Issues and Debates: A New NHS?

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Editorial comment: 'Issues and Debates' is the RPP section designed to bring readers informed comment and opinion on a wide range of topics from those who have their finger on the policy pulse. In this issue we focus on the content and implications of the recently published White Paper on the National Health Service.

For those who had read the Labour Party's ideas for the NHS whilst in opposition (The Labour Party, 1996), the long awaited publication of the Labour Government's White Paper for England, The New NHS (1997), brought few surprises. There is a confident endorsement of the NHS as a national service available to all and a firm commitment to increase spending on the NHS in real terms each year. Tacitly recognising that some of the previous government's reforms were effective, the proposed changes are evolutionary rather than revolutionary, conserving what worked previously - the purchaser-provider separation, the key role of primary care and the devolution of decision-making - but rejecting competition. Competition within the NHS is seen as synonymous with fragmentation, administrative profligacy and unhelpful secrecy.

The changes proposed in the White Paper follow from discernible differences in approach from those of Labour's predecessors. There is a restatement of the long-held principle of equity of health care which of necessity could not flourish in a system based on competitiveness between providers or purchasers. Equity has many facets: the concern about access to services is one of the more obvious and the ability of fundholding practices to accelerate the treatment of their patients was always going to make this initiative an early casualty. The centrality of the government's concern for a more equitable service is also evidenced by its commissioning of the Independent Inquiry into Inequalities in Health, whose report will be published this autumn. The elusive quest for equity will also be addressed in the annual priorities guidance which continue to set the broad commissioning framework for health authorities and consequently PCGs. Equally relevant is the concern in the White Paper to eliminate variations in clinical practice, in the hope of achieving what might be described as more equitable performance throughout the health service. Delivery of this goal is to be accomplished by clinical regulation, the identification of national standards for treatments and services and their incorporation in commissioning strategies. Performance monitoring will continue and will include the performance of the proposed Primary Care Groups (PCGs). Although the market will give way to a less competitive environment, Trusts will be expected to publish the costs of treatments and will face criticism if they are found wanting.

Cooperation and collaboration are to replace competition as the dynamic of change. It is hoped that this will apply not only to relationships between commissioners and providers as well as between community health services and primary care, but will extend beyond the organisational boundaries of the NHS to include local authorities and local communities. 'Local' is a word of great significance in the White Paper, with decision making devolved to the lowest possible level and with '... local doctors and nurses in the driving seat' (DoH, 1997:11). As well as staff in primary care, NHS Trust staff are to have a greater say in health service planning. But the emphasis on involvement moves beyond a narrow association of professional groups to hint at more pluralistic process of decision-making. Openness in governance is an underlined theme: both the New NHS and a subsequent health service circular (NHS Executive, 1998),
indicate the importance of improving public confidence in the NHS and Social Services Departments through more transparent processes and the greater involvement of local people in shaping services.

Some objectives reflect a continuation rather than a disruption of previous concerns. Predictably the drive for efficiency continues and is viewed as the means by which the NHS can safeguard the quality and range of provision. As did the previous government Labour see those new medical technologies, which deliver reduced costs and satisfactory outcomes, as one mechanism by which services can be maintained. Similarly there is concern about a perceived dissipation of scarce resources in unnecessary bureaucracy. Whilst the Conservatives set about reducing the administrative tiers of the NHS and streamlining management structures in general, however, the Labour Government have fixed on the accoutrements of the internal market. Fundholding was the first to be targeted with the eighth wave of fundholders embargoed a few weeks into office, but the writing is on the wall for health authorities in their present form and for purchasing departments in particular.

General practitioners - corralled gatekeepers?

The not unexpected but most significant proposal relates to primary care and general practitioners in particular. Whilst acknowledging the gains achieved by many fundholders, the initiative is described as costly, inequitable and fragmenting responsibility for care. Fundholding is curtly dismissed as 'yesterdays debate' (DoH 1997:3) and is to be replaced by PCGs or Primary Care Trusts (PCTs). There are three categories of PCG with different degrees of responsibility for commissioning whilst PCTs, the furthest along the evolutionary scale, also acquire responsibility for the provision of community health services. PCGs and PCTs are to be established around natural communities of about 100,000 (DoH 1997) and, where possible, boundaries are to be drawn to match those of local authorities (Whitfield, 1998). There is some inconsistency here between organic and bureaucratic approaches to community but past experience with joint planning between health authorities and social services authorities indicates that coterminosity is important (Audit Commission, 1986).

Practices will have some choice of PCG where their patient catchment straddles boundaries but all practices, whether fundholding or not are expected to participate. Subsequent guidance (NHS Executive, 1998) emphasises the need for local consensus and the need to command local support. Unilateral proposals are likely to receive a frosty response.

The simplest form of PCGs will mirror the functions of present locality commissioning groups in that they will advise health authorities on commissioning decisions relating to the local PCG population. Further along the spectrum, PCGs will take responsibility for managing health care budgets for their populations but will be technically a part of the health authority. As PCGs become more experienced they will be established as independent commissioners accountable to health authorities. The most 4mature' category is that of primary care trust in effect a purchaser of secondary care and provider of community as well as primary care services. Although PCGs by dint of their GP membership will also be providers as well as purchasers, the fully fledged PCT will have some similarities with US Health Maintenance Organisations (HMOs). They will not, however, cover as large a population as HMOs and this may possibly disadvantage them. Light (1998) suggests that size does indeed matter in purchasing, perhaps it will also in the 'New NHS'.

PCTs may take over responsibility for some community health services from existing trusts although it is unclear whether these arrangements will be the product of marriages of convenience or hostile takeovers. It is very likely that, in some areas, where there are significant numbers of standard fundholders or more advanced forms of purchasing such as multi-funds or total purchasing
projects, GPs will from the beginning seek independent commissioning or PCT status.

Like fundholding, PCGs will be allocated a budgets for their total population which will cover the purchasing of hospital and community health services, prescribing and practice administration costs and will be allowed to vire funds between budgets. They will also cover emergency care, an unpredictable demand but one which is partly dependent on GP decisions about clinical management. Overall these arrangements are intended to encourage more discriminating commissioning between primary and secondary tiers of care; they will also bring collegiate pressure to bear on maverick GP prescribing and referral practices. Some GPs see these arrangements as the thin end of the rationing wedge (Williams, 1998) a view echoed more generally according to Ham (1998). It is certainly the case that as PCGs progress to PCTs, GPs will take on the responsibility for the allocation of resources between services. The Governments logic that new medical technologies will reduce stays in hospital, coupled with the common and perhaps undiscriminating perception that care out of hospitals is cheaper than care in them, may induce further relocation of care to the community.

Changes at the interface of primary and secondary care are likely to increase pressure on social services departments and other agencies involved in commissioning or providing community care. They will also face a period of transition which will be intensified by the publication of a White Paper on social services later this year. Despite the pressures that changes bring, it will be to the advantage of all involved in the delivery of community-based care, including GPs, to ensure that services run smoothly. Most GPs’ experience of working with other agencies has been limited to social services and has involved mainly operational arrangements for traditional client groups. The role envisaged for PCGs will require collaboration over strategic planning and will involve a variety of agencies. There will be much to learn, not the least about each others’ organisational cultures; failure to work together effectively will have consequences for clients and workers alike.

PCGs however have had a mixed reception amongst GPs. Broadly welcomed by GP leaders (Anon, 1997), fundholders were not unexpectedly more critical about the replacement for fundholding (Williams, 1998). Williams also reported that many GPs were apathetic about the prospects of yet further upheaval. Early results of ongoing research with GPs conducted by the Social Services Research and Information Unit at the University of Portsmouth reveals similar concerns about the additional workload involved and a reluctance to become involved in ‘rationing’, but this is countered by the fear that if they do not participate health authorities will take the initiative. The prospect of influencing or taking control of commissioning seems too good to pass up. Either way, the government seems determined that all GPs should become involved in commissioning health care and that the level of responsibility should increase with time.

Dissolving the barriers

Where PCGs or PCTs take on additional commissioning responsibilities, health authorities will lose them. Their evolving role will entail two requirements: an obligation to improve the health of their population, which will become a new statutory duty placed on health authorities, and the monitoring of PCG/PCT performances which will be accountable to health authorities. Health authorities will be required to set out strategy via Health Improvement Programmes (HIPs) which will reflect national targets for public health. The Labour Government has already signalled its recognition of the broader constituents of public health than health services alone and The New NHS reinforces this perspective, emphasising the need for a collaborative approach with local authorities and other agencies. This approach is to be reinforced by new legislation which will
require local authorities to promote the economic, social and environmental well-being of their areas. Local Authorities will have clear powers to develop partnerships with health authorities and also PCGs or PCTs in order to respond to the needs of local communities. In turn PCGs will have governing bodies which include community nursing services and social services as well as local GPs. The requirement that local authorities and, in practical terms, social services departments become closely involved in prioritising local needs and strategic planning is welcome and institutionalises practices which developed in many areas following the 1990 health and community care reforms.

Although health authorities and local authorities will no doubt welcome the encouragement to work more closely there will be practical difficulties related to the inevitable organisational upheaval as the reforms roll out. Health authority mergers are likely, particularly as budget holding PCGs or PCTs emerge in their area. Organisational change will make it difficult in the short term for shire and metropolitan authorities to build firm relationships. In the longer term new health authority configurations may once again mirror former (Area) health authority boundaries which until 1982 were coterminous with county level authorities. Therein lies a paradox: although the creation of Health Improvement Programmes will remain the responsibility of health authorities, the emphasis on operational and some strategic planning will inexorably shift to the local level. Local social services departments, although they should be involved at an early stage with PCGs, will also gradually assume wider and more complex responsibilities. Maintaining and/or developing relationships as organisations metamorphose in form and function will be challenging for all involved. In contrast the relatively new unitary authorities may find themselves best placed, in a geographic sense, to accommodate the shifting focus of commissioning.

The underlying assumption of closer cooperation at health authority and KG level is that social services authorities will become more involved in strategic decisions about commissioning but from this should follow improved planning at the operational level. More specifically, health authorities are to work more closely with local social services on care planning with the objective of achieving more integrated services generated by joint investment-programmes. The White Paper hinted at the possibility of pooling health and social care budgets, particularly for services meeting the needs of clients with disabilities or mental health problems. This would require legislation to counteract present regulations which prevent local authorities from spending money on health care and which also mean that health service staff, such as care managers, can not allocate resources from social care budgets. Whether or not budgets are integrated, the closer involvement of local social services and health care personnel in planning services could deliver tangible improvements in the community. An early priority may be hospital discharge arrangements which may in turn ease pressure points such as emergency admissions. Shared budgets may also alleviate tensions relating to continuing care provision for client groups with disparate needs, but they will still require either a great deal of mutual trust or unambiguous criteria of access to joint resources. There may be additional beneficial spin-offs from closer social services-GP cooperation over community care planning, for example improvements and better working relationships in child protection processes.

If they needed one, there is a financial and pragmatic logic impelling GP members of PCGs and particularly PCTs to cooperate for, if commissioning processes inexorably lead to more care being delivered in the community, then efficient and effective health and social care services will help to offset what many GPs fear: an increase in their workload. There will be pressure to develop clear agreements. Given that the trend within NHS will be increasingly to structure client management around nationally framed protocols and service standards, arrangements for community care may be subjected to similar
influences. This is all the more likely where integrated services rely on joint funding and where inappropriate access to such provision may in effect result in some form of cost shunting between health and social services. More generally which budget - PCG/PCT or social services’ - funds particular types of cam for certain categories of clients may become a source of friction in embryonic relationships at the local level, as it has been in the past between health and social services authorities. PCGs/PC1s will contain former fundholders experienced in negotiations and contract management. Social services and community nursing departments will need to field staff at PCG level who not only have good analytic skills but also political adeptness. Investment will also be needed in information technology and systems which can share databases on population level information at least.

Collaborative working should help to develop, and in turn benefit from, richer networks. This is not merely about proliferation of contacts, although this will be important in the planning and operational management of services, but is also concerned about the quality of working relationships. Trust in relationships comes with time and experience and whilst many GPs spend their working lives in one practice, social services and community nurse managers are more itinerant, changing jobs and perhaps areas. Nevertheless attempts should be made to encourage the longevity of working relationships as well as ensuring that PCG/PCT representatives of social services departments and other agencies are given discretion in decision-making. GPs, who hitherto have operated with significant professional autonomy, are likely to view deferral of decisions to higher management with dissatisfaction.

Public involvement

The accents within the White Paper on decentralised decision-making and a more pluralistic and openly accountable process involving local communities faintly echo Hadley and Hatch’s (1981) vision of local services and some community development initiatives within the NHS. However, the tradition of patient participation is not well embedded in general practice or has not been accomplished effectively (Agass et al., 1991; Brown, 1994). Although health authorities have taken up the brief of the previous government (NHSME, 1992) and become involved in broader consultation with communities and service user groups, the agenda often has been owned by the health authority (North, 1997) or seen as a potential threat to embryonic HA-GP relationships (Lupton and Taylor, 1997). It is not clear how participative the process will be; there is an emphasis on inclusively ‘where appropriate’ (NHS Executive, 1998 unpaginated) but the clearest proposals relate to consultative processes. In pursuit of this the first national survey of patient and user experiences is to take place before the end of 1998 and there is a requirement that health authorities involve the public in the development of the Health Improvement Programmes and ensure that PCGs take the necessary steps towards encouraging public involvement including open meetings. This will be a political necessity as PCGs will be faced with difficult decisions about priorities in care, although the complex arguments intrinsic to such debates are not readily reduced to simple options.

PM are also to be encouraged to play ‘... an active part in community development and improving health in its widest sense’ (NHS Executive, 1998:39). This ‘could be taken as an endorsement of radical processes but the reality for most PCGs is likely to mean a more cautious engagement with the local community. Even if GPs are supportive of more participative processes, it is doubtful whether they will have the skills or the time to sustain them. In con~ social services departments may be more culturally attuned to the idea of community groups’ involvement and probably have more experience and confidence. They could do much to facilitate this at KG as well as health authority level. A more likely interpretation of the White Papers exhortation is modelled on the Health Action Zones initiative, which combines the ideas and energy of agencies such as
health, social services, housing and education. The added bonus will be that the more 'advanced' PCGs and PCTs will be able to
align resources with strategies in ways that the more ways that the more fragmentary purchasing of the internal market could not achieve.

A gamble?

No one should be in any doubt that GPs will be pivotal to Labour's 'new' NHS. If fundholders achieved streetwise purchasing in the past, then the design is that all GPs combine this 'knowledge from experience' with research based guidance from health authorities. Fundholding did have some successes in securing improvements for patients but the rewards, in the form of budget under spends reinvested in practice premises mid services as well as influence over providers, were self-evident. Conditions now do not seem so favourable. 'Me financial arrangements for PCGs/PCTs are unlikely to be generous and, with larger numbers of GPs, not to mention community nurses and other legitimately interested parties agreement on commissioning decisions may be harder to achieve. Add to this the probability that practices may have to police each others' prescribing, referral and staffing patterns and concerns that GPs might be held responsible for unpopular rationing of services, one can see why there may be reluctance on the part of some. In areas where there are positive experiences of multi-fundholding or locality commissioning, where there is support for the new ethos of the NHS or simply a reluctance to lose the influence GPs have so recently enjoyed, the interest and enthusiasm will carry the reforms forward. The Government are right to permit a gradual evolution; full blown primary care trust status is not for the faint-hearted.

Equally critical to a new NHS is the way the changing relationships between the various stakeholders are negotiated and nurtured. This is not only germane to the health service players - health authorities, PCGs and trusts, not to mention the various professional groups now included in this more consensual approach - but also to the wider network of agencies and community groups. GPs and to a lesser extent, community nurses, will become the common denominator in this complexity of relationships. However it will be the responsibility of all to ensure that cooperation secures a health service as dynamic as before but better placed to face the challenges of 2000 and beyond.

References


The Labour Party (1996) 'Renewing the National Health Service: Labour's agenda


