community trusts (NHS trusts providing community-based, rather than hospital, services), although they will not be expected to take responsibility for mental health or learning disability services. Legislation is promised to establish these new "primary care trusts". Individual fundholding will be wound up, with existing fundholders becoming part of primary care groups in the same way as non-fundholders.

The White Paper emphasises that there is no intention to introduce "big bang" changes: it is envisaged that structural changes will take a period of ten years to be implemented and that the speed of change should be locally driven. Nevertheless, while "primary care groups will begin at whatever point on the spectrum is appropriate for them", all primary care groups will ultimately be expected to progress to the final stage, becoming free-standing bodies with responsibilities for providing community services and purchasing secondary (hospital) services, as well as providing traditional GP services. Groups should develop "around natural communities", typically serving around 100,000 patients; the desirability of aligning boundaries with local social services departments should be one factor when considering locally how groups could best be created.

2. Health Authorities

It is clear from the above description of the purchasing role of the new primary care groups that the role of Health Authorities will change considerably, as they lose their primary purchasing function. Their role is described as one of "strategic leadership" and the White Paper sets out seven key tasks for which they will be responsible:

"
- assessing the health needs of the local population, drawing on the knowledge of other organisations
- drawing up a strategy for meeting those needs, in the form of a Health Improvement Programme, developed in partnership with all the local interests and ensuring delivery of the NHS contribution to it
- deciding on the range and location of health care services for the Health Authority's residents, which should flow from, and be part of, the Health Improvement programme
- determining local targets and standards to drive quality and efficiency in the light of national priorities and guidance, and ensuring their delivery
- supporting the development of Primary Care Groups so that they can rapidly assume their new responsibilities
- allocating resources to Primary Care Groups
- holding Primary Care Groups to account"[7]

The first four of these functions parallel Health Authorities' current responsibilities for assessing the health needs of their local populations and commissioning appropriate services for them, with the obvious difference that the second part of the task, that of actually commissioning the services, will in future mainly be the responsibility of primary care groups. By losing this latter responsibility, Health Authorities should be "freed-up" to concentrate more on public health issues: assessing needs and drawing up plans both for the meeting of these needs and for preventive action to promote good health in the first place. The importance to be placed on the public health function is emphasised in the White Paper: a further Green Paper on public health, *Our healthier nation*, is due to be published shortly and Health Authorities are to be given new statutory duties to improve the health of their populations and to work in partnership both with other NHS bodies and with local authorities. Similarly, NHS trusts will also be given a new statutory duty of working in partnership with other NHS bodies. Joint working between the NHS, local authorities and voluntary agencies will be further encouraged through the development of "Health Action Zones": it is envisaged that up to 10 zones, in which relevant organisations inside and outside the NHS will develop joint strategies to improve local health, will be selected to "go live" by April 1998.

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[7] Cm 3807 p.25

The important role of "Health Improvement Programmes" is also stressed: initial plans will cover a three year period and will be updated progressively. Programmes will cover the "health needs" of the local population, the "healthcare requirements" of local people and the "range, location and investment required in local health services" to meet these needs. Given the nature of the purchaser/provider split, much of the work of implementing these Health Improvement Programmes will be done by NHS trusts and primary care groups, but Health Authorities will be responsible for monitoring their implementation and will have reserve powers to ensure that capital investment decisions are in line with the Programme.

The last three of the new Health Authority functions listed above bear more resemblance to the role of the old Regional Health Authorities which, before their abolition in 1996, were responsible for allocating resources to District Health Authorities and exercising a strategic overview over their purchasing plans. According to the White Paper, Health Authorities will have the ability to intervene (for example by insisting on changes in leadership or management, or by taking back some responsibilities) if a primary care group gets into serious difficulties. They will also be responsible for resolving any disagreements between NHS trusts and primary care groups. Similarly, they will be able to call in the relevant NHS Executive Regional Office to intervene if an NHS trust is failing to deliver its aims under the Health Improvement Programme.

3. The successor to the internal market

The purchaser/provider split will thus remain, with the "purchaser" functions split between two groups of NHS bodies: the Health Authorities, with their role of strategic planning and oversight, and the primary care groups, responsible (ultimately) for the day to day commissioning of care within the framework of the Health Authority's Health Improvement Programme. According to the White Paper, the "internal market" will be abolished by replacing the current contracting system with longer-term "service level agreements" agreed by NHS trusts, primary care groups and Health Authorities. Such agreements must last at least three years, and could last for as long as five to ten years where planning on this time-scale is appropriate.

The White Paper distinguishes between these service level agreements and the current contracting system in a number of ways: through the longer-term approach; through the greater involvement of clinicians in the commissioning process; through a greater emphasis on "programmes of care" for patients, rather than each individual episode of care; and through different methods of ensuring quality of care. While one of the main quality "levers" in the internal market was (in theory at least) the ability to switch contracts from one provider to another, the White Paper emphasises that such switches in future should only occur after due notice has been given and after other avenues, such as discussion between the relevant primary care group and trust, or the involvement of the new Commission for Health

Improvement (see below page 16) have been exhausted. While GPs will still retain the right to refer patients to hospitals outside these service level agreements where there is a clinical need for such a referral, it is suggested that this will happen far more rarely than at present, thus avoiding the transaction costs associated with many individual "extra-contractual referrals". The Government believes that all these changes will result in £1 billion being saved within the lifetime of this Parliament from the bureaucracy associated with the internal market.[8]

4. Resource allocation

A further significant change will take place as far as resource allocation is concerned. In the past, funding for "general medical services" (ie GP services) was routed from the Department of Health via Family Health Services Authorities. This was divided into "cash-limited" funding for GP infrastructure (items such as reimbursement of the salaries of GPs' employees, computing costs and building improvements) and demand-led ("non-cash-limited") funding for other items of GPs' remuneration, including the reimbursement of most drug costs. Funding for hospital and community services, on the other hand, was routed via District Health Authorities and GP fundholders. Even when District Health Authorities and Family Health Services Authorities merged in April 1996 to become "Health Authorities", the two funding streams remained separate.

The White Paper now proposes that the resources allocated to primary care groups for hospital and community services, for prescribing and for "general practice infrastructure" should be merged into one stream, thus allowing groups to move funding around between these broad categories. Effectively, this means that the hospital and community services budget, the cash-limited GP budget and part of the non-cash-limited GP "budget" will be combined into a single cash-limited allocation. There will therefore be no fixed limit on *individual* parts of the budget (such as community services, or drug costs), but each primary care group's budget as a whole will be cash-limited. This could be seen both as an increase in flexibility and a new constraint: there will be new opportunities to move spending between GP services and secondary services as appropriate to benefit patients, but at the same time non-fundholding GPs will have a firm limit on all their spending for the first time. (At present, GP fundholders already have cash-limited budgets both for prescribing and for hospital and community services, but non-fundholders have only "indicative" budgets for prescribing which could be exceeded if the GP practice could convince their Health Authority that there was a good reason for the overspend.)

A new "Advisory Committee on Resource Allocation" is promised, whose remit will be to refine the formula for allocating resources for both primary and secondary services to ensure that all primary care groups receive their fair share of resources. While primary care groups, and not individual GP practices, will agree service level agreements with NHS trusts, it is

[8] Cm 3807 p.75

expected that practices will eventually have "indicative budgets" and may perhaps be able to benefit from practice-level incentive schemes (ie where the individual practice, rather than the group as a whole, benefits from action taken by that practice), if the Health Authority agrees that such schemes will promote the best use of resources. The current funding available for fundholding management costs will be diverted to support the costs of running primary care groups, and each Health Authority area will be set a limit on the amount to be spent on management both by the Authority itself and by the groups within its remit.

B. Efficiency and performance management

One of the main aims of the introduction of the internal market through the 1990 reforms was to increase the efficiency with which NHS resources were used. There have been mixed views as to the success of this technique: there is a general consensus that the market reforms resulted in far more *information* becoming available as to how NHS funding is being spent (hence allowing purchasers to make better-informed decisions) but at the same time concerns have been expressed as to the financial costs of generating and processing this information: the so-called "transaction costs" of the internal market.

Since the 1990 reforms, one important way of measuring NHS performance and encouraging purchasers to contract with the most efficient trusts has been the "efficiency index". The index is basically a requirement that purchasers (through their contracts with NHS trusts) must achieve a set percentage increase in activity over the previous year. In 1996/97, for example, the index was set at 3%, so that in 1996/97 providers were expected to deliver 3% more care than in 1995/96, for the same amount of money from their purchasers. Criticisms of the efficiency index have included the potential for concentrating solely on *volume* of health care, rather than improvements in *quality,* and on the dangers of perverse incentives, where highly efficient trusts are still expected to deliver the 3% increase, regardless of the fact that they may already be operating with much lower costs than their competitors. In response to these criticisms, the Department of Health introduced a quality element to the calculation and also allowed Health Authorities to apply different targets to the various trusts from which they purchase care, in order to take account of initial variations in efficiency. Despite these amendments to the way the index works, it has remained very unpopular: health economist John Appleby commented in the 1997/98 *NHS Handbook* that "so far, experience suggests that it is extraordinarily difficult to devise a robust, meaningful and tamper-proof measure which can act as both a monitoring and target-setting tool".[9]

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[9] NHS Confederation, *NHS Handbook 1997/98,* 1997 p.59

The White Paper proposes a new "performance framework" to encourage efficiency in the NHS, measuring six areas of performance:

- health improvement in the local population
- fair access to services, irrespective of geography, class, ethnicity, age or gender
- effective delivery of effective, appropriate and timely healthcare
- value for money
- the experience of patients and carers, measured through a new national patient survey
- health outcomes of NHS care

A consultation document on the detail of this new performance framework was issued on 21 January 1998.[10] Proposed measures of performance include death rates, emergency re-admissions for older people to hospital, the costs of treatment and the length of stay in hospital. Comments on the consultation paper are invited by 20 March 1998, with the new system being implemented from 1999.

The White Paper also promises that in the future NHS trusts will be required to publish and "benchmark" their costs on a consistent basis, so that costs can be compared from trust to trust. This will create a national schedule of "reference costs". Where local trusts' costs are high in relation to these national reference costs, primary care groups, Health Authorities and NHS trusts will be required to investigate why this is the case, and build plans to increase efficiency in their long-term plans. If trusts are unable to make progress over a reasonable time period, the Regional Offices of the NHS Executive will be able to intervene.

C. Quality

The White Paper gives a particular emphasis to the importance of improving the quality of care in the NHS. It outlines how, in future, national standards and guidelines will be set for the NHS, how an emphasis on quality will be encouraged at local level, and finally how the centre will ensure that these standards are adhered to.

Nationwide standards of care will be promulgated through "national service frameworks", based on research evidence and agreed with the professions for major areas of care. This idea builds on the recent "Calman/Hine" proposals for cancer services: as a result of a report[11] by the Chief Medical Officers of England and Wales in 1995, national guidance was issued on how cancer services should be provided in England and Wales with the aim of eliminating unacceptable variations in services. An annual programme for the development of these

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[10] Dept of Health, *The new NHS modern and dependable: a national framework for assessing performance: consultation document*, January 1998

[11] Dept of Health & Welsh Office, *A policy framework for commissioning cancer services*, April 1995

frameworks should begin in 1998. A "National Institute for Clinical Excellence" will also be set up to improve the dissemination of good practice, through the production of clinical guidelines (based on evidence of both clinical and cost effectiveness) and methodologies for clinical audit. The White Paper recognises that similar work is already being carried out by a variety of organisations (for example the *Effective Health Care* bulletins produced by the NHS Centre for Reviews and Dissemination at the University of York), but suggests that there are benefits to be gained from bringing all such work funded by the Department of Health under one roof.

In order to increase the emphasis on quality at local level, the White Paper states that every NHS trust will be required to take on the concept of "clinical governance", extending the concept of "corporate governance" (the importance of accountability and maintaining public services values) which has been much emphasised in the NHS since 1994.[12] Trusts will be given a new statutory duty concerning the quality of care they provide, and trust chief executives will be ultimately responsible for ensuring that this duty is met, in the same way that they are currently responsible for ensuring statutory financial duties are complied with. It is suggested that one way in which they might meet this obligation could be through the creation of a sub-committee of the trust board responsible for ensuring the internal "clinical governance" of the trust. Boards will receive monthly reports on quality, in the same way as they receive financial reports, and will be expected to publish an annual report on action being taken to assure quality. Quality measures will also be included in the service agreements between Health Authorities, primary care groups and NHS trusts.

In order to "police" quality of care at a national level, the White Paper also proposes a "Commission for Health Improvement". This will be a statutory body, at arm's length from the Department of Health, with the remit of supporting the development of local quality arrangements and, where necessary, of intervening where serious or persistent problems arise. In cases of systematic failure, the Commission will be able to recommend immediate action to the Secretary of State, who will be empowered to remove NHS trust chairs or non-executive directors. It is also suggested that the Commission could undertake a series of thematic reviews, investigating how the national frameworks and guidelines issued by the National Institute for Clinical Excellence are being implemented at local level. Members of the Commission will come from the NHS, the health professions, health academics and patient representatives.

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[12] In April 1994, the Department of Health published a *Code of Conduct* and *Code of Accountability* to set out the values expected in NHS management.

D. Specific promises

In addition to the structural changes described above, the White Paper also makes commitments to three specific initiatives which are seen as exemplifying the new approach:

- the introduction of a new 24 hour telephone advice line, NHS Direct, staffed by nurses, with the aim of giving patients fast and easy access to advice and information on health and the health service;

- the connection of all GP surgeries and hospitals to "NHSnet", the NHS's "information superhighway", so that information can flow quicker throughout the NHS and tasks like booking outpatient appointments and transferring test results can be performed more efficiently;

- a guarantee that anyone with suspected cancer can see a specialist within two weeks of being referred by their GP. This will be guaranteed for everyone with suspected breast cancer by April 1999 and for all other cases of suspected cancer by 2000.

E. Time-scales

The table overleaf sets out the proposed time-scale for the implementation of the White Paper:[13]

[13] Cm 3807 p.79

Early Milestones

1998

- three telephone advice helplines set up
- projects established to demonstrate benefits of NHS' own information superhighway
- new Information Management and Technology Strategy for the NHS published
- consultation documents on quality and performance issued
- Public Health Green Paper *Our Healthier Nation* issued
- Health Action Zones begin
- new NHS Charter
- first survey of users and carers
- Health Authorities begin work with partner organisations on prototype Health Improvement Programmes for the period beginning 1999-2000
- GP Commissioning Pilots begin
- development work on Primary Care Groups, on new financial arrangements, and on new performance indicators

1999

(Precise timing subject to legislation)

- two week waiting time for urgent suspected breast cancer cases
- new Primary Care Groups begin, subsuming GP fundholding
- new statutory duties on partnership, health and quality
- development of local clinical governance, the new National Institute for Clinical Excellence and Commission for Health Improvement
- new unified local health budgets for hospital and community services, GP prescribing and the general practice infrastructure
- new funding arrangements for NHS Trusts in place

III Scotland and Wales

A. The Scottish White Paper: *Designed to care*

The general thrust of the Scottish White Paper[14] mirrors that in *The new NHS* with the same emphasis on the retention of the purchaser/provider split and the abolition of the internal market. However, there are a number of significant differences in the way these aims are to be achieved. Below are summarised the main proposals, with differences from the English White Paper highlighted. Clearly, many of the details of the policy will in fact be decided by the future Scottish Parliament, rather than by Westminster.

Health Boards (the equivalent of English and Welsh Health Authorities) will take on a more strategic role, concentrating on how to improve public health, with new powers of approval in relation to capital planning, property and senior medical appointments. However, they will also retain basic responsibility for commissioning services from NHS trusts, discharging this responsibility through their "Health Improvement Programme" which will cover a period of 5 years and set out how the Health Board intends to promote health, tackle health inequalities, develop services and implement clinically effective practice. NHS trusts, similarly, will have "Trust Implementation Plans", and the Health Improvement Programme and Trust Implementation Plan in each Health Board area will set out the range and quality of services which the trust is required to provide for its allocated funding. This will replace the current contracting system. In most Health Board areas, acute trusts (ie trusts providing acute hospital-based services, as opposed to community services) will be merged so that there is only one trust per Board, although the White Paper suggests this may not be feasible in Glasgow and Lothian. The configuration of acute trusts will be considered as part of the "acute services review" already taking place in Scotland.

The proposed roles for GPs and other health professionals working in primary care could be regarded as both more circumscribed and more radical than the English proposals. The Scottish rough equivalent of the English "primary care groups" will be known as "local health care co-operatives", covering natural communities of between 25,000 and 150,000 people, depending on local geography. However, these co-operatives will not be responsible for commissioning acute hospital services in the same way as in England. Instead, they will be brought together with other primary and community services to form "primary care trusts". These trusts will receive funding from their Health Board to cover the cost of providing GP services, GP prescribing, and community services (including non-acute hospital services for patient groups like those with learning disabilities, people with mental illness and frail older people). The trust will then allocate funding to the co-operative; the extent to which the co-operative, rather than the trust as a whole, takes budgetary responsibility for community

[14] Cm 3811

services will depend on local circumstances. While co-operatives will be responsible for managing their own budget, the actual cash will be administered by the trust. If GPs do not wish to join a co-operative, they will be allocated a notional budget for prescribing, together with their share of GP funding. While GP fundholding in general will be brought to an end, in areas where there is no co-operative, existing GP fundholders will be allowed to continue to hold a budget for community-based services.

Health Board funding will thus be divided between "acute trusts" and "primary care trusts", but the two groups of trusts will not be involved in commissioning care from each other. Trusts will be held accountable to their Health Board through their Trust Implementation Plans; they will also be required to publish a range of clinical performance indicators each year, to demonstrate the effectiveness of their care. Trust boards will be renamed "trust teams", and non-executive directors "trustees", with the chair also acting as a non-executive director of the Health Board. As in England, trusts will also be given a new statutory duty reflecting their responsibility for the quality of care they provide. A review of the various organisations and initiatives involved in promoting quality (the Clinical Resource and Audit Group, the Scottish Health Purchasing Information Centre and the Scottish Needs Assessment Programme) has been commissioned, with the aim of building a "nationally organised process of quality assurance." A new "Scottish Health Technology Assessment Centre" is also promised, with the remit of evaluating the cost-effectiveness of all innovations in health care, including new drugs.

The importance to be placed on collaboration, rather than competition, is emphasised throughout the White Paper. Primary care professionals are expected to work together in local health care co-operatives; acute trusts and primary care trusts will be expected to work together to provide "integrated care" to patients, and to make use of "joint investment funds" held by the Health Authority to support changes in the way care is delivered; and the need to liaise closely with local authorities is also stressed. It is also made clear that potential problems with services in a trust cannot be dealt with simply by moving funding elsewhere: the Paper states that there must be "collective ownership" of such problems, with trusts and Health Boards working together to deal with them. Particular emphasis is given to the need to apply the principles of "partnership" to the NHS workforce, through involving and consulting staff on issues affecting their jobs and encouraging staff development. A comprehensive training and development strategy is promised.

On funding, the Government believes that the new structures will save £100 million in administration costs in the lifetime of this Parliament.[15] The White Paper promises "annual real increases" in funding and states that these increases, together with the ability to find more efficient ways of providing services, will be enough to allow the NHS to provide a comprehensive health service. A review of how NHS resources are allocated between Health Boards will aim to ensure resource distribution is as fair as possible.

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[15] HC Deb 9 December 1997 c.492W

Other specific initiatives and changes announced in the White Paper include:

- the establishment of "one-stop clinics", where all tests are carried out in one day, with results ideally also being available on that day

- providing electronic links between all GP surgeries in Scotland during 1998, with the aim of ensuring that by 2002 it will be possible for all patients to be given a precise time for a hospital appointment before they leave their GP's surgery

- a new Patient's Charter

- extending the remit of the existing NHS Helpline to provide information on local health and social care services

Implementation is planned as follows, subject to the availability of Parliamentary time for the necessary legislation:

• **First Health Improvement Programmes completed**	**March 1998**
• **Boards consult on preferred configurations of Trusts**	**March 1998**
• **All GPs in Scotland linked electronically**	**March 1998**
• **First Trust Implementation Plans published**	**April 1998**
• **Human Resources Strategy for NHS in Scotland published**	**April 1998**
• **Acute Services Review reports, including recommendations on quality assurance**	**May 1998**
• **List of key performance indicators published**	**July 1998**
• **Report of Review of Resource Allocation published**	**December 1998**
• **Scottish Health Technology Assessment Centre established**	**December 1998**

- **Fundholding ends** **March 1999**
- **First Primary Care Trusts established** **April 1999**
- **Reconfiguration of Acute Hospital Trusts completed** **April 1999**
- **Unified funding stream for drugs and HCHS implemented** **April 1999**[16]

B. The Welsh White Paper: *NHS Wales: putting patients first*

The proposals contained in the Welsh White Paper[17] are broadly similar to those in England. As in Scotland, though, devolution of power to a Welsh Assembly will mean that many future decisions on detail will be taken by the Assembly rather than in Westminster.

Health Authorities will take on a more strategic role: they will be given the responsibility for developing Health Improvement Programmes, and will gain new powers to intervene where other NHS bodies are not acting in accordance with the Programme. In particular, they will have reserve powers over the configuration of local services, capital planning and senior medical appointments if they feel that NHS trusts are acting in a way which might conflict with the Health Improvement Programme. They will also be given a new statutory duty of co-operation with local authorities and other NHS bodies.

"Local health groups" of GP practices, other community health professionals, social services representatives and voluntary sector representatives will be set up as sub-committees of Health Authorities, with the remit of commissioning health services for their local populations. These parallel "primary care groups", but with a number of differences: they will remain sub-committees of Health Authorities, rather than gaining independent "primary care trust" status as in England, and they will formally include representatives from social services departments and the voluntary sector. Although they will be sub-committees of Health Authorities, they will be expected to have more than an advisory role: they will have access to budgets covering hospital and community health services, prescribing, and GP staff, premises and computers (currently the "cash-limited" part of GP funding), and will have the freedom to shift funding between these areas in the interests of patient care. The actual flow of funds, though, will be between the Health Authority and the trust, based on the local health group's decisions. Contracts between Health Authorities/GP fundholders and NHS trusts will

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16 Cm 3811 p.32
17 Cm 3841, 15 January 1998

be replaced with longer-term agreements, lasting at least three years. Individual GP fundholding will be abolished.

The proposals aimed at improving the quality of care are also very similar to those in England. The NHS in Wales will be involved in the establishment of the National Institute for Clinical Excellence and the Commission for Health Improvement and will participate in the national service frameworks for particular diseases or patient groups. A specific commitment is made to developing a national service framework for cervical cancer during 1998. NHS trusts and local health groups will also be required to adopt the principles of "clinical governance": trusts will be given a new statutory duty governing the quality of care they provide while local health groups will be required to agree action plans with their Health Authority on clinical effectiveness and clinical audit. The Welsh Assembly will have powers to intervene if there are serious failures in the quality of NHS trusts' services.

NHS trusts will remain autonomous public corporations but will be given a new statutory duty of co-operation with other NHS organisations. The future configuration of trusts is currently the subject of a review,[18] with the aim of much reducing their current numbers. Health Authorities and local health groups will be expected to develop their own arrangements for monitoring the performance of trusts. The main mechanism for doing this will be the long-term agreements between purchasers and trusts, in which expectations regarding volumes of activity, quality of services and financial management will be agreed. Ultimately, the Welsh Assembly will be responsible for monitoring trust performance, and the Assembly will be able to intervene in individual cases if necessary. "Benchmarking" between trusts will be used to highlight where an individual trust's costs are higher than average; where this is the case, the trust, the Health Authority and the local health group will be expected to work together to reduce costs, while retaining the same quality standards.

Specific initiatives, paralleling those in England and Scotland, include a new NHS patients charter for Wales, the testing of a new waiting list prioritising system, and a guarantee that all urgent referrals for breast cancer will be seen within 5 working days.

[18] see Library Research Paper 97/130 for a fuller discussion of this review

IV Reactions to the White Papers

The White Papers have received a generally warm welcome from the healthcare professions, from health and social policy commentators, and from patient representatives; indeed the *Health Service Journal* suggests that "initial reactions to *The new NHS* ranged from the merely warm to the ecstatic".[19] Most of the comments have concentrated on the proposals for England; those specifically concerning Scotland and Wales are discussed below in sections E and F, but many of the general comments will apply across all three countries.

The British Medical Association, the Royal College of Nursing, and the Association of Community Health Councils of England and Wales all offer a "broad welcome" *to The new NHS*,[20] while representatives of senior NHS managers and a range of academic commentators writing in both the health service and mainstream press expressed generally positive views. Chris Ham, director of the Health Services Management Centre at the University of Birmingham, for example, describes the contents of the White Paper as "a radical vision of the future" and "a programme likely to command widespread support from those working in the health service";[21] academics of the King's Fund suggests that the "content of the proposals look sound"[22]; and Howard Glennerster and Julian Le Grand of the LSE offer a "cautious welcome".[23] Stephen Thornton of the NHS Confederation (which represents the employer interest in the NHS) describes the general emphasis as "extremely positive" and "go[ing] with the spirit of the times", while the president of the Institute of Health Service Managers (which represents individual managers) applauds the "direction of travel".[24] Only the *Observer* expressed strong scepticism, calling the proposals a "conjuring trick" and suggesting that they will do nothing to counteract chronic under-funding in the NHS.[25] However, despite the almost universal initial enthusiasm, the phrase "the devil will be in the detail" has been much used and a range of questions have been raised over specific aspects of the proposals. These are discussed further below.

Despite the broad consensus on the desirability of what is proposed, conflicting opinions are being expressed as to its magnitude. A number of commentators, including Chris Ham and the *Guardian* leader writer[26] have emphasised how "radical" they believe the proposals are, while on the other hand academics from the King's Fund suggest they constitute a "compromise", "evolution not revolution",[27] and Glennerster and Le Grand from the LSE

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19 "White Christmas", *Health Service Journal*, 18 December 1997 pp 10-13

20 ACHCEW, *Health Perspectives*, January 1998; Royal College of Nursing, *Parliamentary Briefing*, 9 December 1997; British Medical Association press release, 9 December 1997

21 "Forward through fusion", *The Guardian*, 7 January 1998 p.3

22 "New Labour, new NHS?" *British Medical Journal*, 20-27 December 1997 pp 1639-40

23 "NHS is not dead yet", *The Guardian*, 10 December 1997 p.19

24 quoted in "Managers welcome white paper's radical direction", *Health Service Journal*, 11 December 1997 p.4

25 "Conjuring trick no magic pill for NHS", *The Observer*, 14 December 1997 p.17

26 "New Labour's healthy third way", *The Guardian*, 10 December 1997 p.18

27 "New Labour, new NHS?", *British Medical Journal*, 20-27 December 1997 pp 1639-40

believe that "the key elements of the old internal market will be retained".[28] Such disagreements are perhaps unsurprising, given the lack of consensus on whether the concepts of the "purchaser/provider split" and the "internal market" could or could not be separated (see above, page 9). A number of commentators have emphasised where the proposals build on existing structures, with the *Times* highlighting " a good deal of continuity with the Tories' NHS reforms,"[29] while the *Financial Times* suggests that "the political rhetoric about "sweeping away" the internal market is in danger of obscuring the fact that some of the Conservative reforms remain intact".[30] Responding to the Secretary of State's statement on the publication of the White Paper, the Conservative health spokesperson, John Maples MP, certainly took this line, welcoming "the Government's acceptance of many of the principles of the internal market", but expressing concern that the new group commissioning model might prove "too prescriptive" and opposing the abolition of fundholding.[31] Simon Hughes MP, speaking for the Liberal Democrats, welcomed the abolition of what he called "the Tory internal market", but claimed that an internal market of sorts still remained; while assuring the House that "a serious White Paper on the future of the NHS is very welcome", he went on to make a number of criticisms of the detail, including doubts as to whether the new method of commissioning would really be so much more cost-effective than the existing one.

A. Primary care groups

Much of the comment on the detail of the White Paper has focussed on the role of the primary care groups and their future responsibilities for commissioning services. Comment on the general principle of the groups has been favourable, with, for example, the *Guardian* leader writer suggesting that this "clever compromise" has won over "not just the fundholders but even the Conservative front bench"[32] and commentators from the King's Fund writing that "at first glance, this seems like a sensible evolution from the current plethora of purchasing models".[33] The British Medical Association describing the proposals as "a vote of confidence in general practitioners"[34] and the Royal College of Nursing, who were concerned before the election at Labour's emphasis on the role of GPs over other primary care practitioners such as nurses, welcomed the recognition given to the role of community nurses in the final version of the policy.[35]

It would perhaps be misleading, though, to conclude that the proposals on primary care groups have fully satisfied GP fundholders. The chair of the National Association of Fundholding Practices, Rhidian Morris, was reported in the *Health Service Journal* as saying

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28 "NHS is not dead yet", *The Guardian*, 10 December 1997 p.19
29 "This takes us further down the American way", *The Times*, 10 December 1997 p.11
30 "Some Conservative reforms will remain intact", *Financial Times*, 10 December 1997 p.11
31 HC Deb 9 December 1997 cc 799-801
32 "New Labour's healthy third way", *The Guardian*, 10 December 1997 p.18
33 "New Labour, new NHS?", *BMJ*, 20-27 December 1997 pp 1639-40
34 BMA press release, 9 December 1997
35 RCN, *Parliamentary Briefing*, 9 December 1997

that his organisation as yet did not know whether it supported the proposals; much would depend on the detail, and the extent to which individual GPs and GP practices would have real power to make changes.[36] Similar points were made by Conservative spokesperson John Maples who promised that he "would press the [Secretary of State] to allow maximum flexibility in his new commissioning group structure, and let GPs choose control over practice-based budgets if that is what they want".[37]

Although the concept of "primary care groups" is very much built on GP commissioning groups, representatives of GP commissioners have also expressed some reservations. Ron Singer of the National Association of Commissioning GPs [NACGP] is quoted as stating that NACGP felt "vindicated" by the White Paper, but that the organisation felt some concern about the four stage model of commissioning proposed. As far as NACGP was concerned, the preferred model was the first stage: advising Health Authorities on purchasing plans. Requiring all groups to hold their own budgets he felt would be "problematic".[38] Indeed, before the publication of the White Paper, Dr. Singer described the idea of requiring all GP commissioning groups to hold actual, rather than indicative, budgets as "fundholding made compulsory" and "completely unacceptable".[39]

1. GP incentives

Quite apart from the central issue of how budget-holding will work, both representatives of the health professions and health service commentators have raised a host of questions about the way the policy of primary care groups will develop in practice. One of the most crucial of these relates to the *motivation* of GPs and the incentives that may be necessary for them to work successfully in groups both with other GPs and with community nurses. John Maples MP suggested that the proposed structures showed a "touching old Labour faith in co-operation and good will,"[40] and although Frank Dobson in response was happy to "plead guilty to that any day", a similar point has arisen in a number of commentaries. The King's Fund researchers, writing in the *BMJ*, ask what incentives there will be for GPs to participate in the new groups and suggest that considerable management and IT support will be necessary, particularly for those GPs who are inexperienced in purchasing.[41] It seems clear from the White Paper that the Government envisages all areas of the country will be covered by primary care groups, but it is less clear how unwilling GPs could be required to participate. A *Health Service Journal* editorial alludes to the difficulties inherent in encouraging individualistic GPs (whose status is that of private contractors, not employees) to co-operate with each other, suggesting that many GPs would regard the word "colleague"

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36 "White Christmas", *Health Service Journal*, 18 December 1997 pp 10-13
37 HC Deb 9 December 1997 c.800
38 "White Christmas", *Health Service Journal*, 18 December 1997 pp 10-13
39 "Dobson faces a 'horrible time' over GP budgets", *Health Service Journal*, 27 November 1997 p.8
40 HC Deb 9 December 1997 c.800
41 "New Labour, new NHS?", *BMJ*, 20-27 December 1997 pp 1639-40

as "an excessively warm term of endearment" for their other local GPs. [42] The previous week's editorial in the same journal raised doubts as to how happy the average GP would be to "have so much influence showered on them" and suggested that "steeped in the culture of the independent contractor, their diverse outlooks make collaboration and effective representation tricky".[43]

2. Management

The King's Fund point about the need for high quality management is taken up by a number of other commentators, concerned both to emphasise that GPs (and community nurses, though they are less often mentioned) cannot be expected to take on extra responsibilities without adequate recognition and support, and that good quality management will be essential for the success of primary care groups. The British Medical Association emphasises that "commissioning cannot be done on the cheap" and that GPs will expect the resources necessary both for management support and to reward doctors for their "contribution to the commissioning process." Both the King's Fund researchers and managers' leaders express some concern over the capping of management costs in primary care groups: the former suggest that "without adequate management support, primary care groups will be a damp squib,"[44] sentiments echoed by the Chair of the Association of Managers in General Practice and the director of the Institute of Health Services Management.[45]

3. Structure and accountability

The future accountability and structure of the primary care groups is an issue which most commentators have raised. The role and membership of Health Authority and NHS trust boards has been a subject of controversy since the last reforms: concerns have been expressed as to the criteria used for selection, and allegations made as to undue political bias and undue emphasis on particular backgrounds such as business knowledge or involvement in local government. The extent to which the commissioning decisions of primary care groups are accepted by their local populations may well depend on the extent to which they are seen as locally accountable bodies. Managers' leaders quoted in the *Health Service Journal* disagree on the likely effect on NHS accountability of the proposed changes. Karen Caines of the Institute of Health Services Management, on the one side, expresses doubts as to how much influence Health Authorities will genuinely have to ensure the primary care groups act properly, suggesting that Health Authority powers will be limited either to taking away some of the group's powers, or closing them down altogether and taking over their functions, a role that they are supposed to have lost. Stephen Thornton of the NHS Confederation, on the other

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[42] "Short-lived season of goodwill", *Health Service Journal*, 18 December 1997 p.17
[43] "Papering over the cracks?" *Health Service Journal*, 11 December 1997 p.17
[44] "New Labour, new NHS?", *BMJ*, 20-27 December 1997 pp 1639-40
[45] "White Christmas", *Health Service Journal*, 18 December 1997 pp 10-13

hand, argues that currently Health Authorities are really not in a position to challenge fundholders' decisions and that the proposals will enhance accountability: "under the new regime, people will have to show that they are doing things in the interest of the NHS and health gain locally".[46]

The question of the role of other health care professionals in the groups has also been raised. Although the White Paper emphasises that primary care groups will include community nurses as well as GPs, much of the comment has focused on GPs, and the danger must exist of nurses being "squeezed out" because of their traditionally less powerful position. A *Health Service Journal* editorial, for example, asks how community nurses will become involved in those parts of the country where they are not currently attached to individual GP practices.[47] Representatives of other health professions not included in the primary care groups, such as physiotherapists, have also been reported as expressing concern as to their role.[48]

4. Primary care trusts

The idea of primary care groups developing, at their fourth stage, into "primary care trusts" with responsibilities for providing community services such as district nursing and health visiting as well as traditional GP services has received a fair amount of attention, with Chris Ham of Birmingham University describing the idea as "the most imaginative proposal in the white paper".[49] Professor Ham suggests that such trusts will be beneficial both in that they should bring together aspects of non-hospital care which are currently delivered by separate organisations, and because they will combine the delivery of services in the community with the commissioning of hospital services. This should result in patient services becoming better co-ordinated, in a greater emphasis on health promotion (as the financial benefits of preventing ill-health become apparent) and, possibly, in hospital consultants and GPs working closer together because the trust will provide a base for consultants to work in more community-based surroundings. Interest in becoming a primary care trust has already been expressed by a community trust and six GP fundholding practices in Andover.[50]

Both Professor Ham and a *Times* journalist, Peter Riddell,[51] make comparisons between primary care trusts and "health maintenance organisations" (HMOs) in the United States. Essentially HMOs are both clinically and financially responsible for the health care of patients enrolled with them: they therefore have every incentive to promote good health in the first place to avoid the demand for expensive health services at a later stage. Other aspects of HMOs identified by Ham include the imaginative use of nurses, the use of clinical guidelines

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46 "White Christmas", *Health Service Journal*, 18 December 1997 pp 10-13
47 "Short-lived season of goodwill", *Health Service Journal*, 18 December 1997 p.17
48 "Dobson warned on reform", *Financial Times*, 19 January 1998
49 "Forward through fusion", *The Guardian Society*, 7 January 1997 pp 2-3
50 "Proposal for first primary care trust", *Health Service Journal*, 8 January 1998 p.5
51 "This takes us further round the American way", *The Times*, 10 December 1997 p.11

to ensure uniformity of treatment and the encouragement of doctors from different specialities working closely together. Professor Ham goes on to cite warnings from the HMO experience in the USA, suggesting that they encourage "cream-skimming" of patients (though this would only be a problem if primary care groups were allowed to select their patients in some way, which seems unlikely), may lead to loss of faith in doctors by patients if they believe financial considerations are playing too large a role in clinical decision-making, and may also suffer from a perceived lack of accountability. A letter to the *Times* following Peter Riddell's article made a rather different point, suggesting that "even the most frugal" of HMOs in the US provides rather more elaborate care than is currently available on the NHS and that more "empowered" patients, with a greater willingness to pay for healthcare (either directly or through taxation), would be needed to make a genuine different to the NHS.[52]

B. Quality of care

While much of the press and academic comment on the White Paper has concentrated on the structural changes and the role of the primary care groups, other aspects of the Paper have received more fleeting attention. The proposals on quality, however, have in general received a positive response: the BMA, the Royal College of Nursing, the Association of Community Health Councils for England and Wales (ACHCEW) and Simon Hughes MP for the Liberal Democrats have all made positive references to the proposals to set national standards of service through a National Institute and through service frameworks, and to monitor quality through a Commission for Health Improvement.[53]

The possible roles of a National Institute for Clinical Excellence and a Commission for Health Improvement have been commented on in rather more depth in the *Health Service Journal* by Kieran Walshe from Birmingham University who suggests that the extent of the possible benefits will depend very much on how the proposals are worked out in detail.[54] He sees a very positive role for a National Institute in "sort[ing] out this nonsense of all HAs [Health Authorities] making their own separate decision about whether or not to buy new technologies, like Beta-interferon for multiple sclerosis and Donepezil for senile dementia" and is even more enthusiastic about the idea of the Institute being responsible for ensuring that new healthcare interventions (new techniques as well as new drugs) are both clinically effective and cost-effective before they become available on the NHS. However, to achieve this, he suggests that it will be essential for the Institute's recommendations to have *statutory* force, and not merely constitute good practice guidance. Otherwise, "past experience suggests its recommendations will often be ignored". A slight caveat on the idea of "national service frameworks" governing major diseases or patient groups has been raised by ACHCEW: the Association welcomes their potential for bringing poorer services up to the standard of the

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52 "Hard choices needed to fund NHS", letter to *The Times*, 16 December 1997 p.19

53 BMA press release, 9 December 1997; RCN, *Parliamentary Briefing*, 9 December 1997; ACHCEW, *Health Perspectives*, January 1998; HC Deb 9 December 1997 c.803

54 "NICE ideas on quality", *Health Service Journal*, 18 December 1997 p.20

best, but expresses concern that such frameworks should not be used to deny particular forms of treatment to patients who could benefit from them.[55]

On the subject of a Commission for Health Improvement, Kieran Walshe suggests that it might have two very different roles: either as a monitoring body, facilitating a "government sponsored programme of health service accreditation", or as an organisation mainly responsible for investigating the causes of disasters after they have occurred. He argues that while the former role could lead to worthwhile improvements in healthcare, the latter would reduce the Commission's usefulness to being "the official locker of stable doors". Other possible factors affecting the value of such a Commission raised in the article include its funding (concern is expressed that no new funds will be available to finance it) and the powers it may have: whether or not it will have the "teeth" to ensure its recommendations are followed.

The idea of "clinical governance", under which trust chief executives would become formally responsible for the *quality* of their services, as well as the trust's financial performance, is described by Mr. Walshe as "perhaps the most innovative quality improvement idea" in the White Paper and has also been welcomed by managers' leaders. Karen Caines of the Institute of Health Services Management has been reported as calling it "an excellent idea, and a real change", while Stephen Thornton of the NHS Confederation described himself as "warming to the idea" because of its ability to make clinicians more accountable, but expressed some doubt as to what levers chief executives will be able to use to ensure clinicians comply with protocols.[56]

One point made by a number of commentators on the proposals concerning quality is the emphasis on centralised control which contrasts with other aspects of the White Paper such as the desire to devolve commissioning to as local a level as possible. Karen Caines, for example, comments on the "very interventionist" flavour to the White Paper[57] and the King's Fund commentary in the *BMJ* refers to how the proposals will "strengthen central control over the quality of, and access to, clinical care".[58] While it is certainly the case that the introduction of service level frameworks and the dissemination of evidence-based clinical guidelines from one central point will tend to make care more uniform over the country, there are differing views on the extent to which the changes will affect variations in *access* to healthcare. As Kieran Walshe points out, a lot may depend on the powers of the National Institute of Clinical Effectiveness: if it decides that a particular new drug is clinically and cost-effective, will this mean that all Health Authorities *have* to make it available, or will this still lie within their discretion? Again, opinions vary on the desirability of uniformity: Julian Le Grand and Howard Glennerster from the LSE, for example, complain about "the nostalgic attachment to old-style performance management and the reluctance of the centre to let go"

55 ACHCEW, *Health Perspectives*, January 1998
56 "White Christmas", *Health Service Journal*, 18 December 1997 pp 10-13
57 *ibid*
58 "New Labour, new NHS?" *BMJ*, 20-27 December 1997 pp 1639-40

and describe the way guidance is currently issued by the Department of Health to Health Authorities as a "relentless bombardment".[59] A *Guardian* editorial,[60] on the other hand, complains that the White Paper has ducked the "rationing" argument (ie is it for the centre or for individual Health Authorities to decide what the NHS cannot afford to purchase?). The Royal College of Nursing, though, states that it "shares the Government's view that rationing is not inevitable", that is, that the NHS can afford all clinically necessary treatments.[61]

C. Co-operation with other bodies

The references in the White Paper to the importance of good relationships between the NHS and other statutory and voluntary bodies, especially local authorities, have been received very positively. While this emphasis is hardly new, the idea of a *statutory* duty of co-operation is seen as very helpful, as is the emphasis on co-operation rather than competition. The president of the Association of Directors of Social Services, Roy Taylor, for example, is reported as saying that "the language in the White Paper is very different from what we've become used to in previous years" and that "the idea of working more closely with health colleagues, particularly through the new primary care groups, is an exciting one".[62] Similarly, the *Municipal Journal* suggests that the White Paper proposals "start to recognise, in a meaningful way, the potential of working with local government", as opposed to "the usual woolly exhortations to partnership and mutual understanding".[63] The proposal that local authority chief executives should be able to participate in health authority meetings is particularly welcomed.[64]

While Mr. Taylor goes on to highlight potential practical difficulties inherent in joint working, in particular the issue that at present health and local authorities cannot pool their budgets, Chris Vellenoweth of the NHS Confederation suggests that legislation to make this possible is bound to come in the longer run.[65] It is also argued that much is currently possible, even without changes in legislation: social services managers and primary care groups could meet annually to decide priorities and agree how they would spend their budgets, without actually needing to merge their finances.

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59 "NHS is not dead yet", *The Guardian*, 10 December 1997 p.19
60 "New Labour's healthy third way", *The Guardian*, 10 December 1997 p.18
61 RCN, *Parliamentary Briefing*, 9 December 1997
62 "Primary concerns", *Community Care*, 18 December 1997 - 7 January 1998, pp 8-9
63 "A healthy partnership", *Municipal Journal*, 19 December 1997 pp 16-17
64 *ibid*
65 Primary concerns", *Community Care*, 18 December 1997 - 7 January 1998, pp 8-9

D. Funding

Many commentators highlighted the fact that no extra boost in funding is promised by the White Paper, other than the promise to raise expenditure in real terms every year. King's Fund academics, for example, called it a "notable omission" that there was nothing new as far as the overall funding of the NHS is concerned; the BMA expressed concern that delegating commissioning powers to primary care groups should not be used "as a smokescreen to conceal NHS underfunding" and a critical *Observer* writer suggested that "many doctors are sceptical of the Government's claim that it can cure the NHS without spending more money".[66] Some doubts have also been cast on the claim that the changes in commissioning arrangements will lead to £1bn savings in the lifetime of this Parliament: those expressing scepticism include Stephen Thornton of the NHS Confederation, Peter Riddell of the *Times* (though commenting that the figures had apparently been closely vetted by the Treasury), Simon Hughes of the Liberal Democrats and King's Fund researchers.[67] Managers, in particular, have emphasised that there still *will* be transaction costs associated with agreeing service level agreements with a number of primary care groups; and that, while longer-term agreements will be beneficial, it is misleading to suggest that currently all contracts are renegotiated every year, as many contracts are only amended at the margins.

E. Scotland

Both the Royal College of Nursing and the British Medical Association specifically welcomed the proposals in Scotland.[68] While many of their comments applied equally to the English White Paper (for example the emphasis on collaboration and the emphasis on the role of nurses), the BMA particularly singled out the specifically Scottish initiatives for one-stop clinics and for more convenient hospital appointments, suggesting that they "would make a very real difference".

A *Health Service Journal* editorial went rather further, suggesting that, as far as one can yet tell, the Scottish White Paper "may offer the better answers" to many of the NHS current problems.[69]

> "With a mandatory primary care trust in each Scottish health board area to formulate primary care policies and direct the future development of primary care services,

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66 "New Labour, new NHS?", *BMJ*, 20-27 December 1997 pp 1639-40; BMA press release, 9 December 1997; "Conjuring trick no magic pill for NHS", *The Observer*, 14 December 1997 p.17

67 "Managers welcome white paper's radical direction", *Health Service Journal*, 11 December 1997 p.4; "This takes us further down the American way", *The Times*, 10 December 1997 p.11; HC Deb 9 December 1997 c.803; "New Labour, new NHS?", *BMJ*, 20-27 December 1997 pp 1639-40

68 BMA press release 9 December 1997 & Royal College of Nursing, *Parliamentary Briefing*, December 1997

69 "Short-lived season of goodwill", *Health Service Journal*, 18 December 1997 p.17

> there will be less potential for divergence within each authority area; the model raises fewer accountability issues; and unlike England, it proposes that the local healthcare co-operatives which will replace fundholding should be able to hold budgets only for primary and community health services. The suggestion in *The new NHS* is that England, too, will head in this direction - but more slowly and in less united fashion. Whether the whole NHS will eventually get there must be a moot point, and the process will be painful and long drawn out."

More doubts have been expressed by the other political parties in Scotland. Margaret Ewing for the Scottish National Party, was reported as welcoming the proposals "as far as they go", but saying that they did not address "the main problem of a serious lack of resources for the Scottish health service".[70] In a similar vein, Michael Moore, the Liberal Democrats Scottish health spokesperson, suggested that there could be no long-term improvement in the Scottish health service until a long-term funding strategy is put into place.[71] A *Scotsman* editorial endorsed this view, asking how much difference savings of £100 million over 4 years would make, given a budget of £4.6 billion per year, and suggesting "the old, nagging problem of NHS funding remains".[72]

Other aspects singled out for comment include the reduction in the number of trusts, and the abolition of GP fundholding. On trust numbers, a Conservative spokesperson suggested that it was "bizarre" for a party committed to devolution to take steps which essentially involved centralising services.[73] The chair of the Scottish Association of Fundholding Practices reportedly described the proposed abolition of fundholding as the taking away of doctors' freedoms, and stated the Association's intention to fight for the retention of practice-based budgets.[74]

F. Wales

At the time of writing, very little comment has been received on the Welsh White Paper, but many of the general comments made about *The new NHS* will also apply to the similar proposals for Wales. The Royal College of Nursing "broadly welcomes" the Paper, and particularly its focus on quality, but regrets the fact that Wales will not initially be involved in trials for the new 24-hour helpline, "NHS Direct".[75] The British Medical Association also extend its general welcome to the Government's proposals to those concerning Wales.[76]

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70 "Shake-up delivers unique NHS", *The Scotsman*, 10 December 1997 p.1
71 *ibid*
72 "Closing down the internal market", *The Scotsman*, 10 December 1997 p.18
73 "Shake-up delivers unique NHS", *The Scotsman*, 10 December 1997 p.1
74 *ibid*
75 Royal College of Nursing, *Parliamentary Briefing*, 19 January 1998
76 BMA press release, 15 January 1998